A review of peer support interventions in the recovery of mothers and pregnant people who use substances and an Interpretative Phenomenological Analysis of parents' experiences of power and threat in the context of a strengthening families approach to safeguarding

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THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: Shona Murdoch Date: 25.08.25

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To the parents who participated – thank you for your bravery in sharing such personal stories. The honesty, authenticity and vulnerability you brought was inspiring. Thank you also to the Dandelions group, who consulted on parts of this research. Your input was key to ensuring that the research would capture parents' experiences authentically.

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Contents

Thesis abstract

Paper one presents a systematic review of 10 studies which were concerned with the role of peer support interventions in the recovery of mothers and pregnant people (MAPP) who use substances. Experiences of and satisfaction with interventions were synthesised as well as their outcomes. A range of positive recovery related outcomes were found such as better connection to services, positive impacts on wellbeing, and the sense of community gained from and special relationship with peer support is described. Clinical implications include the use of peer support interventions in engaging this group in treatment and connecting them to the appropriate services, offering peer support as means of providing connection, validation and a sense of community, and more support and training to services and those conducting peer support interventions (PSIs) to ensure their fidelity and safety.

Paper two presents an empirical paper which used interpretative phenomenological analysis to explore parents' experiences of power and threat within a strengthening families approach (SFA) to safeguarding. Power imbalance is a well-documented feature of Children's Social Care (CSC) involvement and consequences of this contribute to poorer outcomes for families. There is no current research which explores parents lived experiences of power and threat within this context, which this study aims to address. Four parents participated in semi-structured interviews to explore their experiences of power and threat in a strengthening families approach to safeguarding. Interpretative Phenomenological Analysis (IPA) revealed three Group Experiential Themes (GETS): "Living in fear", "Invisible and unworthy" and "A space to be seen". Participants described living in threatening home environments, which made it difficult to engage with services. This threat was heightened by experiences of feeling insignificant and unheard within some professional relationships. Professionals who could provide safety and security, allowed parents to open-up, make sense of their difficulties and reclaim parts of their identity. Practice implications included the overt consideration of power by professionals, and ideas for how to rebalance this power somewhat. Future research could aim to understand the intersectionality of power within the lives of parents open to CSC and how this impacts engagement and relationship building.

Paper three presents an executive summary of the empirical paper. This was created as a succinct and accessible summary of key findings for parents who have had, or currently have children open to social care and for professionals working within this context.

Paper 1 – Literature review

Peer Support Interventions in the recovery of mothers and pregnant people who use substances: a narrative synthesis

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Keywords: peer support, substance misuse, mothers, pregnancy, peer support interventions

Highlights

- Peer support interventions take a variety of shapes and forms.
- The included studies represent a variety of aims and methodologies.
- Interventions promoted wellbeing, community and connection within this group.
- Peer support interventions seem viable and useful in the recovery of this group.

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Formatted for the Journal of Substance Use and Addiction Treatment. See Appendix C for guidelines.

Abstract

Peer support is an established method of intervention in a variety of UK sectors, such as criminal justice and substance misuse settings. Positive impacts have been found upon engagement of service users, their overall wellbeing and reductions in stigma. Mothers and pregnant people (MAPP) who use substances, face many barriers to accessing services, are heavily stigmatised and benefit from support for their own, as well as their dependents', health and wellbeing. This review provides a synthesis of peer support intervention outcomes, satisfaction, and experiences within this group. Four databases were searched with 10 studies fitting the inclusion criteria. A range of positive recovery related outcomes were found such as better connection to services, positive impacts on wellbeing, and the sense of community gained from and special relationship with peer support is described. Clinical implications include the use of peer support interventions in engaging this group in treatment and connecting them to the appropriate services, offering peer support as a means of providing connection, validation and a sense of community, and more support and training to services and those conducting peer support interventions (PSIs) to ensure their fidelity and safety. Issues with sampling, confounding variables and treatment fidelity may impact the reliability and validity of the results. Future research is warranted.

Introduction

Peer support can be defined as a structure of non-clinical support based upon shared lived experience, understanding, respect and empowerment (Substance Abuse and Mental Health Services Administration (SAMSA), 2024) and is an established avenue of support within several UK sectors including mental health, criminal justice and substance misuse (Office for Health Improvement and Disparities, 2023). Reviews have been undertaken in establishing the role that peer support can play in both mental health (Jones et al., 2014) and substance use (Stack et al., 2022) recovery[1] with positive effects noted in multiple facets. This review seeks to target a gap in the literature to understand the role PSIs can play in the recovery of MAPP who use substances, a heavily stigmatised sub-group with complex and intersecting needs.

Within the UK, women make up only 32.1% of those accessing substance use treatment (Office for National Statistics, 2023). This likely reflects the distinct challenges, complexities and barriers that women who use substances face. Compared to men, women who use substances are more likely to have more severe psychiatric and medical comorbidities (Campbell et al., 2018) as well as social vulnerabilities such as experience of interpersonal violence (Bailey et al., 2019) and other traumatic experiences, with an estimated 30 – 59% of women accessing treatment having a diagnosis of post-traumatic stress disorder (PTSD) (Najavits, 2002).

Those who are also MAPP face further challenges. Most obviously, detrimental impacts upon dependents such as damage to physical health via exposure to substances in utero (Yeoh et al., 2019) and potential detrimental effects on emotional and physical development (Finnegan, 2013). Children are more likely to be removed from mothers who use substances due to this increased risk of actual or potential harm (Elms et al., 2018), having negative impact on mothers' mental health and substance misuse (Neil et al., 2010), which can reduce the chances of reunification with their children. Distress and guilt associated with their substance

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[1] **Recovery definition -** For the purposes of this review the following definition of recovery was used: "a dynamic process of change characterized by improvements in health and social functioning, as well as increases in well-being and purpose in life." (Witkiewitz et al., 2020).

use (Adams et al., 2021), can similarly compound their difficulties, making it harder for MAPP to seek help. Additionally, MAPP face an additional layer of stigma (Barnett et al., 2021), with those who use substances already a stigmatised group (McNeil et al., 2021). A recent review found that stigma associated with this sub-group operates at many different levels, including institutionally, and suggested that services are upholding stigma and perpetuating barriers to this sub-group accessing parenting and substance-related support (Wolfson et al., 2021).

For those MAPP who do access support, better outcomes have been found for both mother and dependents. Amongst opiate dependent pregnant people, early access to pre-natal care and substance support was related to better foetal outcomes (Guan et al., 2019) and better connection to appropriate services has been linked to less chance of child removal (Grant et al., 2011). Access to support also provides an opportunity to break the intergenerational cycles of substance use and social care involvement (Meulewaeter al., 2019) which are well established in the literature.

The UK's most recent substance misuse policy "From Harm to Hope" emphasises the need to build better links between services to address the many intersects of need which come with substance use as described above and emphasises a need for up-skilling the workforce on these issues. The policy paper also highlights peer support as a valuable resource, reflected in the recent release of guidance on how to successfully integrate lived experience and peer support into substance misuse services to enhance the recovery of service users (Office for Health Improvement and Disparities, 2023).

Peer support can take many forms, for example informally via friends or family with shared experience or formally via a support group or a formal peer support structure such as via an employed peer support worker (PSW). For those who use substances, peer support has been found to be useful in reducing harm, sustaining recovery and maintaining engagement at any stage of their journey (Stack et al., 2022). Engagement with peer support has also been found to improve satisfaction and relationships with services and reduced substance use and relapse rates (Reif et al., 2014), as well as providing a unique working alliance (Bassuk et al., 2016) which offers personal connection, encouragement and hope (Stack et al., 2022).

Peer support initiatives are also commonplace for mothers within the UK and have been found to be effective in reducing anxiety and low mood and increasing self-efficacy and esteem during pregnancy and early motherhood (McLeish & Redshaw, 2017) and has also been found as a helpful space to share experiences and learn and receive care from other mothers (Eronen, 2019). For mothers experiencing perinatal mental health problems, peer support can be helpful in tackling the isolation experienced, improving self-efficacy and providing a source of validation (Jones et al., 2014).

Theoretically, peer support interventions could be well placed to support the intersecting needs of MAPP who use substances. A sense of belonging to a group has been found to be supportive of recovery (Best et al. 2016) something which a peer support intervention could provide. Social Identity Theory of Recovery (SIMOR) posits that recovery is influenced and supported not only by the sense of belonging and community, but also the social influence of others (Best et al., 2016). This is achieved via a process of internalising shared characteristics of the group which in turn helps to provide distance between behaviours which do not correspond with these new characteristics, for example substance use when internalising the characteristics of recovery oriented PSWs. This model provides a theoretical framework for understanding how peer support interventions may facilitate recovery, as well as highlighting the importance of belonging and community in this process.

Rationale for review

Peer support for MAPP who use substances, could therefore be a valuable resource in supporting their recovery and in addressing some of these barriers this group face. Peer support can improve engagement and self-stigma, as well as willingness to seek professional help (Sun et al., 2022). Within substance misuse treatment, women attribute positive outcomes to receiving support and forming bonds with peer mentors who can understand their experiences (With You, 2021).

Whilst reviews have been undertaken within the different intersects, for example the role of peer support for the recovery of people who use substances broadly (Bassuk et al., 2016), and within aspects of motherhood, for example wellbeing (McLeish et al., 2017), no review has looked at how peer support contributes to the recovery of this subgroup specifically.

Aims

- To understand how effective PSIs are in supporting the recovery of MAPP who use substances.
- To understand how satisfied MAPP are with peer support services.
- To understand the experiences of MAPP who engage in PSIs.
- To understand the experiences of those delivering PSIs to this group.

Research question:

How effective is peer support within the recovery of MAPP who are actively using or have a history of substance misuse and how is it experienced?

Section 2: Method

Scoping searches

Google scholar and Staffordshire University databases were used to carry out scoping searches to determine viability of the review. Scoping searches identified reviews exploring the role of peer support in models of care for substance use broadly, (Eddie et al., 2019), the role of peer support in mental health settings (White et al., 2020), and more specifically mental health within the perinatal period (Liblub et al., 2024) and motherhood (Shakya et al., 2017). This indicated a gap in the literature in understanding the role of peer support in supporting the recovery of MAPP.

Search Strategy

Systematic searches were carried out in May 2024 across the following databases: Scopus, Embase, Medline & Psycinfo. Key terms were selected using a thesaurus, reviewing terms used by other literature reviews in similar areas and looking at the relevant thesauruses for each database such as MeSH for Medline. Specific subject headings were applied for databases which used their own thesauruses. Boolean operators “AND” and “OR” were utilised as well as truncations (*) to enable different spellings and variations of words and quotation marks to capture phrases to be searched as a whole term. See Table 1 for search terms.

Once relevant papers were selected by inclusion and exclusion criteria, citation searches were carried out in Google Scholar as a further method of searching. Grey literature was also searched via the British Public Library doctoral theses selection.

Table 1

Search terms

Search Terms				
"Peer support" OR "peer counsel*" OR "peer coach*" OR "peer mentor*" OR "mutual aid" OR "self-help" OR "support group"	AND	mother* OR mum* OR mom* OR pregnan* OR perinatal	AND	"Substance use" OR "alcohol use" OR "substance misuse" OR "drug misuse" OR "alcohol misuse" OR "alcohol abuse" OR "alcoholi*" OR "addict*

Inclusion criteria

- Participants were either those who identified as mothers or were pregnant and used substances (historically or actively).
- Participants were either those accessing peer support or those delivering peer support.
- Studies researching addiction to drugs and/or alcohol only.
- Studies researching interventions which utilised peer support.
- Studies researching outcomes related to substance use recovery (as per previously defined) such as in health and social functioning, well-being and purpose.
- Empirical studies including grey literature and those which were unpublished and not peer reviewed.

Exclusion criteria

- Participants who identified as mothers or were pregnant who had no history of substance use.

- Participants who identified as women but did not care for children or were not pregnant.
- Studies researching interventions which did not utilise peer support.
- Articles not published in English
- Studies focusing only on addictions other than drugs and/or alcohol (tobacco)

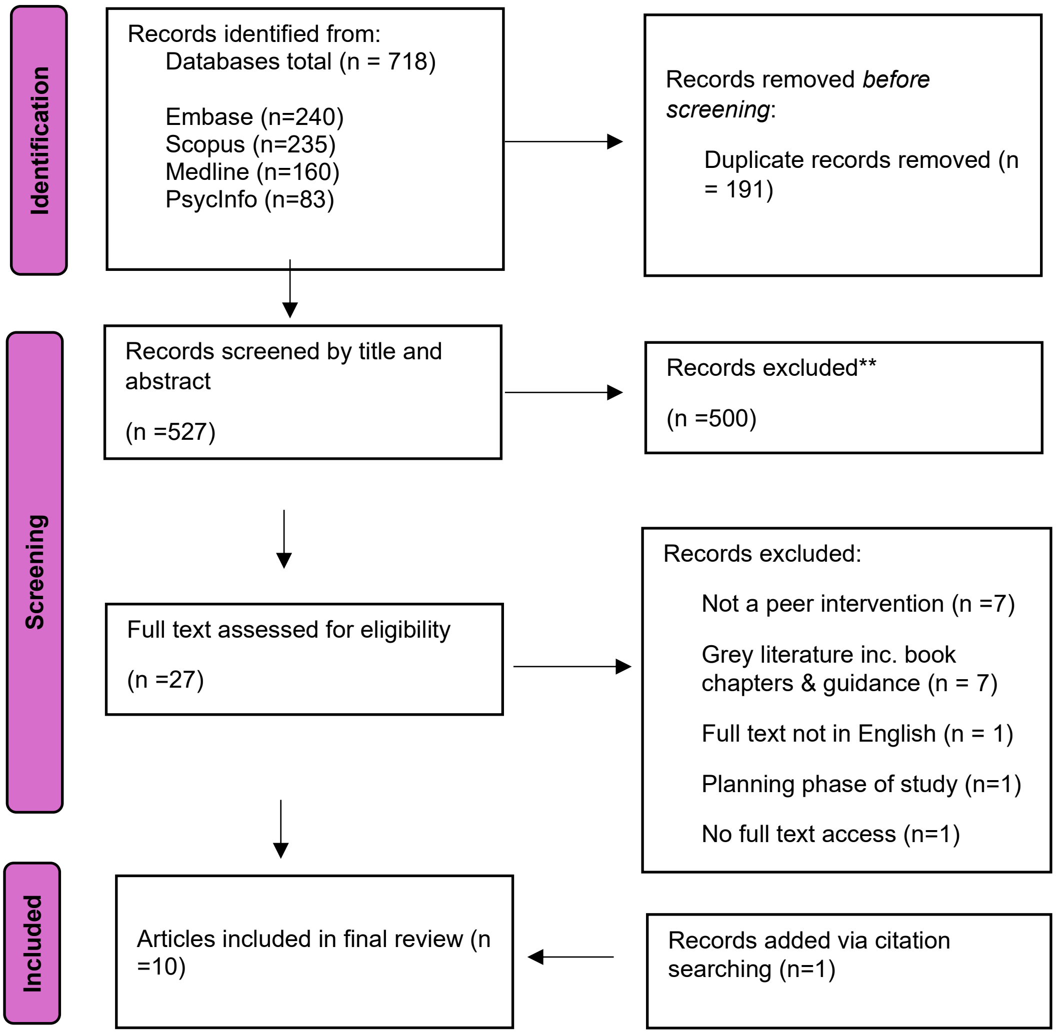
No limits were applied regarding date or year of publication.

Overview of the search

Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA, 2020) guidance was followed to conduct this review. Figure 1 illustrates the search procedure, showing that searches obtained 720 records from all databases, reducing to 529 after duplicates were removed. The 529 records were screened by title and abstract and 500 were removed, themes for removal including studies which focused on the wrong population or difficulty or interventions which did not utilise peer support. The full text of the remaining 29 were screened against inclusion and exclusion criteria, including one record found via citation searching relevant studies. A total of 10 studies met the inclusion criteria and are included in this review.

Figure 1

Search procedure.



Data extraction

Author(s), year of publication, aims, methodology and key findings were extracted from each study and collated into a table (Table 2). A more detailed data extraction table can be found in the appendices (appendix 1).

Quality Assessment

As the studies used different designs and methodologies, the Crowe Critical Appraisal Tool (CCAT) (Crowe, 2013) was used to assess their quality. The CCAT appraises eight categories: preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion, which are individually scored between 0 (low) and 5 (high) and are then added together to give the study an overall quality score out of 40, with higher scores indicating higher quality (see table 2). Utilising a standardised tool to assess quality ensured a consistent appraisal approach across studies. No studies were excluded based on their quality score due to the small number of studies included in the review. A breakdown of each study's scores by category can be found in the appendices (appendix 2).

Publication bias

Publication bias can be defined as the "failure to publish the results of a study on the basis of direction or strength of the study findings" (DeVito & Goldacre, 2019). For this review, grey literature was also searched, for example unpublished doctoral theses, as well as published and peer reviewed papers, this limits the effect of publication bias. Unfortunately, studies conducted in another language were excluded, due to having no resource to translate. This may have had small implications for bias.

Synthesis

A narrative approach was used to synthesise the studies within the review. Narrative synthesis aims to produce a narrative, textual understanding of a group of findings, by exploring relationships within the data and assessing robustness of both the individual studies and the synthesis itself (Popay et al., 2006). This approach was selected due to the limited number of tools available to synthesise the broad array of aims and methodologies of the included studies. Tools utilised included grouping and clustering findings conceptually, tabulation and translating data thematically (for qualitative studies). To assess robustness, individual studies were assessed using the CCAT (Crowe, 2013) and the synthesis critically evaluated within the discussion.

Results

Overview of the studies

10 studies met the inclusion criteria and were included in this review. All but one study (Canada) took place in the USA. Half of the studies were conducted within the last 6 years (2018 – 2024) and half were conducted over 20 years ago (1996-2004). All studies were focused on PSIs with mothers and/or pregnant people who had a history of, or were currently using, substances and had different aims. Six studies were qualitative (Kissman & Torres, 2004; Paterno et al., 2018, Paterno et al., 2019; Fallin-Benett et al., 2020; Gruß et al., 2021; Olding et al., 2022), two were mixed methods (Alemi et al., 1996; Sanders et al., 1998), one was a service evaluation (Newell et al., 2022), and one was quantitative (Ernst et al.,1999). There was a large range of sample sizes from 96 (Ernst et al., 1999) to five participants (Paterno et al., 2018; Paterno et al., 2019).

Sample

One study provided no demographic data (Kissman & Torres, 2004) and another provided no data on participant ethnicity (Gruß et al., 2021). Across the studies, a broad range of ethnicities were represented including, African American, Caucasian, Hispanic, Indigenous (Canadian) and Two-Spirit[2]. Individually, five studies included participants from a range of ethnicities (Alemi et al., 1996; Sanders et al., 1998; Ernst et al., 1999; Olding et al., 2021; Newell et al., 2022). The remaining three which provided demographic data included only Caucasian participants (Paterno et al., 2018; Paterno et al., 2019; Fallin-Benett et al., 2020).

The mean age of participants ranged from 27 years (Ernst et al., 1999) to 48 (Newell et al., 2022) however tended to cluster at the younger end, between 27 years and 33 years (Ernst et al., 1999; Alemi et al., 1996; Gruß et al., 2021; Olding et al., 2021; Fallin-Bennett et al., 2020). Only one study commented on gender identity, with all participants identifying as "mothers", 90% as women and 10% as two-spirit (Olding et al., 2022). See appendix 1 for more detailed demographic data.

Six studies did not explicitly state whether participants were pregnant or post-partum mothers (Kissman & Torres, 2004; Paterno et al., 2018; Paterno et al., 2019; Gruß et

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[2] Two-spirit is a term used to encapsulate different gender expressions and identities in Indigenous culture (Lucchetti, 2023)

al., 2021; Olding et al., 2022; Newell et al., 2022). One study included only pregnant participants (Alemi et al., 1996), one included a mix of 32% pregnant, and 78% post-partum mothers (Sanders et al., 1998) and two made explicitly clear that all participants were post-partum mothers (Ernst et al., 1999; Fallin-Bennett et al., 2020).

Table 2

Data extraction table

Authors and Country	Aims	Methodology	Findings	CCAT percentage score (%)
Alemi et al. (1996) USA	To examine the impact of a voice bulletin board[3] on: 1) Participation 2) Expression of emotional support 3) Development of solidarity 4) Utilisation of health services 5) Health status	Quasi-experimental design. Used questionnaires to look at the impact of a voice bulletin board (experimental group) on several recovery-related outcomes compared to a face-to-face support group (control group).	More participants engaged with the experimental group compared to control group and group solidarity was higher in the experimental group. Calls to doctor and number of outpatient visits decreased significantly in the experimental group. Calls to doctor increased significantly for control group but outpatient visits decreased.	55

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[3] To use the voice bulletin board, participants used their telephones to record a comment on a pre-set topic. This was then saved and could be accessed and listened to by other participants to which they could respond. The system worked as a remote, delayed discussion.

			Those in the experimental group reported statistically higher role functioning than control group. No changes were found in health beliefs or addiction severity.	
Sanders et al. (1998) USA	1) To identify factors related to client satisfaction with specific elements of the service as well as the overall service 2) To examine differences in satisfaction between those who received peer counselling versus professional counselling.	Quasi-experimental design Used questionnaires to identify factors related to client satisfaction and compared satisfaction between two substance misuse services; one incorporated peer delivered and the other professional delivered counselling.	Age, number of elements utilised and length of stay in treatment were positively correlated with satisfaction with specific elements of the service. Number of elements utilised was also positively correlated with overall satisfaction with the service and the extent to which participants felt their needs had been met and were resolved. No significant differences found in overall satisfaction between the	83

			peer-counselled and professionally-counselled groups, however satisfaction with specific elements of the service was significantly associated with membership to peer-counselled group. Those who received peer counselling rated their counsellor as more helpful, empathetic and caring compared to professionally counselled group.	
Ernst et al. (1999) USA	To measure the effectiveness of the paraprofessional[4] advocacy model within five domains: 1) Utilization of alcohol/drug treatment 2) Abstinence 3) Family planning 4) Health and well-being of target child	Quasi-experimental design Interviews were conducted with those in the paraprofessional advocacy intervention and those in control group pre and post intervention.	On average, those in experimental group had significantly higher summary scores post-intervention compared to control group. Scores were also higher in each domain for those in experimental group compared to control.	90

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[4] Paraprofessional here refers to advocates who are employed in a professional role but have similar lived experience to those women they are supporting.

	5) Appropriate connection with community services at endpoint	Assessment scores were derived from the interviews and compared pre-and post and between groups.	Generally, outcomes were better amongst those who spent more time with their advocate.	
Kissman & Torres (2004) USA	1) Describe a program aimed at relapse prevention in a group of incarcerated mothers. 2) To establish how group interactions impact coping strategies	Qualitative data was collected during the group and via log-entries made by participants which were shared in the group	Themes centered around the social support offered by the group as well as encouraging self-acceptance and moving forwards in their lives. Coping strategies were also highlighted as well as the contribution of family conflicts to their difficulties. Anger as an emotion was highlighted as another difficulty which contributed to difficulties.	28
Paterno et al. (2018) USA	1) To assess the feasibility of a digital story telling (DST) intervention[5] with peer mentors	Qualitative Authors recorded (via video and field notes) the DST workshop and conducted	Themes centered around participants making sense of their recovery and making links between their past and present both in their	80

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[5] Digital story telling interventions can be utilised to collect data as well as provide a platform for understanding health-related events. Participants are encouraged to write and record their own 1–3-minute digital story about a health event. The story utilises voice recording, imagery and sound (Gubrium, 2009).

	2) To understand recovery from the perspective of mothers with lived experience of perinatal substance use disorder.	follow up interviews with each participant.	own journeys and their work as peer mentors. Social connection and support between the peer mentors was highlighted via the DST workshop as well as the importance of instilling hope and a sense of purpose via the work of peer mentoring.	
Paterno et al. (2019) USA	1) To understand the insider perspective on the experience of peer mentoring and its relationship to recovery.	Qualitative Authors recorded (via video and field notes) the DST workshop and conducted follow up interviews with each participant.	Themes encapsulate the participant's experiences of moving through their journey from addiction during pregnancy, recovery and their work as peer mentors.	85
Fallin-Bennet et al. (2020) USA	1) To describe experiences of peer support specialists within perinatal opiate use treatment. 2) To gain recommendations to improve services.	Qualitative Authors conducted focus groups with participants who were in receipt of perinatal	Themes discussed the relationship participants had with their PSW, and the ideal qualities of a good PSW. Participants shared their views on how to improve communication with PSWs and highlighted the overall	63

		substance use treatment and were supported by PSWs.	importance of communication within the perinatal period.	
Gruß et al. (2021) USA	1) To gather client perspectives on the role of a support programme for pregnant and postpartum women with substance use disorders played in their recovery. 2) To specifically understand the role of peer support in their recovery.	Qualitative Semi-structured interviews were used to collect views from those enrolled in a perinatal substance use program.	Themes highlighted the importance of the group in maintaining engagement and accountability in treatment as well as how it supported access to well-coordinated care. The role the group played in establishing community, acceptance and validation is also discussed.	83
Olding et al. (2022) Canada	1) To gain client perspectives on the role that PSWs provide, or could provide, to perinatal programs for women who use drugs.	Qualitative Focus groups were conducted with participants who were in receipt of perinatal substance use treatment (three different programs). Two of these programs used PSWs.	Themes highlighted the unique nature of participant’s relationships with PSWs, and the hope and modelling their recovery instills. The importance of keeping a connection with other mums who have similar difficulties was highlighted. Participants highlighted the value of peer support and their view that this	78

			should be reflected in employment/payment.	
Newell et al. (2022) USA	1) To assess client's perspectives of the program in providing a comfortable environment, developing a support system and any other coping strategies. 2) To assess the likelihood of participants continuing to engage in peer support post intervention	Quasi-experimental Pre and post questionnaires researching several recovery-related outcomes were given to participants of a peer support group for perinatal and post-partum substance use.	Improvements were seen in depression and anxiety and stress. Six out of thirteen participants appeared to intend to continue accessing peer support after completion. Qualitative data suggest that participants found the group to be a comfortable, safe and secure space to share their experiences whereby they found a sense of community.	88

Aims of the studies

Three studies looked at the effectiveness of a PSI on a range of outcomes including health related outcomes for the mother (e.g. utilisation of healthcare services, health status) (Alemi et al., 1996), mental health outcomes (e.g. expression of emotional support, anxiety and depression) (Alemi et al., 1996; Newell et al., 2022), substance-related outcomes (e.g., utilisation of treatment, abstinence, intention to attend further support) (Ernst et al., 1999). One study looked at client satisfaction with a PSI compared to a non-peer equivalent (Sanders et al., 1998). Six studies aimed to understand experiences of PSIs, two focused on experiences from the perspective of the PSW (Paterno et al., 2018; Paterno et al., 2019) and four from the perspective of the mothers and/or pregnant people (Kissman & Torres, 2004; Falinn-Benett et al., 2020; Gruß et al., 2021; Olding et al., 2022).

Recruitment

Nine out of the ten studies recruited from the service in which the PSI was delivered, and the remaining one recruited from a pool of participants from a parent study (Alemi et al., 1996). All but two studies (Kissman & Torres, 2004; Fallin-Bennett et al., 2020) reported on methods of recruitment. Some advertised studies via posters or social media (Sanders et al., 1998; Olding et al., 2022; Newell et al., 2022). Others utilised staff from the service (Ernst et al., 1999; Paterno et al., 2018; Paterno et al., 2019; Olding et al., 2022; Gruß et al., 2021) or the research team (Ernst et al., 1999; Gruß et al., 2021). Sampling was purposive and voluntary, as participants were selected based on having attended an intervention.

Study designs

A variety of designs and data collection methods were utilised across the studies. Studies researching effectiveness on a variety of outcomes used quasi-experimental, pre and post designs, whereby data on outcomes was collected before and after an intervention and compared (Alemi et al., 1996; Ernst et al., 1999; Newell et al., 2022). Randomised, pretest and post-test designs are the gold standard for testing effectiveness for interventions (Little et al., 2020). Unfortunately, none of the studies used randomisation to assign their participants, reducing internal validity. Two (Alemi et al., 1996; Ernst et al., 1999) however, did use a control group increasing the reliability and validity of their findings (Maciejewski et al., 2013). To analyse the results of these studies, two studies used ANCOVA (Alemi et al., 1996;

Ernst et al., 1999). ANCOVA is generally regarded as the preferred method of analysis for pre and post – test designs, as it is less influenced by bias and produces less variance compared to other methods such as ANOVA (O'Connell et al., 2017). Neither study however comments on power calculations, nor how sample sizes were decided, therefore increasing risks of type 2 errors. Newell et al. (2022) used descriptive statistics to analyse their findings on effectiveness. Whilst descriptive statistics are appropriate and useful, they do not allow inferences beyond the data set provided (Guetterman, 2019).

One study used a cross-sectional questionnaire design (Sanders et al., 1998) to collect satisfaction data. Questionnaires are a popular and appropriate tool for measuring satisfaction, as they are cost and time effective in reaching a larger population (Safdar et al., 2016). Data was analysed using correlations, regression and non-parametric tests to compare differences between groups. The use of three different tests suggests this was a thorough analysis and allowed confounding variables to be highlighted (age) and accounted for.

For studies which aimed to understand broader experiences of mothers', pregnant people and PSWs', methods such as focus groups (Fallin-Bennett et al., 2020; Olding et al., 2022) and semi-structured interviews (Paterno et al., 2018; Paterno et al., 2019; Gruß et al., 2021) were used to gather data. Both are appropriate methods to gather rich data capturing experience and meaning making of participants (Hammarberg et al., 2016). Both methods took a semi-structured approach, appropriate in providing enough structure so that aims are captured as well as more open discussion (Knott et al., 2022). Data was analysed using a variety of qualitative approaches, two studies named their approaches: thematic analysis (Gruß et al., 2021), constructivist grounded theory (Paterno et al., 2019) and the remaining three described several qualitative techniques and processes utilised to analyse their data (Paterno et al., 2018; Fallin-Bennett et al., 2020; Olding et al., 2022). Utilising a standardised approach to analysis (such as thematic analysis) enhances rigor and trustworthiness of findings. None of the qualitative papers referred to epistemology or reflexivity, reducing the credibility and confidence in the findings (Darawsheh, 2014). Some however did refer to strategies to maintain rigor, such as checking codes for inter-rater reliability (Paterno et al., 2019; Gruß et al., 2021; Olding et al., 2022) or the use of a codebook or coding framework, developed by more than one researcher (Fallin-Bennett et al., 2020; Olding et al., 2022). Kissman & Torres (2004) also used a qualitative design, however provided little information on how data was collected or analysed, reducing methodological rigor and trustworthiness of findings.

Interventions

All interventions included a peer support element and aimed to support pregnant people or mothers in their recovery. Three took the form of a peer support group (Kissman & Toress, 2004; Gruß et al., 2021, Newell et al., 2022), three took the form of one-to-one peer mentoring (Paterno et al., 2018; Paterno et al., 2019; Ernst et al., 1999), one used peer counselling (Sanders et al., 1998), one peer program had a variety of functions (Olding et al., 2022), one utilised a telephone based discussion board (Alemi et al., 1996) and one did not state the nature of the PSI (Fallin-Bennett et al., 2020). Four interventions were based within a wider service offering other interventions to pregnant women and mothers who used substances (Sanders et al., 1998; Fallin-Bennett et al., 2020; Gruß et al., 2022; Olding et al., 2022), whilst the others were standalone interventions, or did not state. Seven interventions were delivered by employed peer mentors, counsellors or support workers (Sanders et al., 1998; Ernst et al., 1999; Paterno et al., 2018; Paterno et al., 2019; Fallin-Bennett et al., 2020; Olding et al., 2022; Newell et al., 2022), another was supported by a PSW (Gruß et al., 2021), two interventions were not facilitated by a peer and the peer support was provided by other group members (Alemi et al., 1996; Kissman & Torres, 2004).

Control or comparison groups

Three of the studies used control or comparison groups. Alemi et al. (1996) used a face-to- face group as a control to compare their voice bulletin board, Sanders et al. (1998) used a non-peer counselling service to compare with peer-led counselling service and Ernst et al. (1999) used a control group who were not offered the peer advocacy intervention.

Outcome measures

Three studies used outcome measures pre and post to measure the effectiveness of the PSI. Two studies used formal outcome measures. Alemi et al. (1999) measured health service utilisation (National Center for Health Statistics

Health Utilisation Survey, no reference), use of physician (symptoms, beliefs and use of physician scale (Sharp et al., 1983)), loneliness (the UCLA loneliness scale (Rusell et al., 1978)), communication apprehension (McCroskey, 1978), addiction severity (Addiction Severity Index, McLellan et al., 1980), general health outcomes (Short Form General Health Outcomes Survey, Stewart et al., 1988)) and group solidarity (Group Solidarity Scale, Wheeless, 1978)). It was not possible to find data regarding psychometric properties for the addiction severity, health utilisation, use of physician or solidarity scales. The loneliness scale (Russell et al., 1978) demonstrates high internal consistency (alpha = 0.96), as well as the general health outcomes scale (alpha = 0.86) (Stewart et al., 1988). Communication apprehension scale has been found to have good predictive validity (McCroskey, 1978).

Newell et al., (2022) measured intention to attend future peer support (Alcoholics Anonymous Intention Measure (AAIM), Zemore & Kaskutas, 2009)), depression and anxiety (Depression, Anxiety and Stress Scale – 21 (DASS-21), Henry & Crawford, 2005) as well as some of their own developed measures to understand expectations of participants, prior experience of peer support, and what attracted them to the group. In terms of psychometric robustness, the AAIM subscales vary in internal consistency from alpha = 0.56 (poor) to 0.95 (excellent) and its predictive power is mixed, reducing its reliability (Zemore & Kaskutas, 2009). DASS-21 (Henry & Crawford, 3005) has been found to have good to excellent internal consistency for all three subscales (alpha= 0.87 – 0.94) (Henry & Crawford, 2005).

Ernst et al., (1999) developed their own outcome measure for effectiveness. An interview schedule was developed around five domains they wished to measure. Numerical scores were attributed to each domain on a 5-point Likert scale. Domain scores were then totalled to provide a total score to compare pre and post intervention. Sanders et al., (1998) developed their own 29 item questionnaire to measure client satisfaction, this was a mixture of quantitative and qualitative questions.

For further information on outcome measures broken down by study, please see appendix 1.

Ethical considerations

All but two studies (Alemi et al., 1999 and Kissman & Torres, 2004) referred to ethical approval stating that this had either been sought or was not required for their research.

Synthesis of main findings

Effectiveness

Amongst the three studies which looked at the effectiveness of interventions (Alemi et al., 1996; Ernst et al., 1999; Newell et al., 2022) on different recovery related outcomes, findings were mixed.

Utilisation of services

Visits to outpatient services were found to be significantly ($p<0.05$) reduced following the voice-bulletin (experimental) and face-to-face (control) intervention but was larger in the voice bulletin group (76% vs. 30%) (Alemi et al., 1996). Telephone calls to doctors reduced significantly in the experimental group but increased for the control group ($p <0.05$). Within this study however, engagement rates varied, with 96% for the experimental, and 32% for the control. This is likely to have exaggerated any differences found between groups, making results less reliable.

When compared to controls, those who received PSIs were connected to a greater variety of services (Sanders et al., 1998; Ernst et al., 1999) at endpoint. Those with a greater variety of connections had a higher summary endpoint score (Ernst et al., 1999), this was higher for both hospital and community recruited experimental group (significantly so for hospital recruited $p=0.04$) compared to controls. At endpoint, the experimental group scored higher on every outcome domain, although not significantly, compared to control group (Ernst et al. 1999). In terms of intention to stay connected to support, results from the AAIM suggested 46% intended to continue accessing peer support (Newell et al., 2022) however qualitative data suggests 92%. This discrepancy makes it difficult to draw inferences regarding this outcome and suggests data collection methods were not reliable.

Health outcomes

Abstinence was achieved with support of PSIs, for 92% (Newell et al., 2022) and 52%, compared to 23% of controls (Ernst et al., 1999). Alemi et al. (1996)'s study did not have enough power to comment on the ASI (McLellan et al., 1980) meaning no inferences could be made regarding this outcome, their study made no significant difference to health beliefs. Out of those who engaged with a PSI, 85% accessed drug and alcohol treatment during the intervention, with 52% completing this (Ernst et al., 1999), unfortunately no data was provided to compare this to the control group.

In terms of impacts on anxiety, stress and depression, scores were improved post PSI, with scores moving from moderate to extremely severe pre-intervention to normal-moderate post-intervention (Newell et al., 2022). PSIs also appeared useful in providing emotional support, with 54.6% of interactions on voice bulletin board used for this purpose (Alemi et al., 1996). Alemi et al. (1996) collected loneliness data pre intervention, but was dropped for post, no justification was provided for this.

Satisfaction

When using a Mann- Whitney U test, no significant differences were found in satisfaction between a substance misuse service (SMS) which utilised peer-led counselling (experimental) and a SMS which utilised professional counselling (control). However, a regression analysis found that satisfaction with specific elements of the SMS was significant with membership to the experimental group ($p<0.035$), age ($p<0.000$) and there was an interaction between the two ($p<0.07$). Further exploration found that members of the experimental group had different satisfaction ratings compared to the control, dependent on age. When categorised into age groups, those in the experimental group had higher mean satisfaction scores within every age category compared to the control group.

No significant differences were found between the groups in the extent to which perceived needs had been met, or issues resolved. Those from the experimental group however were more likely to name their peer-counsellor as the most helpful (64% vs. 23%) and described their counsellor as empathetic and caring, compared to knowledgeable in the control group.

Experiences of peer support

Multiple themes could be drawn from the included studies (Kissman & Torres, 2004; Paterno et al., 2018; Paterno et al., 2019; Fallin-Bennett et al., 2020; Gruß et al., 2021; Olding et al., 2022) aiming to understand the experiences of those who delivered and received PSIs.

Sense of community and connection

A common theme across the studies was the sense of community and connection expressed by participants. PSIs were described as a community and a safe space to share as a mother (Newell et al., 2022) which was free of judgment from others and fostered acceptance from others (Gruß et al., 2021) and self (Kissman & Torres, 2004). Solidarity was high, even amongst virtual interventions (Alemi et al., 1996). Connecting and forming a community with other mothers who use substances (Olding et al., 2022) was highlighted as valuable, with mothers sharing experiences of feeling judged or stigmatised when attending other parent groups. Sharing experiences with peers was also discussed as an important element of connection making (Paterno et al., 2018).

Maintaining recovery

Participants discussed the role the PSI played in maintaining their recovery. Those studies which looked at PSIs from the perspective of the PSWs (Paterno et al., 2018; Paterno et al., 2019) highlighted the role of this work within their own recovery, in that sharing their stories and experiences with those they were supporting facilitated and supported recovery maintenance and promoted self-awareness. Other participants expressed the PSI provided them with a sense of accountability, both to continue engaging with treatment and recovery maintenance (Gruß et al., 2021)

Relationship with peer mentor

The nature of relationships with peer mentors or peers within the intervention was also expressed across studies. From the perspective of PSWs themselves, they described their role as “all encompassing” (Paterno et al., 2019) and felt best positioned to instill hope to others from their lived experience. Those receiving peer support corroborated that shared experiences strengthened their relationship and recovery (Fallin-Bennet et al., 2020). Some felt better able to build a more trusting relationship with a PSW as opposed to professionals with no shared experience; they felt less judged and that the relationship was equally power- balanced (Olding et al., 2022). Participants described PSWs as living evidence that recovery whilst being a mother was possible (Olding et al., 2022; Paterno et al., 2018). One study however found that the boundaries of the relationship could feel confusing, as PSWs were also required to follow procedures for example child protection, which was not always anticipated by participants (Olding et al., 2022).

Critical appraisal

Appendix 2 provides an overview of the total scores and sub-scores by domain within the CCAT. Total scores ranged from 11 (28%) to 36 (90%), with a mean total score of 29.2. The variety of quality scores and issues identified is likely to impact the confidence in the interpretation of findings.

Within the quantitative studies, sampling was often unclear, with no reference made to a power analysis or how the sample size was determined (Alemi et al., 1996; Sanders et al., 1998; Ernst et al., 1999; Newell et al., 2022) increasing the risk of type two errors. Design as a domain was a weakness for 60% of studies, with many not providing adequate information about their research design (Kissman & Torres, 2004; Fallin-Bennett et al., 2020; Sanders et al., 1999), or justification for the choice of outcome measure (Alemi et al., 1996; Newell et al., 2022) or why outcome measures were dropped between phases (Alemi et al., 1996).

Strengths observed across studies were in the introduction and discussion, with papers providing a strong overview of current literature, a good justification for their current research and clear aims. A strong grounding in the literature then provided a solid basis for the discussion, embedding their findings into this with many providing recommendations for future research and clinical implications.

Discussion

The aim of this review was to understand the role PSIs can play in the recovery of MAPP who use substances. This was broken down into: effectiveness on several recovery-related outcomes, service users' satisfaction with PSIs and experiences of delivering and receiving PSIs.

Findings suggest that PSIs play several roles in the recovery of MAPP who use substances. They were found to be effective in reducing the use of health services (Alemi et al., 1996). This finding differs from established literature reporting that engaging with PSIs increases use of other services (Kamon & Turner, 2013; O'Connell et al., 2020) and contrasts with findings from Ernst et al. (1999) in this review, who reported that their PSI facilitated connections to a greater variety of services, which supported better outcomes compared to control group (Ernst et al., 1999). In terms of satisfaction (Sanders et al., 1999), results were mixed, no significant differences were found between PSI and control when using Mann-Whitney U test, but when examined via a regression analysis, satisfaction levels were higher within every age group of the PSI group when compared to control. No significant differences were found between the groups, in the extent to which perceived needs had been met. Due to the conflicting findings, no clear conclusions can be drawn as to whether the PSI was favourable.

Interventions appeared to somewhat support abstinence (Newell et al., 2022; Ernst et al., 1999), corroborating findings in the literature (Kamon & Turner, 2013). PSIs were helpful in maintaining accountability and improving engagement with treatment (Ernst et al., 1999; Fallin-Bennett et al., 2021; Gruß et al., 2021), reflecting findings from reviews on the impact of PSI in recovery across all groups (Reif et al., 2014). These findings highlight the important role PSIs can play in supporting engagement with this sub-group, who face many barriers to treatment.

PSIs also appeared to have a positive impact on wellbeing, with clinically significant reductions seen in anxiety, depression and stress (Newell et al., 2022), this corroborates findings from literature looking at peer support in pregnancy and substance abuse broadly (McLeish & Redshaw, 2017; Bassuk et al., 2016).

Many studies found that PSIs were a space in which MAPP found a sense of community, solidarity and connection (Alemi et al., 1996; Kissman & Torres, 2004; Paterno et al., 2018; Gruß et al; 2021; Olding et al., 2022; Newell et al., 2022) and fostered acceptance of self and from others (Kissman & Torres; 2004; Gruß et al., 2021). Relationally, PSWs felt that they were specially positioned to provide hope to those they support (Paterno et al., 2019). Participants corroborated this, with peer counsellors described as empathetic and caring, compared to professional counsellors as knowledgeable, reinforcing a difference in relational qualities (Sanders et al., 1999). Difference in relational qualities between peer and professional support is a key theme also reported in the evidence base (Jones et al., 2014) and is linked to positives such as an increased ability to trust peers and a greater sense of mutual respect amongst parents who use substances (Munns et al., 2016). Relationships between PSWs and service users, can however have their difficulties, for example with boundaries (Moran et al., 2013). It is important therefore to reinforce the need for adequate support and training for PSWs and their employing services to support this valuable and unique role and its contribution to the recovery of service users.

It is well documented that this MAPP who use substances are a heavily stigmatised sub-group and often do not encounter opportunities to feel part of a community, accepted or validated (Jones et al., 2014; Barnett et al., 2021). It is therefore of clinical importance to provide spaces which serve this purpose and can provide positive impacts on multiple aspects of recovery including wellbeing and self-stigma, which can serve as a barrier to recovery for this group (Wolfson et al., 2021). This finding also supports the applicability of the SIMOR (Best et al., 2016) to this sub-group, reinforcing the importance of belonging, and social influence within recovery.

Limitations of the papers

The range of quality appraisal scores was varied across the included studies, with weaknesses found in methodological design and analysis. Overall, there was a need for more transparency in the reporting of methodological design, particularly in relation to sampling and analysis. Qualitative studies lacked methodological rigor in that none provided information on reflexivity or justified their chosen analysis method.

Whilst the papers all looked at PSIs, the definition or mode of peer support was varied and due to this, it is difficult to make accurate comparisons between findings as they are all likely to influence outcomes differently, this weakness has been similarly recognised in other reviews looking at PSIs (Bassuk et al., 2016).

Strength and limitations of the review

This review was the first of its kind, adding to already established literature on the role of peer support in recovery for people who use substances (Stack et al., 2022), perinatal mental health (Jones et al., 2014), and motherhood (Yamashita et al., 2022). The review also contributes to the sparsity of research into the recovery of parents who use substances, and more specifically how peer support can be utilised to support them. This sub-group is particularly marginalised and stigmatised, making it difficult for them to access support, and it is hoped that the findings of this review can be a starting point for understanding how peer support can be harnessed to better support this group and their dependents.

The use of the CCAT (Crowe, 2013) allowed for consistency within the quality appraisal process. This ensured that scores could be easily compared and interpreted. Due to time constraints however, a second rater was not utilised for screening of papers, nor the appraisals, therefore no inter-rater reliability could be deduced, a limitation of this review.

Research implications

Future studies could seek to add depth to the current literature; by contributing to similar topics such as the experience of PSI's, this could aid in triangulation of findings. Alternatively, gaps within the literature could be addressed, for example aiming to understand how PSI's impact upon family-related outcomes, such as removal of children or reunification of children with their families, or more specific child-related outcomes such as wellbeing or development. Additionally, it would be useful to understand more about how PSI's can support the reduction of substance use, or abstinence within this sub-group, which is likely to have positive consequential effects on all areas of their recovery.

Future reviews could take multiple avenues to improve the precision of findings and therefore strengthen the clinical applications. Firstly, by operationalising what a "PSI" is, for example including only interventions delivered by paid PSWs to improve accuracy in comparison or limiting designs to those of higher quality such randomised controlled trials.

Conclusion

This novel review aimed to explore how peer support can aid the recovery of MAPP who use substances. The review's findings reflected the variety of studies included and were therefore mixed. A lack of methodological quality within some of the studies, and the lack of consistency between the PSIs overall may reduce the confidence in the findings. This review did, however, add to the evidence base around the utility of PSIs for different sub-groups. Whilst the conclusions that can be drawn are limited, this review provides a useful springboard for research aiming to understand how peer support can be utilised to meet the complex needs of this under-served group. Future research would benefit from operationalising "peer support" with clear intervention protocols and the use of control groups.

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Appendices

Appendix A. Detailed data extraction table

Author, year & country	**Aims**	**Sample**	**Intervention**	**Methodology & Analysis**	**Key Findings**
Alemi et al. (1996) United States of America (USA)	To examine the impact of a voice bulletin board on: 1) Participation in self-help efforts 2) Expression of emotional support 3) Development of solidarity within the group 4) Utilisation of health services 5) Health status of participants	*Recruitment:* Participants were recruited from a pool of participants from a parent study. *Sample:* 53 pregnant women who used substances No comment on power analysis or how sample size was decided. *Demographics:* • Average age – 29.3 • 92% of participants were African American & 8% Caucasian • Average age of first drug use – 17.4 and daily alcohol use – 16.7 *Grouping:* Not randomised, allocated to match group status in parent	*Experimental group:* Voice Bulletin Board – Participants are provided with a discussion topic and then voice record their comments via telephone. Other participants listen to these recordings and leave their own messages in response. Works like a delayed discussion. *Control group:* Face-to face-group– provided with the same discussion topic and discuss within a bi-weekly face-to-face group. Length of intervention not explicitly stated but understood to be 16 weeks from tables included in paper.	Data collected pre & post participation in voice bulletin or face-to-face group. *Measures at baseline:* • National Center for Health Statistics Health Utilisation Survey (not referenced) • Symptoms, beliefs and the use of physician scale (Sharp et al., 1983) • The UCLA loneliness scale (Rusell et al., 1978) • Concern for appearance (Hayes & Ross, 1987) • Personal Report of Communication Apprehension Scale (McCroskey, 1978) • Addiction Severity Index (McLellan et al., 1980) • Short Form General Health Outcomes Survey (Stewart et al., 1988) *At exit:* Measures were repeated however loneliness and communication scales removed (no context provided as to why) and Group Solidarity Scale (Wheeless, 1978) added. *Quantitative analysis:*	*Participation* – participants engaged more in the voice bulletin board (96%) than the face-to-face group (32%) after the initiation session into each condition. Maximum number of participants in each group was very different – maximum number in experimental was 22 and in control was 5. *Expression of emotional support* Instance of positive emotional expression was higher (54.6%) than negative emotional expression (6.4%) and task-orientated comments (39%). Suggested that bulletin board was used to offer positive emotional support and practical advice. *Solidarity* Mean solidary rating was higher for voice bulletin board (89.9) than control (80.6) however this difference was not significant. *Utilisation of health services* • Telephone calls to doctors reduced significantly in experimental but increased in control group ($p<0.05$). • Number of outpatient visits decreased significantly for both

		study. Non-randomisation justified on basis of no significant differences on outcomes between groups at baseline. • Experimental group – Voice bulletin board, 28 participants • Control group – face-to-face group, 25 participants.		Analysis of Co Variance (ANCOVA) comparing the experimental and control data. *Qualitative analysis:* Content of voice bulletin board was analysed using Interaction Process Analysis (Bales, 1950). Content of face-to-face groups was not analysed.	groups (p<0.05) but was larger for experimental group (76% vs. 30%). • No significant changes in visits to health professionals or health beliefs for either group. *Impact on health* • Role functioning was significantly higher in experimental group, compared to control (4.9/5 vs. 4.5/5 p<0.05). • No significant differences between groups on other sub-scales of the health outcomes survey. • There was not enough power to report on addiction severity index.
Sanders et al. (1998) USA	1) To identify factors related to client satisfaction with specific elements of the service as well as the overall program (both the services combined) 2) To examine differences in satisfaction between those who received peer counselling and professional counselling	*Recruitment:* Voluntary sampling from both services using a poster in the service. *Sample:* • Pregnant people and non-pregnant mothers • 25 SISTERS (pregnant) and 56 (not pregnant) comparison clients. • No comment on how sample size was decided. • All of those treated by SISTERs programme were pregnant, those by MSAS are non-pregnant mothers	SISTERS programme vs. Maternal Subtance Abuse Service (MSAS). Both offer a range of services to support pregnant and postpartum women with substance abuse inc. midwifery, parenting support, housing support and counselling. Difference between two is that SISTERS use peer counsellors (those in recovery) and treat pregnant women.	Questionnaire developed by authors and consisted of 18 closed ended and 11 open ended questions. Questions referred to expectations, utilisation of services and satisfaction overall (using a global question to rate general satisfaction) and of specific services (on a 4-point Likert scale). Participants were also asked to rate the extent to which the service met their individual needs (on a 4-point Likert scale) and the number of problems which had been resolved (on a 3-point Likert scale). They were also asked to rate how the program compared to previous programs they had engaged in (5-point Likert scale). Individual satisfaction scores were gained by adding up scores for each	Combined data across the services *Factors correlated with satisfaction* • Age was positively correlated with satisfaction with specific services (p<0.009*). • Use of midwife (p<0.037*) and attendance at Narcotics Anonymous meetings (p<0.023*) were positively associated with total satisfaction with specific services. • Use of acupuncture was positively associated with overall satisfaction (p<0.039*). • Number of services used in the last month was positively associated with satisfaction with specific services (p<0.099) and overall satisfaction (p<0.091). Frequency of use however was not a significant correlate of either specific (p<0.49) or overall (p<0.241) satisfaction.

		Group assignment: Participants were already grouped as per their service status. . *Demographics:* • Average age – SISTERS group 29 and MSAS group 34 (significantly different, p<0.001). • Ethnicity - • SISTERS group – 64% African American, 28% Hispanic, 12% other • MSAS – 66% African American, 27% Hispanic, 8% other. • Engaged with prior drug treatment - • SISTERS – 64% and MSAS – 66%	MSAS uses "professional" counsellors and treat non-pregnant women.	of the eight services and divided by number of services they had used within the past month. Data collected from those at various points in treatment journey to control for those who may drop out. No data collected from dropouts. To assess what factors were associated with satisfaction (aim 1), data was combined from both groups. *Data analysis* • Correlation used to identify components of treatment associated with measure of satisfaction. • Logistic regression was conducted to reveal those factors that best predicted overall satisfaction and satisfaction with specific services • Mann Whitney U Test was used to compare data between the two groups on levels of satisfaction, mean length of time in the program and number of program services used.	• Client's perception as to whether their needs had been met (p<0.0001) and problems resolved (p<0.001) were influenced positively by number of services utilised. • However, no differences were found between groups in the extent to which needs had been met or needs understood by staff. • The quality of the program compared to others was positively correlated with the extent to which individual needs were met (p<0.037*). *Predictors of satisfaction* • Best predictors for specific satisfaction were number of services used in last month (Wald = 3.71; p<.054) and client age (Wald = 3.67; p<0.59) which predicted satisfaction with specific services 91.49% of the time. • Best predictors of overall satisfaction were number of services used (Wald=2.65; p<0.103) and quality of current service compared to others (Wald=4.03; p<0.045*) which predicted overall satisfaction 96.1% of the time. Comparisons between two programs • The Mann Whitney Wilcoxon Sum Test revealed no significant differences between groups in overall satisfaction or satisfaction

					with specific services, both groups reported high satisfaction. - The SISTERS group utilised a greater variety of services than the comparison group (5.6 vs. 3.8 p<0.001) - Regression model, controlling for age, found that satisfaction with specific services was significant with SISTERS membership (p<0.035*), age (p<0.000*) and interaction between SISTERs membership and age (p<0.07). - When broken into age categories, SISTERs group had higher satisfaction levels than MSAS within every category, with the largest difference in the under 25's (3.9 vs. 2.3). - No difference was found between groups in likelihood of recommending the programme *Qualitative data:* Counselling ratings – 64% of those in SISTERS reported their counsellor was the most helpful compared to 23% of MSAS and were more likely to rate their counsellor as empathetic and caring, with those from MSAS rating their counsellor as knowledgeable and understanding of substance abuse.
Ernst et al. (1999) USA	To measure the effectiveness of the paraprofessional advocacy model within five domains:	*Recruitment:* Recruited via two channels *Hospital recruitment:*	*Experimental:* The Seattle Model of Paraprofessional Advocacy is a 36-month intervention from birth of child to 3	All participants (intervention and control) were interviewed post-partum to garner a "baseline assessment score" and at then at end point (36 months) to garner an "end point	Follow up for experimental group was 92% and 83% for controls. - At baseline, control group had more positive scores compared to

	1) Utilization of alcohol/drug treatment 2) Abstinence from alcohol and drugs 3) Family planning (use of birth control, subsequent pregnancies) 4) Health and well-being of target child (health care, custody) 5) Appropriate connection with community services at 36 months.	- Those delivering in two hospitals were approached by the research assistant and screened for eligibility. - *Community:* Community professionals referred women into the programme, and these were screened by the programme director. *Sample:* To be eligible participants had to be pregnant or up to 1-month post-partum at commencement of intervention and "heavy" drug or alcohol users during pregnancy with no or little effective health/social care during pregnancy. *Group assignment:* Those referred from community were automatically allocated to experimental condition as it felt this	years. Paraprofessional advocates share personal experiences, motivate clients to achieve goals and refer to services for support. Clients received weekly visits for first six weeks, and then as frequent as client needs. Follow up evaluation visits were conducted at 4,12,24 and 36 months. *Control:* Participant takes part in baseline interview and is called every six months for tracing, then participates in endpoint interview but receives no intervention from this service. However, whether they partake in any other intervention from external sources is not monitored therefore uncontrolled for. Participants take part in baseline interview	score". The interviews gathered information across the five domains. Each domain is comprised of items on which a subject was scored on a 5-point scale (most positive outcome +2, positive +1, neutral 0, negative -1, most negative -2). Item scores were summed to create domain scores and domain scores summed to create a total summary score. Client level of involvement with their advocate was also documented using a client contact log and reviewing their attendance at goal review meetings every 4 months. *Analysis* T-tests and ANCOVA of the endpoint score adjusting for baseline score, were used to analyse differences between hospital recruited controls and hospital recruited experimental group. The community referred clients (in experimental group) are included as a third comparison group. Intervention effects were tested by permutation test procedure (Good, 1994) on group differences by domain.	experimental, although this was not significantly different. - Hospital recruited experimental participants summary Endpoint score was significantly higher than control (17.1 vs. 10.1, t = 2.11, p =0.04) - Community recruited experimental participants also scored higher then controls however not significantly (16.8 vs. 10.1, t = -1.78, p = 0.08). - On every outcome domain, both experimental groups (hospital and community recruited experimental) had higher scores on average than the control group, despite the control group having higher baseline scores at enrolment. None of these differences were statistically significant. *Involvement with advocates* - 38% of the experimental group were involved with their advocate for at least 32/36 months, 51% between 9 and 31 months and 11% participated for 8 months or less. - For the experimental group (hospital and community recruited), the more involvement with advocates, the more improvement on outcome domains. *Alcohol/drug treatment* 85% of experimental group completed some form of treatment during the program, with 52% completing treatment. No data for control group.

		was responsive to the community need. Hospital clients were initially randomly assigned however then were assigned to balance out demographics of each group. Control group: All hospital recruited - 31 participants – Experimental group: mixture of community and hospital recruited - 65 participants No information provided as to how sample size was calculated. *Demographics* • Ethnicity – 48% African American, 29% White, 15% Native American, 8% Other (Hispanic, Asian) • Mean age: 27 years • Substance used during pregnancy – 79% alcohol, 39% binge drinking,	and endpoint interview.		*Abstinence (defined as no use for a period of at least 6 months)* Abstinence rates were higher amongst experimental participants most involved with advocates (53%) compared to least involved (27%) and controls (23%). *Family planning* At endpoint, 73% of experimental group were using birth control. *Health of child* • No significant difference between groups. • For purpose of analysis looked at custody status of target child at end point, and "appropriate custody" which was defined as the child being in care of a mother who was at least 6 months abstinent, or child not being in the custody of a mother unable to maintain abstinence. • The custody status of children at endpoint was 67% for control group, vs. 52% of experimental group. However, when looking at "appropriate custody" this was 29% for control group and 69% for experimental. *Connection to services:* • Experimental group were better connected with needed service providers than control group at 36 months. • Although both groups were poorly connected to services at entry into the study (averaging approximately

		89% cocaine, 48% marijuana, 22% heroin, 12% other illicit drugs.			1.4 service linkages), at completion of the program clients with higher summary scores had a greater number of provider connections (6.2 vs. 4.4) In general, for those in the experimental group, those who spent more time with their advocates, were more likely to enter treatment, remain abstinent, deliver fewer subsequent children, and retain custody of their children.
Kissman & Torres (2004) USA	1) To describe a pilot program aimed at supporting mothers in a city jail with substance relapse prevention. 2) To establish positive effects of group interactions on coping strategies	*Recruitment:* Voluntary sampling, not randomised from pool of 180 people in the jail *Sample:* A total of 30 incarcerated mothers who misused substances. *Group allocation* 15 participants allocated to two mutual support groups. No information provided as to how allocated or how number was decided. *Demographics:* No information provided.	1.5-hour weekly group sessions for duration of three months. Sessions explored responses to triggers related to recurrent substance abuse relapses Group content was based on evidence base indicating positive effects on substance abusing and incarcerated mothers.	Qualitative data was gathered from group sessions to understand the group interactions and coping strategies. Log-entries shared by participants were also collected. No other information provided about how data was gathered or analysed.	Three themes were presented: 1) Social support and spiritual connection through sharing 2) Coping, problem solving and family interaction. 3) Anger management in interaction with others. Themes centered around the social support offered by the group as well as encouraging self-acceptance and moving forwards in their lives. Coping strategies were also highlighted as well as the contribution of family conflicts to their difficulties. Anger as an emotion was highlighted as another difficulty which contributed to difficulties as well as the origins of this anger.
Paterno et al. (2018) USA	1) To assess the feasibility of a digital story telling (DST)	*Recruitment:* Opportunity sampling, via word of mouth with support from peer mentor in the group.	Authors facilitated a three-day DST workshop with participants, whereby they created a 1–3-	*Data collected:* DST workshop, the digital stories and semi-structured interviews were utilised to gather data.	Three themes emerged: 1) making linkages from past to present

	intervention[6] with peer mentors 2) To understand the meaning and process of recovery from the perspective of mothers with lived experience of perinatal substance use disorder.	*Sample:* Eligibility criteria: peer mentors, in recovery from substance use, lived experience of perinatal substance use, participated in the “moms supporting moms” program, and over 18 years old. Five participants – no information provided on justifying sample size. *Demographics* - All identified as white, non-Latina. - No data on age or any other demographics.	minute digital narrative about their recovery journey and work as peer mentor. Participants then had a follow up semi-structured interview.	Activities within the DST workshop were recorded, as well as semi-structured interviews. Digital stories were also kept for analysis. Authors also kept field notes throughout the DST workshop to capture elements which weren’t recorded. Recorded data was professionally transcribed and digital stories were transcribed in a way to preserve their visual and sensory elements. *Data analysis* No broad analytic method is named however reference is made to qualitative analysis methods such as open coding, memo writing, and reviewing of themes within the study team to maintain reliability and validity.	2) fostering deeper social connections among mentors in the workshop through shared experience, and 3) identifying spaces of hope and a sense of purpose Themes centered around participants making sense of their recovery and making links between their past and present both in their own journeys and their work as peer mentors. Social connection and support between the peer mentors was highlighted via the DST workshop as well as the importance of instilling hope and a sense of purpose via the work of peer mentoring, and how crucial this is to recovery.
Paterno et al. (2019) USA	To understand the insider perspective on the experience of peer mentoring and its relationship to recovery from substance use disorder.	*Recruitment.* Participants were recruited via word-of-mouth with support from a peer mentor who connected potential participants to principal investigator (PI).	Participants were recruited from a pool of people who had participated in a 6-month, formal peer-mentoring program for pregnant women with substance use disorder (SUD).	*Data collected:* - Digital stories were transcribed. - Elements of the workshop were recorded and then transcribed, and field notes taken by authors to account for un-recorded elements. - Facilitators also debriefed at the end of each day to note their	Four themes: 1) Addiction in pregnancy 2) Path to recovery 3) Maintaining recovery 4) The work of peer mentoring Themes encapsulate the participant’s experiences of moving through their journey from addiction during

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[6] Digital story telling (DST) interventions can be utilised to collect data as well as provide a platform for understanding health-related events. Participants are encouraged to write and record their own 1–3-minute digital story about a health event. The story utilises voice recording, imagery and sound (Gubrium, 2009).

		PI then met with potential participants to provide overview and check eligibility. *Eligibility criteria:* peer mentors, in recovery from substance use, lived experience of perinatal substance use, participated in the "moms supporting moms" program, and over 18 years old. *Sample:* Five participants – no information provided on justifying sample size. *Demographics* • Ethnicity – all participants were white, non-Latina. • Ages ranged from 31-56, mean age 44.	Peer mentors with lived experience were paired with pregnant women with SUD to provide support and advocacy throughout pregnancy and post-partum. It was abruptly closed due to lack of funding. Participants were introduced to DST and provided with prompts to write their story, for example "write about a time when you understood what it meant to be "in recovery". Participants were supported by authors to create their digital story over the three-day workshop. On the third day, there was a group screening of all the digital stories. 2-4 weeks after completing the workshop, participants took part in an approximately 1-hour long semi-structured interview to further explore their experiences of peer mentoring, recovery	interpretation of events and notes were also taken for this. • Semi-structured interviews were audio-recorded alongside interviewer taking notes post interview to record initial impressions, any non-verbal communication. Interviews were transcribed. *Analysis* • Constructivist grounded theory (Charmaz, 2014). • First and second author separately coded all transcript data and met multiple times during the process to compare codes and categories and discuss themes. • Meetings continued until a final list of themes and consensus was reached to ensure rigor. • Member checking also took place to improve trustworthiness.	pregnancy, recovery and their work as peer mentors.

			and participation in the workshop.		
Fallin-Bennett et al. (2020)	1) To describe experiences of perinatal women opiate use disorder treatment with peer support specialists. 2) To describe recommendations for improving peer support services.	*Recruitment:* Recruited from a clinic which provided care for opiate use disorder for post-partum women parenting a child under 5 years old. No information provided about how they were recruited. *Eligibility criteria:* Those who had interacted with peer support specialists (PSS) during their pregnancy or post-partum period. *Sample:* 9 post-partum women receiving medication for opiate use disorder. No information to justify sample size. *Demographics:* • Ethnicity -All identified as white/Caucasian. • Age - range • 27-29, mean age 33	Two semi-structured focus groups were conducted by one of the authors (no information provided about how participants were split or if attended both). Participants were asked about their experiences of interacting with PSS's during pregnancy, in hospital and post-partum.	*Data collection:* Data was collected via the focus groups. They were audio-recorded and professionally transcribed. *Data analysis:* No specific analysis approach specified or referenced but qualitative analysis approaches described as below: • Trained research assistant coded the transcripts line by line according to codebook which had been developed. • Line by line coding was reviewed by principal investigator. • A code report was created, whereby data was organised by code and then into categories and themes.	Four themes emerged from the data: 1) Feeling supported by PSS 2) Qualities of an ideal PSS 3) Strategies to improve interactions with PSS 4) Importance of communication across the perinatal period Themes discussed the relationship participants had with their PSS and the ideal qualities of a good PSS. Participants shared their views on how to improve communication with PSSs and highlighted the overall importance of communication within the perinatal period.

Gruss et al. (2021) USA	1) To gather client perspectives of an integrated support programme which supports pregnant and postpartum women with substance use disorders and the role it played in their recovery. 2) To understand specifically the role the peer support group played in their recovery.	*Recruitment:* Two of the authors attended the support group twice to invite participants of the group to participate in research. Group facilitators continued to recruit in the weeks following. Those who were interested were then contacted to organise interviews. *Sample:* Eligibility criteria: Had to have participated in the group for at least four consecutive weeks. *Sample:* 12 participants. No info as to whether pregnant or mothers. No information provided to justify sample size. *Demographics* - No data provided on ethnicity - Age- range of 21-36, mean age 29.	Recruited from "Project Nurture" – an integrated care program offering social care, maternity care and substance use treatment to pregnant and post-partum women with SUD. Part of the offer is a weekly peer support group, attended by a peer support worker, addiction therapist and social worker.	*Data collection:* Researchers recorded field notes on their attendance at the group to invite participants which documented interactions and behaviours. These field notes contributed to the development of the interview guide, alongside consultation with the program physician. Questions were focused on the participants experiences of participating in the program and more specifically about the group including their motivation, skills acquired and experiences of stigma. Semi-structured interviews were conducted by one of the authors, lasting 30-60 minutes and were audio recorded and transcribed. *Data analysis* - Thematic analysis was used to analyse the transcripts. - Two of the researchers developed code books, generally reflecting the questions, based on a review of a subset of the interviews. - Each researcher coded same two transcripts to assess coding agreement and compared coding decisions. - Coding definitions were then refined, and the final 10 transcripts were transcribed by one researcher.	Three themes: 1) Sustained engagement in and accountability for SUD treatment 2) Access to well-coordinated medical and social support and resources 3) Establishing community around motherhood to learn self-acceptance and experience validation. Themes highlighted the importance of the group in maintaining engagement and accountability in their treatment as well as the role it played in supporting access to well-coordinated care and resources. The role the group played in establishing community, acceptance and validation is also discussed.

				- Heatmap also provided to show support of themes by participant number.	
Olding et al. (2022) Canada	To gain an understanding of support that PSWs' provide, or could provide, to multiservice perinatal programs for women who use drugs, from the perspective of those enrolled in the program.	*Recruitment:* Convenience sampling, participants were referred through program staff and recruitment posters. *Sample:* 20 pregnant and/or newly parenting mothers participated. No justification provided for sample size. No breakdown as to which services participants were recruited from. No information provided about how many participants were in each group, or if attended all three. *Demographics:* - Ethnicity -55% identified as indigenous, 35% white – no comment on other 10%.	Recruited from three perinatal programs supporting pregnant or newly parenting mothers who use illicit drugs or alcohol. One was based in acute care maternity unit and the other two were community programs. Both community programs employed peer support workers, the maternity unit did not but wished to. Peer support workers had a variety of duties. Focus groups were held with the participants to understand participant's experiences with peer support workers.	*Data collection* Three semi-structured focus groups were held (focus groups selected as minimally intrusive), which asked mothers about their experiences with PSWs, benefits and concerns of peer support and their own interest in becoming a PSW. Focus groups were audio recorded and professionally transcribed. *Data Analysis* - No qualitative analysis approach named specifically, however used inductive and deductive approaches. - Individual team members evaluated the data and then came together as a team to create a coding framework which generally reflected the questions as well as being informed by theory links on mothers who use drugs. - The team then identified themes and refined them until a consensus was made.	Four themes were generated: 1) "It's good to have that peer support, but they should offer them jobs" 2) "there's a different sort of relationship" 3) "You know if they can do it, you can as well" 4) "Anything to keep you connected to moms." Themes highlighted the unique nature of participant's relationships with PSWs, and the hope and modelling their recovery instills. Participants also spoke of the importance of keeping a connection with other mum's who have similar difficulties. Participants highlighted the value of peer support and their view that this should be reflected in employment/payment.

		• Age – range 18-40, mean age 29. • Gender identity - 90% identified as women, 10% identify as two spirit. • Drug use – 95% were poly drug users. • Drug use in 30 days before focus groups – 31.5% - heroin and/or fentanyl, 26% cocaine and/or crack cocaine, 21% crystal methamphetamine.			
Newell et al. (2022) USA	1) To assess participant's perceptions of the program in providing a comfortable environment, developing a support system and any other beneficial coping strategies. 2) To assess the likelihood of participants	*Recruitment:* Recruited from multiple sources: existing group members, the local treatment centre, and social media sobriety groups. *Sample:* 13 participants, all identified as women and mothers. No justification provided for sample size.	The meeting initially met weekly at a women's health unit and ran for 12 weeks. This then moved online due to COVID restrictions. The meeting used peer support concepts and called on those with years of sobriety to share their experiences followed by those who are newer to sobriety to	*Data collection:* Quasi experimental Pre and post questionnaire design delivered at the start of the intervention and at the end (12 weeks). Outcomes measured: • The Alcoholics Anonymous Intention Measure (AAIM; Zemore & Kaskutas, 2009) • Depression, Anxiety, and Stress Scale–21 (DASS-21; Henry & Crawford, 2005).	*DASS-21* Substantial improvement in every category. Pre-evaluation scores were generally extremely severe – moderate and post-evaluation scores predominantly were within normal-moderate range. *AAIM* 6 out of 13 had equal or increased scores, implying they intended to return to peer support, the other 5 decreased suggesting they would not. *Qualitative data:*

	continuing to engage in peer support after the evaluation.	*Demographics:* - Ethnicity - 92% white, 8% Hispanic. - Age - range – 30 – 67, mean age 48. - Time sober – 0 – 8%, <6 months – 46%, < 1 year – 15%, + 10 years – 31%	share their successes and challenges.	Authors also developed their own survey questions focused on length of abstinence, thoughts of the meeting, any feedback and meeting habits. The prequestionnaire consisted of four open ended questions about what attracted them to the group, what they hoped to gain, whether they attended any other groups and if being a mum made it hard to stay sober. The post questionnaire consisted of six open ended questions – could not be accessed. Surveys were reviewed by a substance misuse counsellor, a nurse who was in recovery and a nurse researcher. *Data analysis:* Statistical analysis was conducted in Microsoft Excel Narrative descriptions were provided for qualitative data.	- Feedback from all participants was positive. - Qualitative data suggest that participants found the group to be a comfortable, safe and secure space to share their experiences whereby they found a sense of community. - Twelve of the 13 participants stayed sober for the duration of the 3-month program.

Appendix B. CCAT (Crowe, 2013) quality scores by domain

Author & Year	**Preliminaries**	**Introduction**	**Design**	**Sampling**	**Data collection**	**Ethical matters**	**Results**	**Discussion**	**Total (/40)**	**%**
Alemi et al. (1996)	2	4	3	4	2	0	3	4	22	55
Sanders et al. (1998)	4	5	3	3	5	3	5	5	33	83
Ernst et al. (1999)	4	4	4	5	5	5	5	4	36	90
Kissman & Torres (2004)	2	3	1	2	0	0	1	2	11	28
Paterno et al. (2018)	4	4	4	4	4	4	3	5	32	80
Paterno et al. (2019)	4	4	4	3	5	5	4	5	34	85
Fallin-Bennett et al. (2020)	3	5	3	3	3	2	3	3	25	63
Olding et al. (2022)	4	5	4	3	4	5	4	4	33	83
Gruß et al. (2021)	4	3	4	4	4	4	4	4	31	78
Newell et al. (2022)	4	5	4	4	4	5	4	5	35	88

Appendix C – Journal of Substance Use and Addiction Treatment author guidelines

See link for detailed guidelines: https://www.sciencedirect.com/journal/journal-of-substance-use-and-addiction-treatment/publish/guide-for-authors

- **Systematic Reviews and Meta-Analyses** are typically articles of up to 7,500 words (exclusive of abstract, references, tables, or figures) that synthesize the research in a particular area. They should follow the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines, and be registered in the international database of prospectively registered systematic reviews (PROSPERO). JSAT will not accept articles in this category from authors with a financial conflict of interest.
- **Title page**
    - You are required to include the following details in the title page information:
    - Article title. Article titles should be concise and informative. Please avoid abbreviations and formulae, where possible, unless they are established and widely understood, e.g. DNA.
    - Author names. Provide the given name(s) and family name(s) of each author. The order of authors should match the order in the submission system. Carefully check that all names are accurately spelled. If needed, you can add your name between parentheses in your own script after the English transliteration.
    - Affiliations. Add affiliation addresses, referring to where the work was carried out, below the author names. Indicate affiliations using a lower-case superscript letter immediately after the author's name and in front of the corresponding address. Ensure that you provide the full postal address of each affiliation, including the country name and, if available, the email address of each author.
    - Corresponding author. Clearly indicate who will handle correspondence for your article at all stages of the refereeing and publication process and also post-publication. This responsibility includes answering any future queries about your results, data, methodology and materials. It is important that the email address and contact details of your corresponding author are kept up to date during the submission and publication process.
    - Present/permanent address. If an author has moved since the work described in your article was carried out, or the author was visiting during that time, a "present address" (or "permanent address") can be indicated by a footnote to the author's name. The address where the

author carried out the work must be retained as their main affiliation address. Use superscript Arabic numerals for such footnotes.

- **Abstract**
    - You are required to provide a concise and factual abstract which does not exceed 350 words. The abstract should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:
    - Abstracts must be able to stand alone as abstracts are often presented separately from the article.
    - Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
    - Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.
- **Keywords**
    - You are required to provide 1 to 7 keywords for indexing purposes. Keywords should be written in English. Please try to avoid keywords consisting of multiple words (using "and" or "of").
    - We recommend that you only use abbreviations in keywords if they are firmly established in the field.
- **Highlights**
    - You are required to provide article highlights at submission.
    - Highlights are a short collection of bullet points that should capture the novel results of your research as well as any new methods used during your study. Highlights will help increase the discoverability of your article via search engines. Some guidelines:
    - Submit highlights as a separate editable file in the online submission system with the word "highlights" included in the file name.
    - Highlights should consist of 3 to 5 bullet points, each a maximum of 85 characters, including spaces.
- **Reference style**
    - Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the *Publication Manual of the American Psychological Association, Seventh Edition (2020)* ISBN 978-1-4338-3215-4.
    - The reference list should be arranged alphabetically and then chronologically. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication

Paper 2 – Empirical paper

Hidden by fear, found in safety: An interpretative phenomenological analysis of parent's experiences of power and threat within a strengthening families approach to safeguarding.

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Shona Murdoch

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Abstract

Power imbalance is a well-documented feature of Children's Social Care (CSC) involvement and consequences of this contribute to poorer outcomes for families. There is no current research which explores parents' lived experiences of power and threat within this context, which this study aims to address. Four parents participated in semi-structured interviews to explore their experiences of power and threat in a strengthening families approach to safeguarding. Interpretative Phenomenological Analysis (IPA) revealed three Group Experiential Themes (GETS): "Living in fear", "Invisible and unworthy" and "A space to be seen". Participants described living in threatening home environments, which made it difficult to engage with services. This threat was heightened by experiences of feeling insignificant and unheard within some professional relationships. Professionals who could provide safety and security, allowed parents to open up, make sense of their difficulties and reclaim parts of their identity. Practice implications included the overt consideration of power by professionals, and ideas for how to rebalance this power somewhat. Future research could aim to understand the intersectionality of power within the lives of parents open to CSC and how this impacts engagement and relationship building.

Key words: Power, Threat, IPA, Child Protection, Parents

Introduction

An imbalance of power between professionals and parents is a well-documented feature of the involvement of children’s social care (CSC) within the UK & Ireland (Buckley et al., 2011; Muench et al., 2017; Smithson & Gibson., 2017). This imbalance can contribute to lack of participation (Corby et al., 1996), parents feeling threatened and shamed (Gibson., 2020) and consequently poorer outcomes for families (Featherstone et al., 2014; Muench et al., 2017). Whilst this phenomenon is established, there is a lack of research into parents’ lived experiences of power and threat within a CSC context. It is important to understand these experiences to improve outcomes both for children and families, and to also give voice to an often marginalised and stigmatised group (Grey, 2024; Mason et al., 2020; McGrath et al., 2023). This research aims to understand parent’s experiences of a strengths-based approach to safeguarding, particularly focusing on the role of power and threat within this.

Within the UK, Children’s Social Care (CSC) aims to support children and their families, intervene if children are at risk of harm and provide statutory care to children who need it (UK Government, 2023). CSC support families at three levels; early help (EH), child in need (CIN) or child protection (CP) and reflect escalating levels of risk within families. Where risk of harm is significant, CSC involvement is compulsory, with parents not having a choice within this (UK Government, 2023). Common difficulties which bring families to the attention of CSC include poor parental mental health, parental substance misuse and domestic abuse within the home (NSPCC, 2023).

Within the last decade, the number of looked after children in England has increased by 20% (Department for Education, 2024). The “strengthening families, protecting children” initiative, introduced in 2019, aims to reduce the number of children entering care and enable more children to remain safely within their family home. This initiative was introduced following a shift in statutory priorities, for example the NHS long-term plan (2019), Department for Education and Department for Levelling Up, Housing and Communities (2022) towards “stronger starts” for children via the prevention of and early intervention for difficulties within families and strengthening consistent and multi-disciplinary support for such difficulties. The “Hertfordshire” or “Family-safeguarding” model (FSM), developed as part of this initiative, utilises a multi-disciplinary team approach, including clinical psychologists and specialist adult workers, to directly support parents with their mental health and issues relating to substance use and domestic abuse with the aim of empowering parents with the tools to maintain change. Traditionally, parents access support for these difficulties from separate external agencies for example, local drug and alcohol or mental health services which can serve as a barrier for parents who have co-occurring needs (Mason & O'Rinn, 2014).

Literature suggests that parental experiences of traditional CSC is often negative, stressful and intimidating (Ghaffar et al., 2012; Lever Taylor et al., 2019). Parents describe feeling judged, stigmatised and reluctant to seek support for fear of this being used as evidence against their parenting capability (Broadhurst & Mason, 2017). Parents whose experiences have been more strengths- focused, described feeling more hopeful and encouraged by professionals (Fuller et al., 2013) and felt that this approach facilitated collaboration and a more trusting relationship between parents and professionals, as well as more empowering (Toros & Falch-Eriksen, 2021). Regarding the FSM, parents' feedback has been largely positive reporting improved quality of life, mental health and relations within their families. Compared to previous non-FSM CSC involvement, the model was experienced as more empowering, encouraging and participatory (Department for Education, 2020). Parents particularly valued the support of specialist workers for their own difficulties, however continued to report difficulties in terms of communication, lack of involvement, and feeling judged (Buivydaite et al., 2024).

When considering how best to support parents under the FSM, it is important to recognise that many will have their own adverse childhood experiences (ACEs) which are likely to contribute to their difficulties in parenting. In a sample of mothers whose child was subject to care proceedings, 70% reported childhood physical abuse, 47% childhood sexual abuse and 45% were care experienced themselves (Broadhurst & Mason, 2020). It is of note therefore, that parents bring with them their own experiences of feeling threatened and disempowered due to their trauma histories, and that this needs to be considered as part of CSC process. Research has also identified intergenerational transmission of ACEs from parents to children. Children of parents who had ACEs were more likely to have difficulties in a variety of sociopsychological outcomes such as developmental delays, impaired emotional development and poorer educational attainment (Arnold et al., 2023). Similarly, outcomes have been found within the children of care-experienced mothers compared to those whose mothers were not care-experienced (Parsons et al., 2024). These findings highlight the necessity of supporting parents with their own difficulties as part of a strengthening families approach (SFA) to empower them to make changes which, reduce risks posed to their children, support them to remain in their family home and disrupt the intergenerational transmission of ACES, trauma and care experience. Findings also emphasise the need for working with families in a trauma-informed manner, to avoid re-traumatisation and mirroring previous highly threatening and disempowering experiences.

The Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018) can be a useful tool to understand how power dynamics contribute to distress. The framework highlights the importance of a person's environment and context in relation to their distress, with a particular focus on power, how this contributes to feeling threatened and what methods a person adopts to manage and survive the distress. Within the literature, the framework has been applied to understanding several distressing experiences such as violence within prisons (Gallagher et al., 2023) and psychosis (Rainey et al., 2025). More pertinently to the current study, is the application of the PTMF to synthesise literature on compulsory child removal (Enlander et al., 2022), which highlights the necessity of shifting the narrative of blaming parents to understanding what they have experienced in life to bring them to the attention of CSC such as developmental trauma and systemic adversity.

The FSM is well positioned to consider these difficulties, particularly as part of the direct work offered to parents by the specialist adult practitioners (APs). It also aims to empower parents, with social workers (SWs) trained to deliver motivational interviewing which aims to promote ownership of change (Rodger et al., 2020). Hearing parents' experiences can help us to consider whether the FSM provides a different experience in relation to power and threat, when compared to traditional CSC which is experienced as highly threatened and imbalanced in power. It also ensures that we understand features of the model which contribute to a positive experience (Tilbury & Ramsay, 2018), ensure that they feel heard and valued, contributing to positive relationships, improved engagement (Baginsky, 2022) and to give voice to a marginalised and stigmatised group.

Current study

This study aims to explore the experiences of parents who have been supported by the family-safeguarding model, with a particular focus on the processes of power and threat within this. The two aims therefore are:

- To explore the experiences of parents whose families have been supported under the FSM
- To explore how parents experience power and threat within this process.

Research question

What are parent's experiences of power and threat in the context of a strengthening families approach to safeguarding?

Methods

Design

A qualitative design was adopted, as they are valuable in illuminating the complexity of the human experience via in depth accounts (Sofaer, 1999). Semi-structured interviews were utilised as they bring pertinent topics into focus, whilst being flexible to each interviewees experience (Mason, 2017). Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) was selected as the method of analysis as it is considered to be well suited to understanding complex and emotionally burdensome experiences, such as the involvement of CSC, due to the detailed nature of analysis and the double hermeneutic which consists of two layers of interpretation. Firstly, the participants own sense-making of their experience and secondly the researcher's interpretation of the participant's sense-making of their experience (Smith & Osborn, 2015). This, in addition to the idiographic nature of IPA, allows for a deeper exploration of the participants subjective experience, whilst additionally acknowledging the influence of the researcher via their interpretation. The phenomenological approach used to acknowledge one's pre-conceived ideas about an experience, lends itself well to the sub-group the research focuses on, as they often heavily stigmatised and misunderstood by society. This approach allows for the lived experiences of this group to be heard without a pre-conceived lens and is why it was selected over other qualitative methods of analysis.

Ethical Issues

Ethical approval was obtained from University of Staffordshire (appendix A) and the Health Research Authority (Appendix B). All participants provided verbal and written consent, with written consent confirmed at interview (Appendix G). Identifiable information was redacted from transcripts, and participants were allocated a pseudonym to preserve anonymity. Specific care was taken to ensure that parents were well informed of the risks of taking part prior to participating; namely psychological distress and sharing of information with the local authority should there be a new safeguarding concern. Information was to be shared via the clinical supervisor and then to the participant's assigned SW if still open to the service, or to the access team if discharged (see flowchart as part of appendix D). No safeguarding concerns arose throughout the course of the research, nor distress which required additional support post-interview.

Recruitment

Participants were recruited from one NHS site which delivered the FSM. Staff members acted as gatekeepers and initiated first contact with potential participants. The researcher shared details of the research study with staff via multiple avenues; a recruitment video, attendance at team and service meetings, and follow ups via e-mail. Staff members contacted eligible (see Table 1 for eligibility criteria) participants to inform them of the research opportunity. Should they be interested, they gained written consent (appendix F) for the researcher to make contact and provided them with an information sheet (appendix D). The researcher then made contact, checked eligibility, answered questions and informed of risks of taking part. Should participants wish to continue, consent was gained to participate (appendix G) and interviews arranged either virtually or face-to-face.

Sampling and participants

Purposive sampling was used to recruit a homogenous group, imperative to the method of IPA to enable a nuanced exploration of a shared experience. 17 parents were approached by professionals as eligible participants, ten did not wish to participate and seven expressed interest and consented to contact from the researcher. Initially, all seven agreed to take part, however three dropped out leaving four who made up the final sample. A sample size between 6 and 10 is recommended for professional doctoral level research (Flowers et al., 2022), and six participants was the target sample size. Recruitment was a challenge due to service pressures and staff managing competing demands, meaning that supporting the research was understandably perhaps not a priority, staff sickness was also an issue meaning less people were available to support the recruitment process. Participants own context may have also influenced difficulties in recruitment, such as fear of consequences, worry about anonymity and difficulties with trust (Mirick, 2016).

All four participants identified as female, white British, and their mean age was 32 years. Three participants had been discharged from the team, and one was due to close shortly. Participants had been involved with the service for between 1 and 9 (intermittent) years. All participants had social work involvement and had experience of being in abusive relationships. Four therefore had received domestic abuse support from the service, three had received mental health support from the service, and one had received substance use support from the service.

Table 1

Inclusion and exclusion criteria for participants

Inclusion criteria	Exclusion criteria
Parents whose family has been supported within the FSM at any level (Child In Need or Child Protection[7]) including those whose children were removed and are now looked after children (LAC).	Any parent who was experiencing a self-determined current mental health crisis or elevated distress, or who felt discussing the topic would be too emotionally challenging in interview
Parents who were about to be discharged from (within the following two months) or had been discharged from FSM (within last six months).	Parents whose family were open to FSM, with no plan for discharge within the near future (2 months).
	Parents whose case was in legal proceedings.

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[7] . Children in need are defined as children who are unlikely to reach an adequate level of health or development without the input of services. These children will be placed on a “Child in Need” plan to support them and their family. Child Protection Plans support families where there are concerns that a child is at significant risk of likely or actual harm. These are both statutory services from CSC. (UK Government, 2023).

Procedure

Two interviews were conducted online via Microsoft Teams and two face-to-face. All interviews were audio and video recorded and transcribed via Microsoft Teams. Transcription was then checked manually and amended as necessary. Interviews took place between March and July 2025. Pseudonyms were used alongside redaction of identifiable information to maintain confidentiality. Interviews were followed up with clinical supervision to discuss any concerns that may have been raised during the interview.

Data collection

Four semi-structured individual interviews were used to gather data. Interviews lasted between 45 and 77 minutes (average = 57.5 minutes). The researcher developed an interview guide (appendix H) inspired by different sources; published research exploring parental experiences of CSC, published research using interviews to understand power and threat in different contexts (mental health and forensic services), the PTMF, and principles of trauma informed care. A member of the service user group attached to the service was consulted on the interview guide, to ensure that the questions were accessible and captured important elements of the family-safeguarding process. Questions covered parents’ general experience of the FSM and more specific questions pertaining to power and threat within their experience, for example how much they felt involved within the planning of their care and how anxieties/setbacks were managed. Demographic data was collected at the beginning of the interview, and parents were provided with a debrief form (appendix I) at the end of the interview which signposted them to support services.

Data analysis

The seven steps of analysis were followed (Smith et al., 2022). Following creation of the transcripts, the researcher immersed themselves in the data via re-reading transcripts and listening to interview recordings. Exploratory noting (appendix J) then documented any initial thoughts or reflections throughout the transcript. Exploratory notes were then constructed into experiential statements (ES) (appendix J) which aimed to summarise conceptually the core of the participants experiences. ESs were cut out and organised into clusters by similarities and differences to create personal experiential themes (PET) (appendices K & L). These steps were repeated in turn for each transcript. PETS were also then cut out and organised similarly into clusters to form Group Experiential Themes (GETs) (appendices M, N, O).

Rigor and trustworthiness were ensured via discussion regarding themes with supervisor, and a peer supervision group of those using the IPA approach throughout the analytic process. Quoted material was also used to support themes.

Ontology, epistemology and reflexivity

The researcher took a relativist ontological stance, which posits that reality is not fixed nor objective and is a subjective experience created by an individual and their context (Rassokha, 2022) and a social constructivist epistemological stance, which suggests that knowledge is created through human experience and interaction with others and the world itself (Schwandt, 2008). The researcher therefore adopted an approach which recognised that each participant will have constructed their reality differently (Boyland, 2019) and simultaneously recognised their own role in the interpretation of this reality.

Prior to doctoral training, I worked with parents with difficulties relating to substance use whose children were open to social services. I therefore already held my own views about power and threat within broader children’s social care settings, having witnessed the powerlessness and high levels of threat amongst the parents I supported. I acknowledge that this experience is likely to have influenced my interpretation of the data via the “double hermeneutic” principle (Smith & Larkin, 2022). I utilised a reflective log and used open-ended questions to elicit participant experience as organically as possible. I also attended peer IPA supervision sessions to discuss themes generated.

Results

This research aimed to explore parents' experiences of power and threat within a SFA to safeguarding. Analysis revealed three GETs and six subthemes (See Table). GETs included: "Living in fear", "Invisible and unworthy" and "A space to be seen".

Group experiential theme	Subtheme	Participants contributing to the theme
1. Living in fear		Rosie, Michaela & Louise
2. Invisible and unworthy	2.1 Made out to be a sh*t mum	Louise & Tina
	2.2 Belittled and insignificant	Tina, Louise & Michaela
	2.3 Unheard and excluded	Tina, Louise & Michaela
3. A space to be seen	3.1 Building a connection	All participants
	3.2 Validation and making sense	All participants
	3.3 Empowered and reclaiming me	All participants

1. Living in fear

All participants had experiences of being in abusive intimate relationships. For three, these experiences were recent and contributed to their referral to CSC. They reflected on living in fear of their partner's violence and control and how this impacted on their ability to reach out or receive support from CSC.

Rosie shared how worries about the consequences of reaching out, such as an increase in the violence perpetrated towards her by her partner, had delayed help-seeking.

> *“Yeah, I didn't reach out enough because, well, I was scared of him. So yeah (…) there was repercussions for everything that I did.” Rosie P4*

Louise had a similar experience in delayed help-seeking. Within her circumstances, professionals were attempting to reach out to her to offer support however her partner’s influence was so strong that she appeared to internalise the belief that she didn’t need support therefore did not accept help.

> *“N was trying to get involved with me in that. But because of M, I couldn't. So. So things were being offered but because he was telling me, no, I don't need them. I don't need them. So I was, I was, I was stuck”. Louise P16*

Louise referenced how her partner’s influence not only made it difficult for her to seek help from professionals but also impacted her ability to parent. Whilst her child was kept safe and looked after, she did not appear to identify with being a “mother”, perhaps as she was not able to be the best version of that or because his control and influence had taken that aspect of her identity away.

> *“I couldn't be a mother because M wanted that control of everything. And don't get me wrong, O was looked after and he was safe, but I couldn't be the best version of myself to parent.” Louise P7*

Michaela described feeling totally powerless within her relationship. Her partner had control over all elements of her life, even her basic needs such as eating. This meant that the consequences of being honest with professionals about the abuse, would be putting her basic needs at risk.

> *“If he wanted me to do something, I’d have to do it there and then. He'd starve me if I wasn't…you know…I couldn't.” Michaela P10*

Michaela also referenced how “brainwashed” she was by her partner, reflecting the level of power and influence he over her, and how this had eroded her self-worth and self-esteem. This served as a very strong barrier to her accepting support from professionals sooner, as she did not believe in her capability as a mother without him, and knew that by opening up she would be encouraged to leave him.

> *"I was literally completely brainwashed. So I I truly believed that I I was incapable of being on… like without him." Michaela P4*

Michaela described "manipulation" as a strategy that she had adopted to keep herself and her children safe, and as one that CSC should be conscious of when supporting parents who are in abusive relationships.

> *"…because they've been manipulated for so long, they learn to be a manipulator as well. Not in a narcissistic way, but in a way of protection. Yeah. So they do become good actors." Michaela P37*

She described "acting" as necessary to hide the extent of the abuse from her partner from professionals, so not to escalate his violence. Speaking about herself in the third person reflected Michaela's perception that she was no longer a "victim" as she had left her abusive relationship and therefore did not identify with being a "manipulator" anymore. Louise also hid information from professionals to protect herself from further harm.

> *"When I ended the relationship, I said, listen, obviously I wasn't being honest with you because of what I was going through" Louise P9*

2. Invisible and unworthy

For some participants, the threat that they were already experiencing within their intimate relationships was then compounded by threats from the system and professionals involved in the care of them and their families. Participants experienced some professionals as judgemental and belittling, who made them feel insignificant and excluded. These experiences clearly increased threat amongst families, making it difficult to form safe and trusting relationships with such professionals. This also led to parents being disempowered, as their voices were not sought out, heard or valued.

*2.1 Made out to be a sh*t mum*

One feature of these relationships was a sense of feeling judged and was a shared experience between Tina and Louise. Louise felt that the judgment was relentless, particularly in relation to her parenting capabilities and identity as a mother.

> *"I just I was getting judged all the time and I was made out to be a sh*t mum and just things like that, yeah". Louise P11*

She recalled a conversation with her SW about her substance use. Louise felt that nothing was ever going to be good enough for her SW, and that despite managing to maintain abstinence for long periods in the past, her SW felt that this wasn't evidence that she could manage this again. This could also be interpreted as the SW prescribing to the stigmatised and stereotyped ideas around substance use, that those who have had difficulties with substances will inevitably relapse.

> *"And I was clean for three years. But I was still on methadone and then J, she was like "how long is long enough to be clean? like you're always going to revert back to drugs." Louise P12*

This is likely to have contributed to Louise feeling powerless in the relationship, as she did not feel good enough or able to prove herself. It is also likely to have contributed to the poor relationship she had with the SW and her engagement with her going forward, as she did not provide validation for the progress and achievements Louise had made.

Tina provided examples of professionals passing judgement on her home environment. Whilst this is to be expected and is certainly within the remit of the role of CSC, the way in which this was communicated to Tina felt passive aggressive and critical and this altered her ability to trust professionals and feel safe within her interactions with them.

"But they turned around and said "Oh, you've tidied up this time" (…) I don't know if they were joking or not. This is why I don't trust professionals." Tina P12

2.2 Belittled and insignificant

Participants shared feeling belittled by and insignificant to some professionals involved in their care. This included experiences of being put down and undermined as well as feeling unworthy within the professional relationships.

Louise felt her interactions with her SW were often negative and belittling. She also referenced her SW's position as a professional, the power that this carried and compared this to "people like me", suggesting that she viewed herself to have much less power and influence in the dynamic.

> *"She would always say, like snarky comments to try and put me down (…) obviously because she's the professional they (…) (other professionals) tend to believe her over people like me." Louise P4*

Tina reflected a similar position and described an example of feeling belittled by her SW after they had a misunderstanding regarding some feedback from another professional. Tina felt that her position was undermined leading to her feeling angry and upset.

> *"I felt I felt awful. (…) Yeah, absolutely shit. I said she made me feel so small. I was fuming." Tina P3*

Louise reflected on how she felt insignificant to CSC once her child was removed, in that her worth was attached to having her child in her care. The violence in her relationship escalated following removal, describing life at home as "hell". She believed that professionals knew how at risk she was, but did not offer the bare minimum such as a check in.

> *"… soon as O went, that's when things got really bad. And it was like she didn't give a sh*t about me. Like, she knew that I was going through hell, but no one would even come check on me." Louise P6*

Michaela shared similar experiences of feeling insignificant, reflecting on her experience of one SW who just wanted to "get the ticks". To her this felt tokenistic and as if they didn't truly try to understand or care what happening within her family.

> *"But I think sometimes she saw, but she just thought there's too much hassle" Michaela P33*

In this example, she felt that some signs of abuse were noticed but not acted upon, reinforcing feelings of insignificance. Michaela felt let down by professionals and that opportunities were missed to save her and her children from further harm. This is likely to have compounded her feelings of powerlessness as professionals with power, did not help her.

2.3 Unheard and excluded

Parents reflected on instances whereby they felt that their opinions or views were not sought out, not respected or incorporated in a way which felt meaningful to them.

Tina reflected on attending multi-professional meetings and struggling to understand professionals. She referenced difficulties in understanding the language that was used, as well as having to process such a high volume of information.

> *"I just don't process anything. (…) I'll forget what you've said, especially the meetings. It's like, can you just write something down and tell me what what is?" - Tina P6*

Tina described adopting a passive approach when not understanding professionals stating, "I'll just nod", as she found it difficult to be honest with them about her struggles with comprehending. This could be interpreted as a threat response to an imbalance of power, in that she perceived it safer to stay quiet than challenge. In the context of judgement by professionals, she may have also worried about she would be perceived should she be honest about not understanding.

When Tina tried to make decisions about her children's care, these were often disregarded. She recalled a discussion about her child's medication, which she felt was making her child more unwell and so decided to stop this. Professionals disagreed with this decision.

> *""So I put her back on them after they was having a go at me and saying we've got to put her back on them - even though it's my child." Tina P3*

Ultimately, Tina was disempowered. Without an understanding of her children's care plan, she was unable to meaningfully contribute towards it and when she did attempt to contribute, her views were disregarded. Her voice was therefore excluded as their mother.

Louise described instances of being more overtly excluded. She reflected on when her child was removed from her care and how powerless she was in this, in that her permission was not sought, nor her beliefs asked for.

> *"Like they just thought, "Oh, Louise is in a shit situation. So we're just gonna remove the child" sort of thing. Without even my permission, without even my talking about my beliefs and everything." Louise, P8*

Louise shared how she continued to feel uninvolved as her circumstances escalated into the legal arena. She described feeling blindsided by the professionals involved as she had not been involved in such a huge decision. She reflected on how unjust and wrong this felt as a parent.

> *""you've got to wait until court (...) And I was just like, well, what's going on? I said no one's told me nothing. (…) How has it even led to this without me knowing? So it's f*cked up really." Louise P3*

3. A space to be seen

Despite some professional relationships feeling threatening and unsafe, all four participants shared experiences of professional relationships which felt comfortable, safe and enabled them to open up, make sense of some of their difficulties, and feel empowered to reclaim elements of themselves.

3.1 Building a connection

Participants described the process of building a connection with professionals and valued qualities such as authenticity, informality and empathy. These safe and secure relationships appeared to be more balanced in power and allowed for vulnerable moments of connection.

For Tina and Rosie, an informal approach was key to breaking down barriers and easing anxiety. Both described relationships with some professionals involved in their care as feeling "like friends", suggesting that there was an authenticity to these relationships and that they were more balanced in power. Rosie shared how the informality contributed to building trust with professionals quickly.

> *"It was just comfortable and they would just come in and act like your friend was visiting. And it wasn't so formal. (…) So. that put me at ease straight away." Rosie P5*

Rosie also described opportunities for genuine connections as humans, rather than professional and client. The informality and the authenticity this professional brought into the relationship, allowed her to feel safe and let her walls down.

> *"We had chance to have normal conversations as well. (…) So it just flowed. I think if someone came in and just treated it an interview, I would be stand off-ish. (…) It wasn't like that." Rosie P5*

Tina referenced "talking like a normal person" as important to supporting building trust, rather than using jargon and lots of professional language. This is likely to have helped Tina feel less "different" to professionals, as they were using a shared language and supported the rebalancing of power.

Louise described being met with a non-judgemental attitude and reassurance from the AP involved in her care. This positive regard allowed her to be open and honest in the face of difficulties. The encouragement she received from them also signalled that they were in alignment with her, cared for her and wanted her to do well.

> *"I could just be open and honest with them, and even if, like I had a step back (…) they sort of said like it's OK and like as long as I'm trying to focus on the positive and just trying to look forward, like they were really encouraging like that." Louise P5*

Feeling safe and comfortable allowed participants to be more vulnerable in these relationships. Michaela described the unique relationship she had with one of her APs. Qualities of kindness and understanding were felt to be authentic, which perhaps conflicted with previous experiences of feeling "manipulated". This suggests that Michaela was able to trust F, reducing threat and enabling safety in their relationship.

> *"I opened up to F, like I'd never opened up to anyone in the services. I did you know, because she knew how to do it without manipulation. But with, with kindness and with understanding" Michaela P37*

Tina described a vulnerable moment she shared with one of the APs and reflected on the gravity of this. The expression of a withheld emotion, alongside the humour she shared within the moment, suggests that she felt very safe and secure within this relationship and described how it felt to share that moment.

> *“And I actually cried in front of her, I'd not cried for years. Family members died and I didn’t cry. So when I did cry it was weird *laughter*, it was. So I said “this is your fault” *laughter*, but in the goodest, good way”. Tina P5*

3.2 Validation and making sense

Within the safety of these relationships, participants were able to begin to make sense of some of their difficulties, were allowed a space to feel validated, and for some, remove shame and self-blame

Michaela spoke about the experience of making sense as one which confirmed a previously conflicted view of herself, that she was not to blame for her abuse. This was an important step in reclaiming self-worth and beginning to treat herself with compassion as lessen the guilt she had carried relating to the distress caused to her children.

> *“F taught me … to see… what I already knew, but I didn't know. (…) to see that it wasn't my fault. She taught me to see that little things I'd, that I truly thought I'd done wrong, weren’t wrong.” Michaela P12*

Rosie also reflected on the work she did around domestic abuse. She spoke the mixed emotions that come with leaving an abusive relationship and how these were embraced and validated by the AP: she was “allowed to feel all those feelings” and not “push it away”. This allowed Rosie’s true experience to be respected and normalised, in turn supporting her to feel less ashamed and shift the blame.

> *“To be understood that way, was just the best feeling, because it was like, OK, I'm not crazy yeah, like, he used to make me feel. Yeah, it was nice that they kind of got that out of my head that it wasn't my fault. It was his fault.” Rosie P6*

Tina also referenced the experience of making sense as one which removed her self-blame. Within the safety of her relationship with her AP, she was able to shift the perspective that her distress was out of her control, and “determined” and understand how events may have contributed to her difficulties.

> *“Yeah actually realising why I’m like this (…) Because I used to blame myself, that I’m just programmed to be like this. And then looking back, what all the events happened, I was like, oh, that might be why I went downhill.” Tina P5*

These experiences of validation extended not only to making sense of one’s circumstances but also to feeling acknowledged and truly “seen” by professionals. Michaela and Louise described powerful moments in their relationships whereby they felt acknowledged beyond the “surface” and understood in their entirety.

> *“You know, but they understood me. (…) Yeah, they didn't just understand me as a person sitting there. They understood everything that was about this person sitting there”. Michaela P34*

These experiences reflected the depth of the relationships they had with some professionals. The weight and importance of this recognition was reflected powerfully by Louise, who began to cry whilst sharing the below statement. This signalled how validating this moment was, to be seen beyond a stereotype or a label.

> *“(…) because they didn't see me as a drug addict or…like they just seen me as a person” Louise P5*

3.3 Empowered and reclaiming me

Participants reflected on how these relationships were also empowering and allowed them to reclaim parts of their lives or identities.

Michaela described how her relationship with F, contributed to her understanding that there was more to her than her partner. This shift in perspective, as well as the building of her self-worth and connection with F, empowered her to leave her abusive relationship.

> *“But without F I would never have had the tools to do it. You know, she gave me the.. she, she, she just opened my mind and let me know that I wasn't just K’s little bubble. I was a person. Yeah. Yeah”. Michaela, P17*

Louise described being empowered to change old patterns of coping. The validation and understanding of herself she gained throughout her safe relationships, allowed her to change a lifetime of “self-destruct”. It suggests that she had built self-worth and realised that this way of life was not what she deserved, nor was serving her and was able to shift her direction.

> *“Like they said, like after everything that I've gone through, like you could either go one way like in self-destruct, which I've always done my whole life or technically, like wake the f*ck up and realise you need to change your life and that's what I've done this time” Louise P12*

Rosie was able to use the nurturing environment to reconnect with who she was before her abusive relationship. She reflected on how she had lost her identity, and that the handholding, and connection with professionals had made it possible to rediscover herself and move on.

> *“I feel like I lost myself before, but now I'm getting myself back. Yeah, remembering who I was before. Feisty. (…) and it’s all thanks to them. I don’t think I could have done it without them” Rosie P12*

Discussion

This study explored parents’ experiences of being supported under the FSM, with a particular focus on power and threat within this. Three GETs were identified “Living in fear”, “Invisible and unworthy” and “A space to be seen”. These findings will be discussed in the context of current literature and theory as well as outlining implications for future research and practice. Strengths and limitations will also be discussed.

Participants described “Living in fear” due to the abuse that they were experiencing within their intimate relationships. The fear of their partners, and the consequences associated with seeking support, acted as a barrier to seeking or accepting support from CSC. These experiences represented how participants were existing in threat and survival mode attempting to avoid escalating violence or control. A review of 3.6 million social work assessments in England and Wales, found that single factor domestic abuse was the most common category of need (Nuffield foundation, 2024) reflecting the prevalence of this issue. Fear of consequences such as escalation in violence, retaliation or fear of child removal are well documented barriers to survivors of abuse seeking help (Rose et al., 2024) and these worries reflect experiences within this study. In the face of feeling threatened, parents adopted strategies to survive these experiences. These included concealing information from professionals and passivity. The PTMF calls these “threat responses” and are methods of coping we adopt to ensure our safety in the face of danger (Johnstone et al., 2018).

Participants referenced feeling “Invisible and unworthy” to some professionals, which made for a threatening and disempowering relationship. This included receiving judgement on their home environment and histories. Whilst professionals are to use judgement to inform decision making, these judgements were perceived as critical and not constructive. Within the literature, parents have described similar experiences of judgement, for example feeling like a “criminal” and that professional perceptions were majority negative (Ghaffar et al., 2012). Mothers who were in abusive relationships also described an additional level of judgement and shame attached to their experiences of CP citing that they felt to blame or embarrassed (Ghaffar et al., 2012). This may explain, in addition to safety concerns, why those in abusive relationships adopt strategies such as silence, passivity and withholding information. Experiences of exclusion, whereby parents’ voices were disregarded or not included meaningfully within their families care are echoed within the literature, with parents describing themselves as bystanders rather than participants within the CP process (Corby et al., 1996) and that it was only the views of professionals’ that influenced decisions about their family’s care (Arbeiter & Toros, 2017). Negative interactions with professional’s impact parent’s ability to form relationships with them as positive interactions form the basis of a trusting relationship, which is critical for meaningful engagement and change by parents (Lehtme & Toros, 2020).

Simultaneously however, parents experienced “a space to be seen” within safe, comfortable and authentic relationships with professionals and allowed for validation of their difficulties, a space to make sense of themselves and reclaim parts of their identity. This finding was also reflected by other parents’ experiences of the FSM describing being well supported by professionals who empowered them to make positive changes (Buivydaite et al., 2024). Features of these relationships reflect those of a “secure base”, in that professionals provided a relationship whereby parents and professionals were attuned and parents felt safe and responded to (Bowlby, 2005). Providing a secure base is well established as promoting better outcomes in therapeutic relationships such as improved engagement (Jacobsen et al., 2024), establishment of trust and promotion of change (Podolan & Gelo, 2024).

In terms of experiences of power, this study suggests that participants were disempowered at two different levels. Within their relationships participants described ways in which they were silenced by their partners' power. Duluth's (1980) power and control wheel depicts how abuse perpetrators use certain strategies to maintain power and control over their partners such as using isolation, intimidation and coercion and threats, reflecting experiences of those in this study. Parents also referenced feeling powerless within the social care arena. Power within health and social care systems has been described as "not a level playing field" (Smithson & Gibson, 2015). Observations were made regarding the influence of different professionals, and how this often-left parents oppressed and disempowered which is reflected within the literature (Ross et al., 2017).

The results of this study suggest that the PTMF can be applied to the experience of being supported by a SFA to safeguarding. Whilst some relationships with professionals felt more balanced in power, threat and experiences of disempowerment were still present. These were compounded by experiences of feeling judged, insignificant and not listened to. Within those more balanced and safe relationships though, participants were able to let their walls down, open up and understand more about themselves which was an empowering and important feature of the FSM.

Strengths and limitations

A strength of this research is that it is novel. No other research has explored power and threat within service users' direct experience of CSC or within the FSM. The research also gives voice to an underrepresented, heavily stigmatised and marginalised group (Broadhurst and Mason, 2013; McGrath et al., 2023). This serves as a gesture of empowerment to this group.

Unfortunately, as referenced in the methods, the sample size was smaller than planned due to difficulties in recruitment, a limitation of this study. The researcher also noted some anxieties within teams about how potential participants may reflect on their experiences of care, which could have served as a further hinderance in recruitment. The nature of the difficulties faced by this group also served as barriers for some such as declining mental health and difficult events within families.

The sample also lacked diversity, in that only white British females were represented, meaning that the voices of other ethnic groups and fathers were not captured. The majority were also no longer open to the service, a method which provided more anonymity, such as questionnaires, may have felt safer for those who were still open to CSC and encouraged their representation.

Implications for practice

Since experiences of feeling powerless were common amongst this sample, it is recommended that the role of power be overtly considered by professionals within the FSM. SFAs do aim to empower parents, and whilst there were examples of this in this study, it was not consistent amongst the different professionals. Clinical Psychologists working within this context could offer training on the intersectionality of power and use the PTMF (Johnstone et al., 2017) to illustrate how imbalances in power can contribute to distress and can manifest in threat responses such as relational difficulties or disengagement. The PTMF could serve as a useful tool to broaden systemic thinking and contextualise and reframe these challenges.

As participants also struggled with feeling heard and included throughout their journey with the FSM, it is important to consider how parents could be better collaborated with. Peer parental advocacy (PPA) initiatives have been introduced into some local authorities in England, which match parents with peer advocates who have experience of the CSC process themselves. These initiatives been found to be useful in addressing power imbalances between professionals and parents, building and facilitating trust and supporting parents to make meaningful contributions (Fitz-Symonds et al., 2024).

Participants offered a largely “split” perception of their relationships with professionals, broadly feeling safer with the APs. SWs hold the difficult role of building and maintaining a safe and trusting relationship with parents, whilst holding the power to make very difficult decisions for families. SWs working within the FSM reflected on the importance of APs in their practice, particularly in better understanding a family’s difficulties and containing anxieties around more positive risk taking (Cucciniello & Melia, 2024). This reinforces the important role that Clinical Psychologists can play in providing consultation and reflective spaces to offer containment but also support in the balancing of risk assessment and maintenance of strong therapeutic relationships. The strong relational skills held by Clinical Psychologists could also be applied to supporting in the delivery of difficult decisions to families and repairing ruptures between families and professionals where necessary.

Implications for future research

Future research could focus specifically on the intersectionality of power within the lives of families open to CSC and how this impacts upon their ability to engage meaningfully with services and build therapeutic relationships. This could provide a systemic lens on how much power imbalance is influenced by structural and societal factors and how much power can be rebalanced within the context of CSC.

The FSM and its use of multi-disciplinary working aims for professionals to work as “one team” to provide support to the family. The findings of this study however suggest parents “split” SWs and APs in terms of their perceptions of them and that they are not viewed as “one team”. It may be of use to understands professionals’ perception of this split, if it is present, and ways to work within this.

Conclusion

This study found that parents continue to experience high levels of threat and disempowerment within a SFA to safeguarding. Threat and powerlessness were influenced both by parents own microsystem but also by that of judgemental, exclusionary and invalidating professionals. Simultaneously however parents also experienced relationships in which they felt safe and nurtured and were empowered to reclaim elements of themselves. It appears that professional qualities of empathy, active listening and encouragement were facilitators to these experiences. Further research could focus on the intersectionality of power and how this influences relationship building and engagement with services. In attempt to address power imbalances and reduce threat within clinical practice, training could be provided on the PTMF to bring more awareness to the role of power within this setting, or initiatives such as PPA could be considered or adopted.

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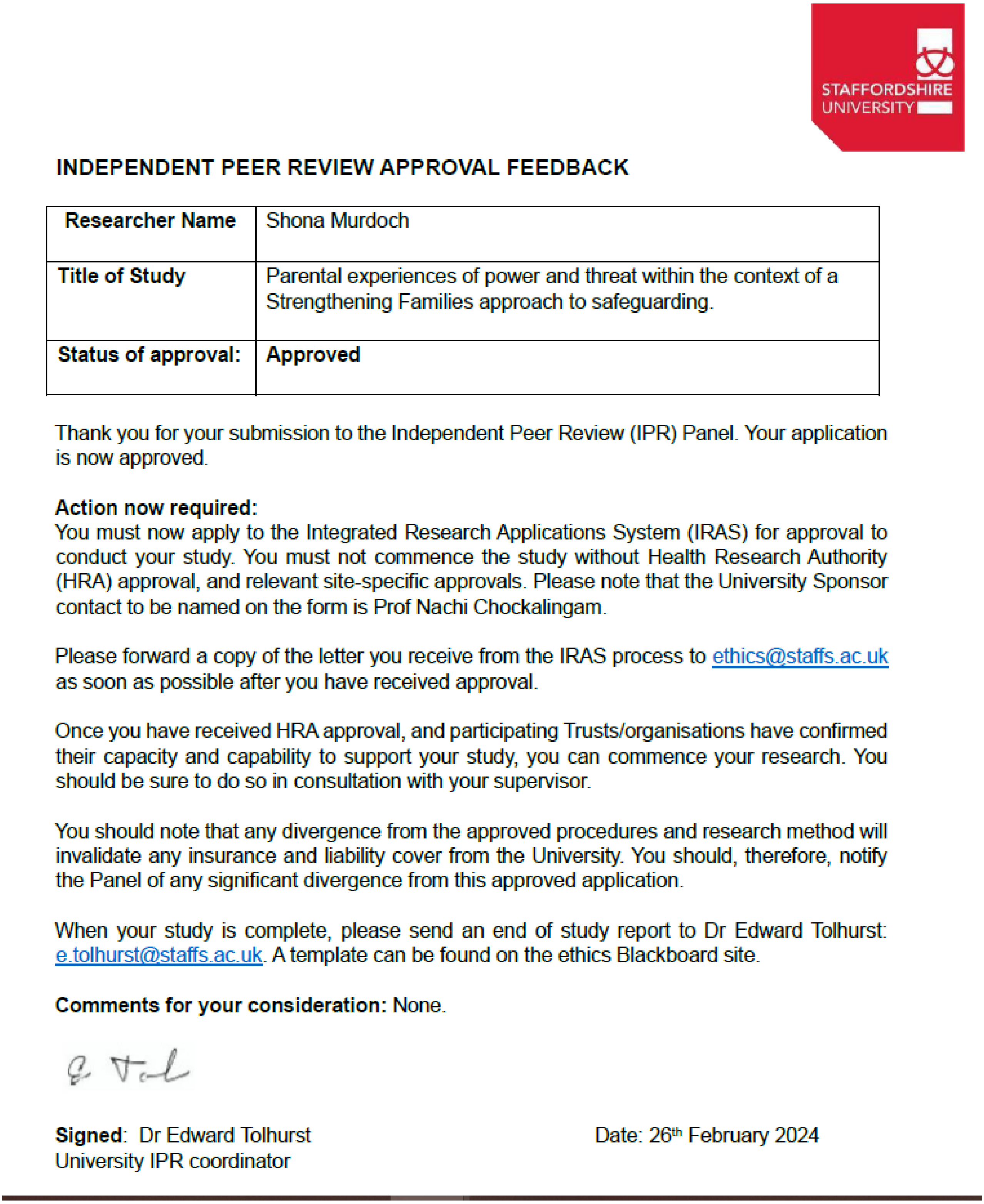
Appendices

Appendix A – Independent Peer Review Approval



STAFFORDSHIRE UNIVERSITY

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Shona Murdoch
Title of Study	Parental experiences of power and threat within the context of a Strengthening Families approach to safeguarding.
Status of approval:	**Approved**

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved.

Action now required:
You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) approval, and relevant site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Nachi Chockalingam.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received HRA approval, and participating Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved application.

When your study is complete, please send an end of study report to Dr Edward Tolhurst: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

Comments for your consideration: None.

E. Tol

Signed: Dr Edward Tolhurst
University IPR coordinator

Date: 26th February 2024

Appendix B – Health Research Authority (HRA) approval

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

19 November 2024

Dear Miss Murdoch

HRA and Health and Care

Study title:	**Parental experiences of power and threat within the context of a Strengthening Families approach to safeguarding.**
IRAS project ID:	XXXX
REC reference:	**XXXX**
Sponsor	**Staffordshire University**

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

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

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

How should I work with participating non-NHS organisations?

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

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID isXXXX. Please quote this on all correspondence.

Yours sincerely,

HKPoole

Helen Poole

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Yvonne Melia*

List of Documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		21 March 2024
Interview schedules or topic guides for participants [Interview schedule]	2	30 September 2024
IRAS Application Form [IRAS_Form_10042024]		10 April 2024
Letters of invitation to participant [Invite Letter]	1	10 January 2024
Organisation Information Document [OID]		07 May 2024
Other [Response to REC comittee]	1	02 October 2024
Other [Response to REC & HRA Queries]		15 November 2024
Other [Debrief sheet]	2	30 September 2024
Other [Consent to contact]	1	05 July 2024
Other [Insurance]	1	21 March 2024
Other [Risk assessment]	1	21 March 2024
Other [Uni Ethics Approval]	1	21 March 2024
Participant consent form [Consent form to participate]	2	05 July 2024
Participant information sheet (PIS)	4	04 November 2024
Research protocol or project proposal [Protocol flow chart & disclosure flow chart]	3	30 September 2024
Research protocol or project proposal	2	04 November 2024
Summary CV for Chief Investigator (CI) [CI/student CV]		21 March 2024
Summary CV for student [CI/Student CV]		21 March 1924
Summary CV for supervisor (student research) [Supervisor CV]		21 March 2024
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol flow chart]	3	30 September 2024

Appendix C – Trust Capacity and Capability confirmation e-mail

Dear Shona,

RE: IRAS XXXXX – Confirmation of Capacity and Capability at MPFT

Full Study Title: Parental experiences of power and threat within the context of a Strengthening Families approach to safeguarding.

On behalf of Ruth Lambley-Burke (Director of R&I), this email confirms that Midlands Partnership University NHS Foundation Trust has the capacity and capability to deliver the above referenced study; please find the agreed Organisation Information Document attached as confirmation.

Midlands Partnership University NHS Foundation Trust agrees to start this study from today.

If you wish to discuss further, please do not hesitate to contact me; good luck with your study.

Many thanks,

Chris

Appendix D – Information Sheet

INFORMATION SHEET FOR PARTICIPANTS

IRAS ID: XXXXX

Parental perspectives of power and threat within the context of a Strengthening Families approach to safeguarding.

Invitation Paragraph

I would like to invite you to participate in this research project which forms part of my professional doctorate in clinical psychology research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The study aims to gain an insight into parental experiences of being supported by the team, with a particular focus on understanding the influence of power and threat within this.

Power relates to the experience of working with the team, and whether parents felt included in the planning and process of support, whether they felt that their opinions were heard and understood by professionals, and generally about their relationships with professionals and whether they felt empowered or oppressed.

Threat relates to how threatening the experience of being supported by the family safeguarding model felt, asking parents to think about any anxieties they felt, how supported they felt, including how their wellbeing was looked after, and how they perceived they were viewed by professionals.

The main objectives are:

- To explore parents' experiences of their family being supported under the family safeguarding model (Hertfordshire model).
- To explore parental perspectives about how power and threat operate when being supported by this model.

Why have I been invited to take part?

You have been invited to participate in this study as your family has been supported by the team. You are either working towards discharge from the team, or you have been discharged from the team within the last six months.

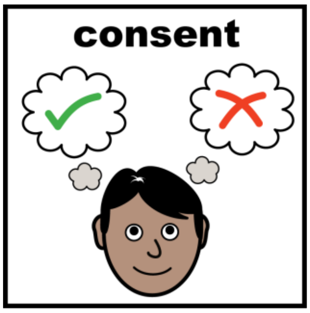
Given the sensitive nature of the research, you are not eligible to participate if you are in current mental health crisis, or should you feel that this topic would be too upsetting for you to discuss in interview.

What will happen if I take part?

If you decide to take part in this study, you will be invited to attend an interview with the researcher. This interview will last around one hour and can either be conducted face to face in a mutually agreed location, or online via Microsoft Teams. This interview will be audio or video recorded, and the researcher will create a transcript (a written document of your verbal responses in interview) to use when analysing your responses. The recording will be deleted once the transcript has been produced. Questions will ask about your experience of being supported by the team, your involvement in the process and any challenges or difficulties you encountered.

Interviews will be recorded via Microsoft Teams (if online or face to face) and will be transcribed by the researcher. All data will be anonymised, and you will be allocated a pseudonym to protect your identity. Recording will require your consent, and this will be gained before recording takes place.

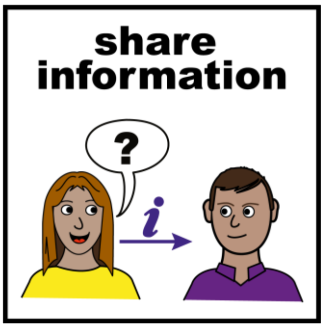
Do I have to take part? No



No, participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway.

Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form, and you will be given a copy of this consent form to keep. You have two weeks to decide as to whether you would like to participate in this study following being provided with this information sheet.

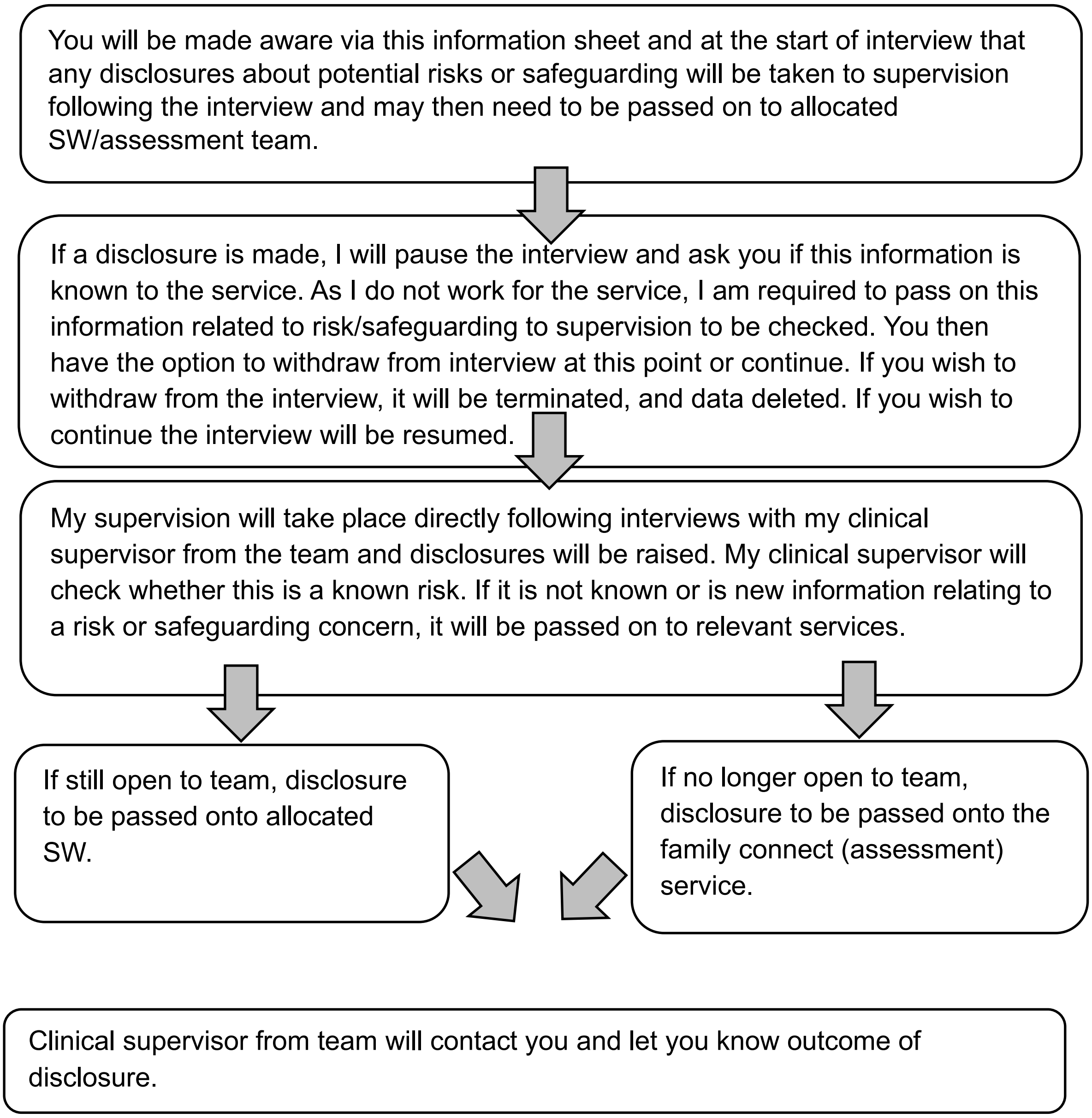
What are the possible risks of taking part?



Due to the topic of this research being potentially sensitive and distressing, it may be that you experience some distress or upset during the research process.

The researcher is also required to share any concerns they may have regarding risk to yourself or others, including safeguarding concerns, with their clinical supervisor working within the team. These are both risks which should be considered carefully before agreeing to take part in the study.

Please see below for the protocol which will be followed regarding disclosures related to risk or safeguarding.



You will be made aware via this information sheet and at the start of interview that any disclosures about potential risks or safeguarding will be taken to supervision following the interview and may then need to be passed on to allocated SW/assessment team.

If a disclosure is made, I will pause the interview and ask you if this information is known to the service. As I do not work for the service, I am required to pass on this information related to risk/safeguarding to supervision to be checked. You then have the option to withdraw from interview at this point or continue. If you wish to withdraw from the interview, it will be terminated, and data deleted. If you wish to continue the interview will be resumed.

My supervision will take place directly following interviews with my clinical supervisor from the team and disclosures will be raised. My clinical supervisor will check whether this is a known risk. If it is not known or is new information relating to a risk or safeguarding concern, it will be passed on to relevant services.

If still open to team, disclosure to be passed onto allocated SW.

If no longer open to team, disclosure to be passed onto the family connect (assessment) service.

Clinical supervisor from team will contact you and let you know outcome of disclosure.

What are the possible benefits of taking part?

Not known.

By taking part in the study, you will be contributing to building research into this area and will have an opportunity to have your experiences heard and considered.

Data Protection Statement

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

The data controller for this project will be University of Staffordshire. The University will process and store your personal data in line with its data protection policy for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

How will we use this information about you?

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a pseudonym instead.

We will keep all information about you safe and secure.

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

What are your choices about how your information is used?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks following your interview date after which withdrawal of your data will no longer be possible.

If you choose to withdraw from the study within the two-week period, we will not retain any information that you have provided us as a part of this study.

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

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by speaking to University of Staffordshire's data protection officer, via i.blachford@staffs.ac.uk

What if I change my mind about taking part?

As noted above, you are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks following your interview date after which withdrawal of your data will no longer be possible.

If you would like to withdraw your data within this period, please e-mail the principle researcher, Shona Murdoch via m042174m@student.staffs.ac.uk.

If you choose to withdraw from the study within the two-week period, we will not retain any information that you have provided us as a part of this study.

What will happen to the results of the study?

This study forms part of the researcher's professional doctorate in clinical psychology, and the results will therefore be shared with colleagues and peers as part of the qualification process. It may be that the researcher also publishes the results in a peer-reviewed journal, or research may be shared via a presentation at a conference for example.

You have the choice if you would like to be contacted after the research project is completed, and if you would like to provide feedback on the research project or receive a summary of the research report itself. You can select either opt in or opt out on the Consent Form to indicate your choice. If this is the case, please provide an e-mail or postal address for this to be sent to following the completion of the study.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact using the following contact details:

Principle Investigator: Shona Murdoch – m042174m@student.staffs.ac.uk

Research Supervisor: Dr. Yvonne Melia, Principal Lecturer in Clinical Psychology & Academic Director, University of Staffordshire - yvonne.melia@staffs.ac.uk

Clinical Supervisor: Dr. XXXXX, Clinical Psychologist, Team 1 -

What if I have further questions, or if something goes wrong?

If this study has harmed, you in any way or if you wish to make a complaint about the conduct of the study you can contact the research supervisor (Dr. Yvonne Melia) or the Co- Chair of the University of Staffordshire Ethics Committee for further advice and information:

Co- Chair of the University of Staffordshire Ethics Committee: Professor Sarahjane Jones. Professor Jones's email is: Sarahjane.jones@staffs.ac.uk.

Research Supervisor: Dr. Yvonne Melia, Principal Lecturer in Clinical Psychology & Academic Director, University of Staffordshire - yvonne.melia@staffs.ac.uk

Clinical Supervisor: Dr. XXXXX, Clinical Psychologist, Team 1 -

Thank you for reading this information sheet and for considering taking part in this research.

Appendix E – Invitation letter

Shona Murdoch
Professional Doctorate in Clinical Psychology
University of Staffordshire
Leek Road
Stoke-on-Trent
ST4 2AR
E-mail: m042174m@student.staffs.ac.uk

Dear potential participant,

You are receiving this letter because your worker has spoken with you about participating in my research project “Parental perspectives of power and threat within the context of a Strengthening Families approach to safeguarding”, and you have expressed an interest in participating.

I have attached an information sheet about what the study aims to achieve and what participating would involve.

If you would like to participate, please confirm so with your worker. You will then be asked to sign a consent form before I contact you to arrange an interview.

Please feel free to contact me via email, or your worker, should you have any questions or queries regarding the project.

Best wishes,

Shona Murdoch

Professional Doctorate in Clinical Psychology

Appendix F- Consent to contact form

RESEARCH PROJECT CONSENT TO CONTACT FORM

Title of Project: Parental perspectives of power and threat within the context of a Strengthening Families approach to safeguarding.

Researcher: Shona Murdoch, Professional Doctorate in Clinical Psychology

Prospective participant's name and contact details

Name:

Contact telephone number:

Contact e-mail address:

	Initials
I have read and understood the information sheet.	
I consent to my contact details (as above) being provided to the principle researcher and clinical supervisor.	
I consent to the principle researcher contacting me to discuss my potential participation in this research study.	
I consent to the principle researcher leaving me a voicemail message should she not be able to reach me via the telephone number provided.	

Name Participant (print) Date Signature

____________________ ______________ __________________

Name Researcher (print) Date Signature

Who should I contact for further information?

If you have any questions or require more information about this study, please contact using the following contact details:

Principle Investigator: Shona Murdoch – m042174m@student.staffs.ac.uk

Research Supervisor: Dr. Yvonne Melia, Principal Lecturer in Clinical Psychology & Academic Director, University of Staffordshire - yvonne.melia@staffs.ac.uk

Clinical Supervisor: Dr. XXXXX, Clinical Psychologist, Team 1 -

Appendix G – Consent to participate form

RESEARCH PROJECT CONSENT FORM

Title of Project: Parental perspectives of power and threat within the context of a Strengthening Families approach to safeguarding.

Researcher: Shona Murdoch, Professional Doctorate in Clinical Psychology

	Initials
I have read and understood the information sheet.	
I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.	
I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation.	
I understand that the interview will be audio-recorded.	
I understand that the interview will be video-recorded.	
I consent that data collected could be used for publication in a scientific journal or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes and understand that all data will be presented anonymously.	
I agree that data will only be used for this project as named above although the data may also be audited for quality control purposes.	
All data will be sorted safely on a password protected computer (electronic data) or locked away securely (hard copies of data) for 10 years before being destroyed.	
I would like to be contacted after the research has ended to receive a summary of the study findings once complete and therefore consent to my contact details (e-mail or address) being stored securely by researcher.	
I hereby give consent to take part in this study.	

____________________ ____________________ ____________________

Name Participant (print)	Date	Signature
Name Researcher (print)	Date	Signature

.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact using the following contact details:

Principle Investigator: Shona Murdoch – m042174m@student.staffs.ac.uk

Research Supervisor: Dr. Yvonne Melia, Principal Lecturer in Clinical Psychology & Academic Director, University of Staffordshire - yvonne.melia@staffs.ac.uk

Clinical Supervisor: Dr. XXXXX, Clinical Psychologist, Team 1 -

Appendix H – Interview Schedule

Interview schedule.

To develop this interview schedule, different resources were consulted. A literature review was conducted, looking at research which had interviewed parents about their experiences of being involved with children's social care and also research which used interviews to understand issues of power and threat within other human experiences (for example mental health caregiving and involvement in forensic services). The power threat meaning framework was considered alongside the principles of trauma informed care, as both resources seek to provide a more empowering and less threatening environment. Questions pertaining to elements of these therefore were thought to clarify whether the family safeguarding model encapsulates some of these ideas.

Introductions

Welcome! Today I will be asking you some questions about your experiences of being supported by the team. The questions will focus on your broader experiences but also some more specific questions about relationships with professionals, how included you felt within the process and any challenges you may have faced. The interview should hopefully last around one hour but may be longer or shorter depending on how we get on. If you need to take a comfort break for any reason, you are more than welcome to, just please let me know.

Just to remind you, this interview will be video or audio recorded, so that I can make a transcription of the interview. Once I have done this, the recording will be deleted. Is that ok with you?

It's important to remind you that any information that you provide to me during this interview which may indicate that you are at risk, or someone else is, for example your child or another family member, I am required to share this with the team (if still open) or the access team (if not open). Before we begin, can you confirm that you understand this?

General experiences:

1. Please share the ways in which the team supported your family? If you found it to be helpful, can you describe how so? If not helpful, can you describe how so?
   Prompts: What were your strengths? How were these worked with? What went well? Range of activities include meetings, e.g. CP or CiN meetings, formal assessments by SWs/feedback r.e. these. Family Court, removal of children. Supervising family time. Direct work between SWs/other professionals and parents/children. Referrals to other services.
2. How was your experience of working with different professionals? How were relationships built, including establishing trustworthiness and safety within these?

Prompts: What was it like developing relationships with professionals and then working with them?
Did you feel safe, or not? Can you describe this a little?
Was trust developed between you and other professionals? If so how was this done, if not how could it have been done?

3. To what extent do you feel that your life circumstances (i.e what has happened to you? mental health, substance misuse, life experiences etc.) were considered throughout your involvement with the team? In what way were these experiences considered?
   Prompts: The meaning behind why you may be using substances/your mental health is poor/why your relationship is difficult?
   Making links between how these difficulties have led to involvement with the team?
   What was your experience of how your difficulties were understood by the team? How is it made sense of by everyone around you? Does it make sense to you?

Power

1. How were you involved by professionals in the:
   - planning
   - decision making
   - overall process of support for your family?

   Prompts: E.g. Formal contributions made during meetings but also should be done informally with SW during 1-2-1 time or visits to children. May also be explored with adult practitioners, in terms of receiving input or feedback or wishes and feelings.
2. To what extent did you feel that your opinions, input and difficulties were a) heard and b) understood by the team?
   Prompts: What helped or hindered this?
   Did professionals act on things that you contributed?
   How did they respond, could you see that they had understood/considered your difficulties/any tangible changes?
   Times when you noticed this or can recall something changed based on your contribution for example?
   Did you feel able to make complaints?
3. How did you feel you were viewed by professionals involved in the care of your family?
   Prompts: How did you feel when working with professionals, comfortable/uncomfortable?
   Were there any examples where professionals made it clear about their views/judgements about you?
   How was feedback delivered?

Threat

1. Did you experience any anxieties and challenges whilst being supported by the team? Did you share these with professionals, if so how were they handled?
   Prompts: Were there any barriers to sharing your concerns/anxieties?
   How open did you feel like you could be with the team about your worries?
   Can you tell me a little bit more about this?
   Did you feel able to make complaints?
   1a. Were there times where the plan didn't work/bumps in the road (i.e. relapse, contact with someone not supposed to etc). How were these responded to by the team/what happened?
   Prompts: Did you share this with your worker/did it feel challenging to do this?
   Did it come to light in some other way?
   Times when you were unable to stick to the "safety plan"?
2. How did you view the professionals you were working with? i.e trustworthy, judgemental, empathetic?
   Prompts: What experiences/contact etc. contributed to your views of the professionals
   Are there any examples you can give?
3. How supported did you feel, as a parent/caregiver, throughout the process? What did this support look like?
   3a. How do you feel your wellbeing was considered by the team?

Appendix I – Debrief form

DEBRIEF SHEET

Thank you for participating in this study.

The aim of the research was to:

- To explore parents' experiences of their family being supported under the family safeguarding model (Hertfordshire model).
- To explore parental perspectives about how power and threat operate when being supported by this model.

You are able to withdraw your data from the study up until two weeks following your interview date after which withdrawal of your data will no longer be possible. If you would like to withdraw your data within this period, please e-mail the principle researcher, Shona Murdoch.

If you wish to know the overall findings of the study or would like more information, please feel free to contact Shona Murdoch - m042174m@student.staffs.ac.uk

Should you wish for further information, help or support with any of the issues raised in the study, you can contact the support organisations below:

- **Mental Health Support (NHS) –** local urgent mental health support for Telford & Wrekin (0808 196 4501) **or visit NHS information page** - For information and advice regarding mental health https://www.nhs.uk/mental-health/
- **Family Action UK** – A national organisation providing support to families with a range of difficulties including financial hardship, mental health, substance misuse and domestic violence. Call - 0808 802 6666, Text - 07537 404 282 or e-mail familyline@family-action.org.uk – all contact is free. https://www.family-action.org.uk/
- **XXXXX Children's services** – Local council offering a range of support for children and families (including XXXX- 01952 385385 or https://www.telford.gov.uk/info/1006/children_and_young_people

<u>Who should I contact for further information?</u>

If you have any questions or require more information about this study, please contact me using the following contact details:

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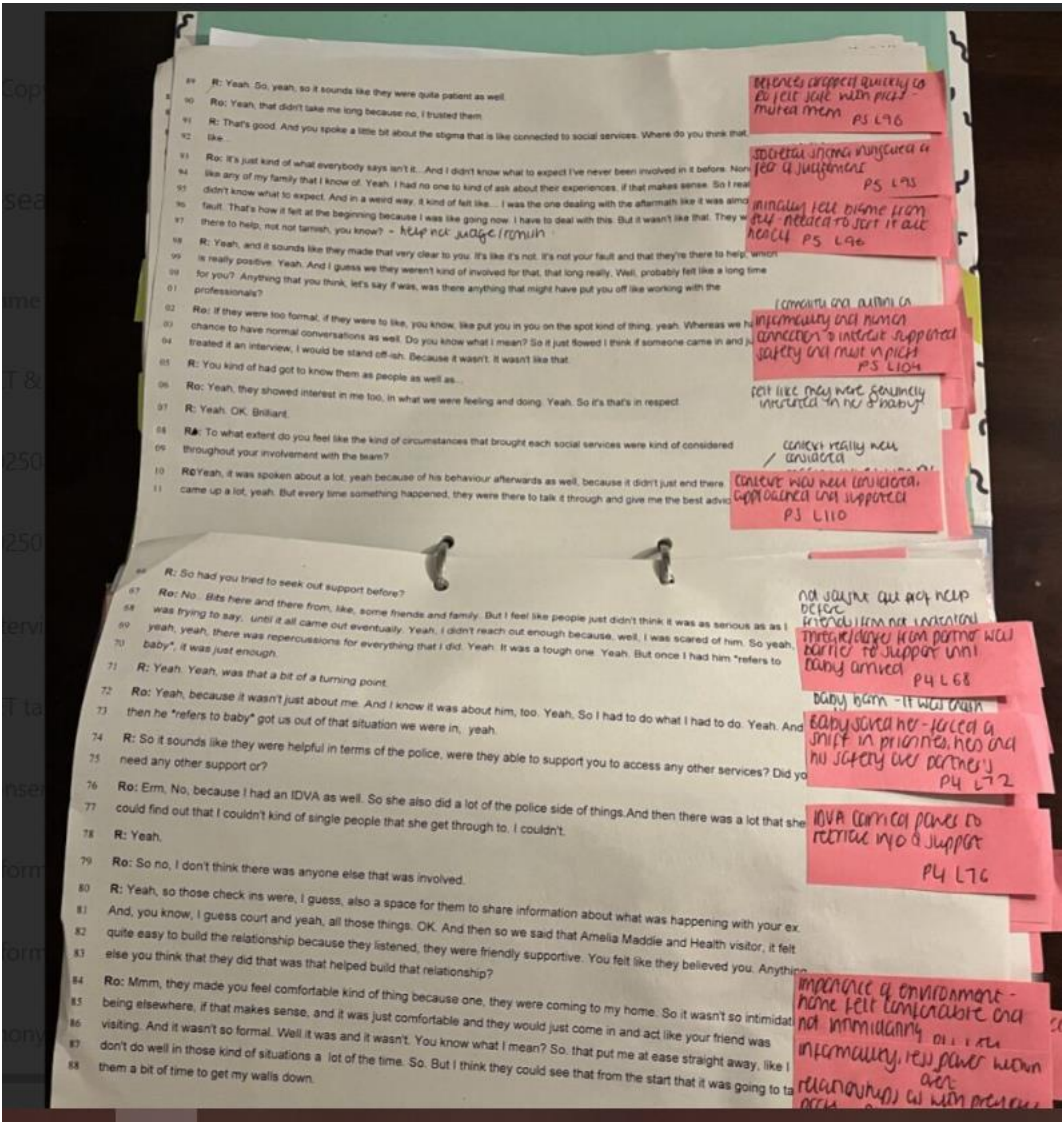
Clinical Supervisor: Dr. XXXXX, Clinical Psychologist,

Thank you again for your participation.

Appendix J – Excerpt from transcript to show exploratory notes (on paper) overlayed with experiential statements (pink post-its)



R: Yeah. So, yeah, so it sounds like they were quite patient as well

Ro: Yeah, that didn't take me long because no, I trusted them

R: That's good. And you spoke a little bit about the stigma that is like connected to social services. Where do you think that, like...

Ro: It's just kind of what everybody says isn't it... And I didn't know what to expect I've never been involved in it before. Non like any of my family that I know of. Yeah. I had no one to kind of ask about their experiences, if that makes sense. So I rea didn't know what to expect. And in a weird way, it kind of felt like.... I was the one dealing with the aftermath like it was almo fault. That's how it felt at the beginning because I was like going now. I have to deal with this. But it wasn't like that. They w there to help, not not tarnish, you know? - help not judge/punish

R: Yeah, and it sounds like they made that very clear to you. It's like it's not. It's not your fault and that they're there to help, which is really positive. Yeah. And I guess we they weren't kind of involved for that, that long really. Well, probably felt like a long time for you? Anything that you think, let's say if was, was there anything that might have put you off like working with the professionals?

Ro: If they were too formal, if they were to like, you know, like put you in you on the spot kind of thing, yeah. Whereas we h chance to have normal conversations as well. Do you know what I mean? So it just flowed I think if someone came in and ju treated it an interview, I would be stand off-ish. Because it wasn't. It wasn't like that

R: You kind of had got to know them as people as well as...

Ro: Yeah, they showed interest in me too, in what we were feeling and doing. Yeah. So it's that's in respect

R: Yeah. OK. Brilliant.

R: To what extent do you feel like the kind of circumstances that brought each social services were kind of considered throughout your involvement with the team?

Ro: Yeah, it was spoken about a lot, yeah because of his behaviour afterwards as well, because it didn't just end there. came up a lot, yeah. But every time something happened, they were there to talk it through and give me the best advic

Defences dropped quickly as felt safe with profs - trusted them P5 L90

Societal stigma influenced a fear of judgement P5 L93

Initially felt blame from self - needed to sort it all herself P5 L96

formality and authority

Informality and human connection & interest supported safety and trust in profs P5 L104

felt like they were genuinely interested in her & baby

context really well considered

Context was well considered, approached and supported P5 L110

R: So had you tried to seek out support before?

Ro: No. Bits here and there from, like, some friends and family. But I feel like people just didn't think it was as serious as as I was trying to say, until it all came out eventually. Yeah, I didn't reach out enough because, well, I was scared of him. So yeah, yeah, yeah, there was repercussions for everything that I did. Yeah. It was a tough one. Yeah. But once I had him *refers to baby*, it was just enough.

R: Yeah. Yeah, was that a bit of a turning point

Ro: Yeah, because it wasn't just about me. And I know it was about him, too. Yeah. So I had to do what I had to do. Yeah. And then he *refers to baby* got us out of that situation we were in, yeah

R: So it sounds like they were helpful in terms of the police, were they able to support you to access any other services? Did yo need any other support or?

Ro: Erm. No, because I had an IDVA as well. So she also did a lot of the police side of things.And then there was a lot that she could find out that I couldn't kind of single people that she get through to. I couldn't.

R: Yeah.

Ro: So no, I don't think there was anyone else that was involved.

R: Yeah, so those check ins were, I guess, also a space for them to share information about what was happening with your ex. And, you know, I guess court and yeah, all those things. OK. And then so we said that Amelia Maddie and Health visitor, it felt quite easy to build the relationship because they listened, they were friendly supportive. You felt like they believed you. Anythin else you think that they did that was that helped build that relationship?

Ro: Mmm, they made you feel comfortable kind of thing because one, they were coming to my home. So it wasn't so intimidat being elsewhere, if that makes sense, and it was just comfortable and they would just come in and act like your friend was visiting. And it wasn't so formal. Well it was and it wasn't. You know what I mean? So. that put me at ease straight away, like I don't do well in those kind of situations a lot of the time. So. But I think they could see that from the start that it was going to ta them a bit of time to get my walls down.

not sought out prof help before

Threat/danger from partner was barrier to support until baby arrived P4 L68

baby born - it was enough

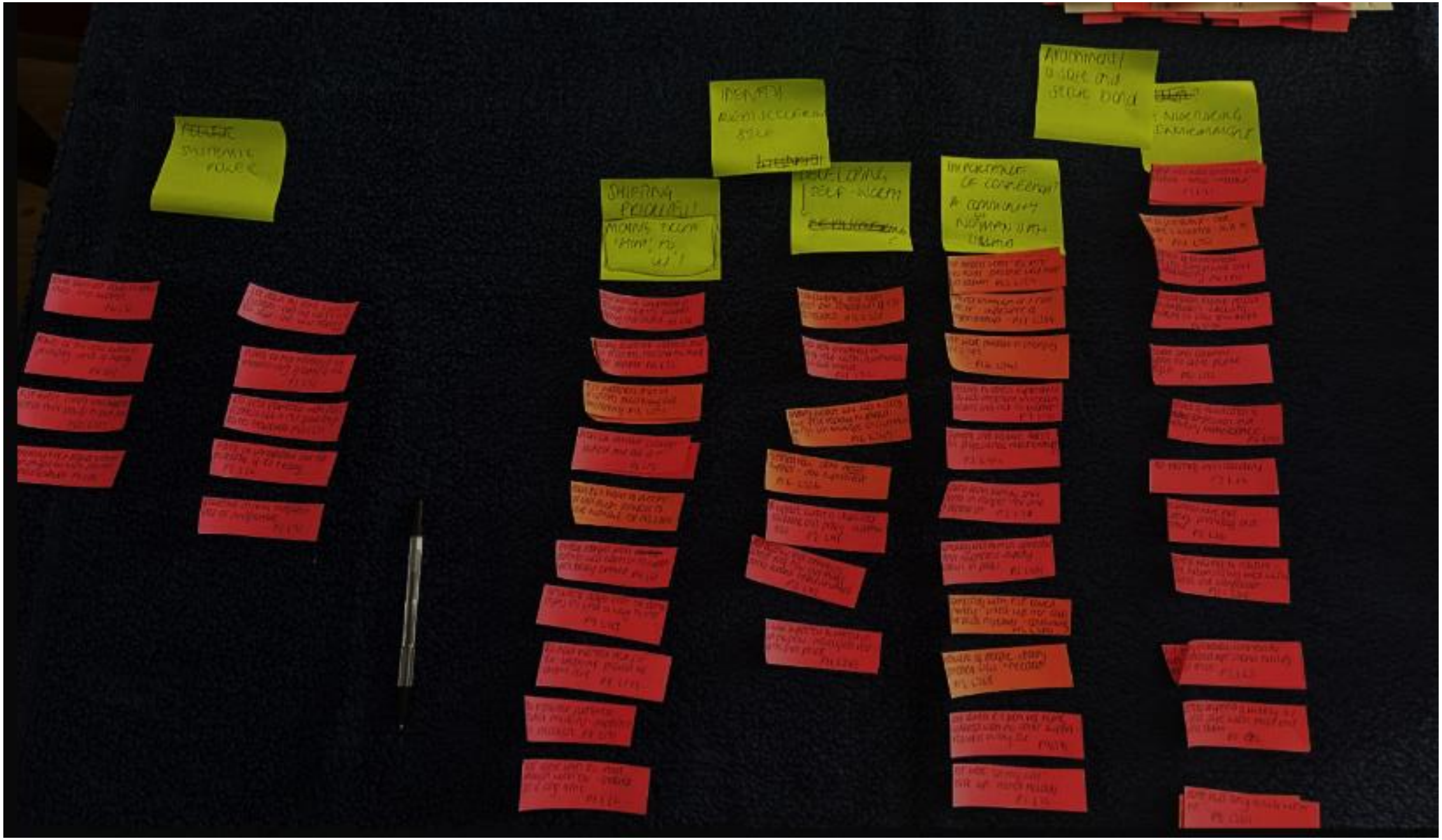
Baby saved her - forced a shift in priorities, hers and his safety over partner's P4 L72

IDVA critical power to retrieve info & support P4 L76

Importance of environment - home felt comfortable and not intimidating

Informality, less power held over relationships with them previous

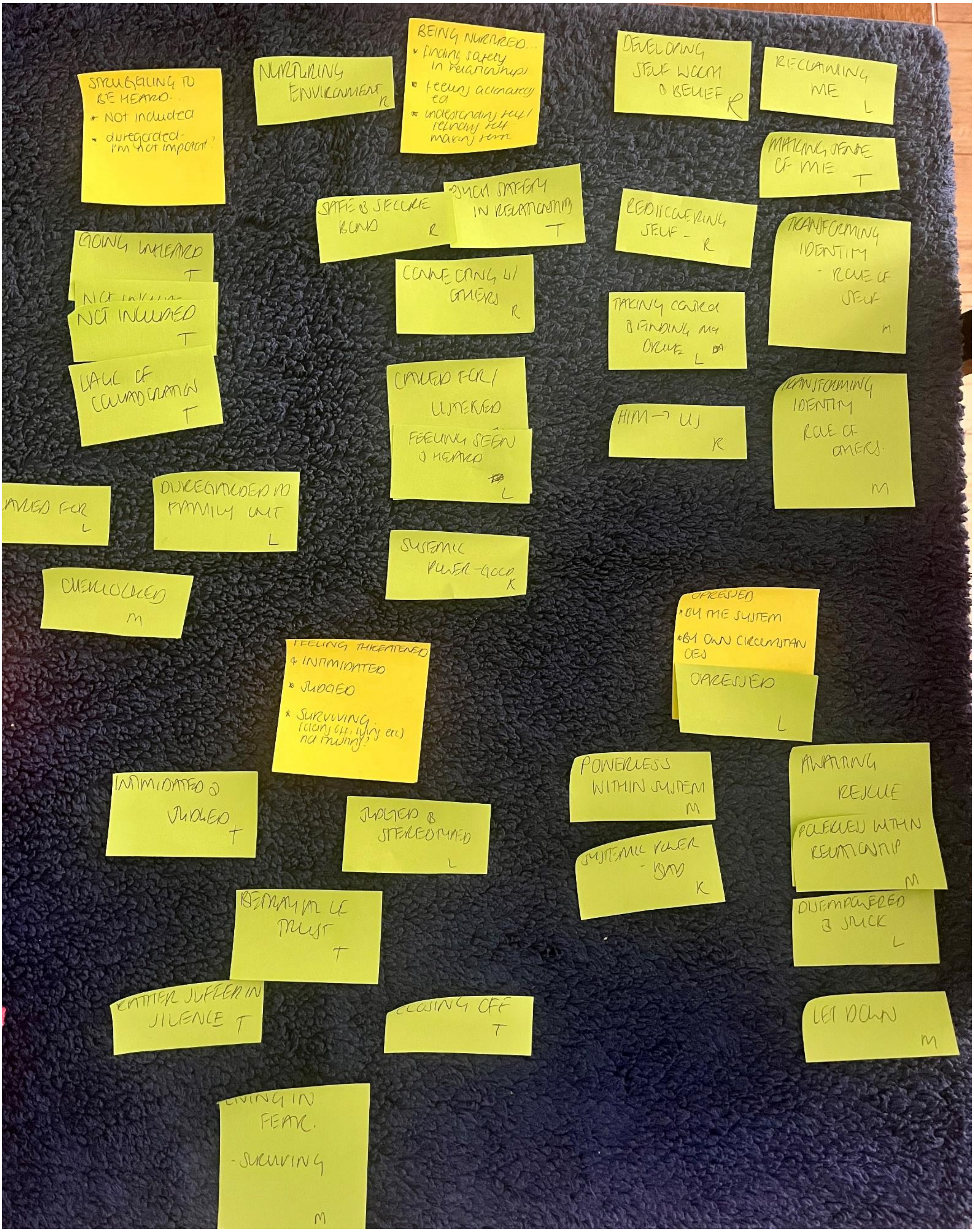
Appendix K – Clustering of experiential statements into personal experiential themes



Appendix L – Sample PET table including ES, with page and line referencing to quotes.

Rosie PETs & ETs		
Systemic power	**Rediscovering self**	**A safe and secure bond**
For good • *Informality and less obvious power within relationships as has been with previous professional relationships P4 L86* • *professionals were caring and supportive used their power for good P10 L219* • *powerful legal system provided a sense of safety P6 L113* • *IDVA carriage power and used it to retrieve information and support P4 L76*	*Moving from "him" to us"* • Professionals came when she had enough with her ex she had enjoyed for a long timeP1 L20 • Her EX's behaviour justified decision making it supported her decision P8 L171 • She wanted the best for her ex until he proved he didn't care P8 L179 • consistent danger from ex partner he was trying to find a way to her P9 L185 • threat/danger from partner was a barrier to support until her baby arrived P4 L68 • They held her hands to pull her out and push forward to a future without her ex P12 L164 • professionals our saviours or rescuers they pulled me out of it P6 L132	*Connecting with others* • Professionals helped settle her into a new home their presence was safe and calm P15 L329 • presence of professionals was welcome simple uncomplicated and made sense P14 L317 • I'm not on my own so I can do it - importance of companionship P18 L399 • professionals were pivotal in changing her life P16 L345 • connecting to others experiences of DV was important in feeling less alone and not to blame P7 L141 • enjoyment and value was taken from the professional relationship P3 L44 • isolated from family and trapped in danger she had no one to depend on P2 L28

Appendix M – Example of working with PETS to develop first GETs



Appendix N – Evolution of GETs with reflection and supervision

First version of GETS and *subthemes*	Reflections from supervision	Second version of GETS and *subthemes*	Reflections from Supervision	Final GETs and *subthemes*
Struggling to be heard		**Relationships with professionals**		**Invisible and unworthy**
Not Included	Some overlap with the content from feeling threatened and also between one another	*Qualities of safe relationship*	Not experiential enough, could incorporate with opening up – feeling safe contributes to opening up	*"Made out to be a sh*t mum"*
Disregarded – I'm not important		*Qualities of unsafe relationship*	Not experiential enough, could incorporate more into the belittling/intimidated	*Belittled and insignificant*
				Unheard and excluded
Feeling threatened		**Feeling threatened**		**Living in fear**
Intimidated	Too much overlap between intimidated and judged	*Within own context*	Feels like this is quite significant to whole experience of threat – standalone GET? Incorporate survival strategies from "surviving"	
Judged		*Intimidated, belittled and insignificant*	Insignificance feels strong and relevant this is too much to pull together into one subtheme – unpack further	
Surviving		*Surviving*		

Oppressed	Certainly is a sense of this but could be incorporated into other experiences – e.g. within relationships with professionals			
Within System	Not experiential enough – needs to be better clarified			
Within Circumstances				
Being nurtured	What did being nurtured bring?	**Making sense/Moving on**	Making sense only part of this whole experience	**A space to be seen**
Finding safety in relationships		*Opening up*	More about what facilitated opening up, incorporate from safe qualities	*Building a connection*
Feeling acknowledged	More than this, to do with being seen more holistically and also cheerleading professionals provided	*Validation and shifting blame*	More came from validation, shifting blame was part of but not whole experience	*Validation and making sense*
Understanding self/making sense of self		*Empowered and reclaiming me*		*Empowered and reclaiming me*

Appendix O – Table of PETS for each participant which contributed to GETS

Participant	**Personal Experiential Themes and subthemes**			
Michaela	Powerless • Within the system • Within my relationship	Transforming my identity • Role of self • Role of others	Living in fear • Survival strategies • Awaiting rescue	Relational patterns • Overlooked • Let down • Cared for and listened to
Louise	Disregarded • As a family unit • Uncared for • Not included	Reclaiming "me" • Taking control and finding my drive • Feeling seen and heard	Oppressed • Feeling judged and stereotyped • Disempowered and stuck	
Rosie	Systemic power • For good • For bad	Rediscovering self • Moving from "him" to us" • Developing self-worth & belief	A safe and secure bond • Connecting with others • A nurturing environment	
Tina	Psychological safety • Developing safety in relationships • Making sense of me	Going unheard • Not included • Lack of collaboration	Closing off • Betrayal of trust • I'd rather suffer in silence • Intimidated and judged	

Living in fear, Invisible and unworthy, A space to be seen

Appendix P – Journal guidelines for Journal of Child Abuse and Neglect

Link to author guidelines : https://www.sciencedirect.com/journal/child-abuse-and-neglect/publish/guide-for-authors

Specifically relevant items have been copied as below:

Research Article: Child Abuse and Neglect publishes quantitative, qualitative, and mixed-method research. Particular focus will be placed on thorough and appropriate methods, strong data analysis and discussion of implications for the field.

Length and Style of Manuscripts

Full-length manuscripts should not exceed 35 pages total (including abstract, text, references, tables, and figures), double spaced with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller).

Abstracts should follow a structured format of no more than 250 words including the following sections: Background, Objective, Participants and Setting, Methods, Results (giving specific effect sizes and their statistical significance), and Conclusions

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Subdivision

Divide your article into clearly defined sections. Three levels of headings are permitted. Level one and level two headings should appear on its own separate line; level three headings should include punctuation and run in with the first line of the paragraph.

Reference style

Text: Citations in the text should follow the referencing style used by the American Psychological Association (view the APA Style Guide). You are referred to the Publication Manual of the American Psychological Association, Seventh Edition, ISBN 978-1-4338-0561-5.

List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Paper 3 – Executive summary

Hidden by fear, found in safety

An interpretative phenomenological analysis of parent's experiences of power and threat within a strengthening families approach to safeguarding.

Shona Murdoch

An executive summary prepared for an audience of parents who are currently in contact with, or have previously had contact with, children's social care and professionals working in children's social care

Word count: 2451

Thank you to the Dandelions for your help in reading and providing feedback on this summary.

Thank you to the parents who took part in this research. Your honesty, authenticity and resilience was inspiring.

Keywords and what they mean:

Keywords will be bold in the text.

Power: Power in terms of a society means how much influence or control a person has over what happens. Different people and systems have different amounts of power. For example, the government has a lot of power as it has a huge influence and ability to control.

Threat: A threat is when something or someone makes you feel unsafe or in danger

Strengthening families approach to safeguarding: A model of safeguarding which aims to offer support not only to the child but also to others involved in their care such as their parents.

Family safeguarding model (FSM): This is a type of “strengthening families approach”. As part of the support offered to the whole family, parents are offered support from psychologists, domestic abuse workers, substance use workers and other mental health professionals. With this support, it is hoped that parents can be empowered to make changes which positively impact their children and family.

Qualitative research: Is a way of studying someone’s experiences and feelings. This usually involves talking to someone about their experience, for example, in an interview or a focus group.

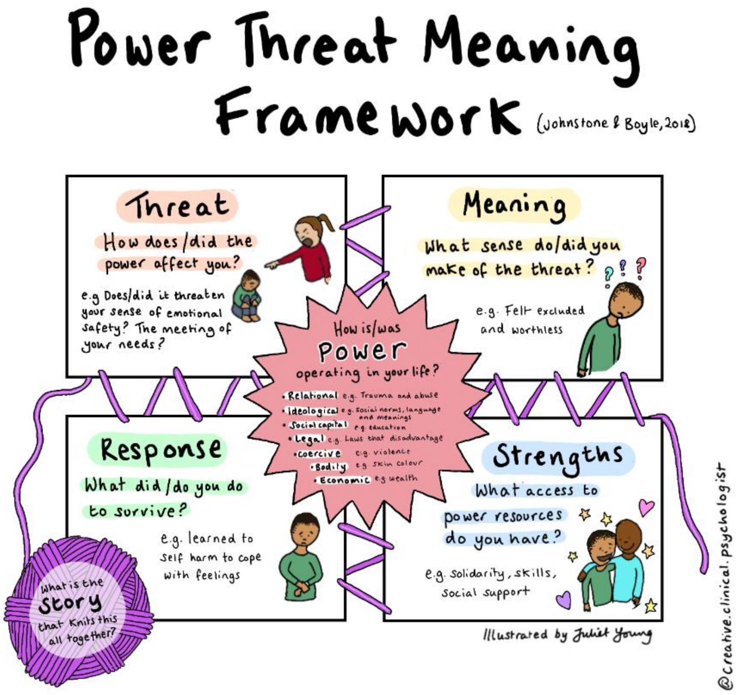
Why is this research important?

Within the experience of children's social care (CSC) involvement, it is well known that there is an imbalance of power between parents and professionals, with professionals having more power and parents having less (Buckley et al., 2011). This can make parents feel scared and make it difficult for them to share their views on what support they and their child(ren) might need, which can have a negative impact on their care (Featherstone et al., 2014).

Parents whose children are open to CSC often have their own difficulties arising from adversity such as a history of abuse in childhood and experiences in care (Broadhurst and Mason, 2020). For those supporting these parents, it is important to understand what experiences have brought them to the attention of CSC so that they can be offered the right support.

[8]Imbalances in power can contribute to poor mental health and distress. The **Power Threat** Meaning Framework (PTMF) (Johnstone et al., 2018) can be a useful tool to understand this. This framework highlights how important it is to consider a parent's upbringing, particularly focusing on when they have had less power – for example in an abusive relationship, how threatened that made them feel and how they coped with these experiences. The support that parents receive under the FSM should take these experiences into account to best support them and to improve their own quality of life and that of their child(ren).

It is important for us to hear what parents have to say about how much **power** they feel they have, and how **threatened** they are when



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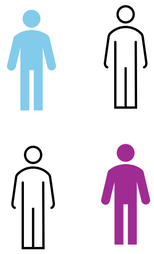
[8] Juliet Young, also known as the Creative Clinical Psychologist, gives permission for use of her illustrations for non-commercial purposes.

being supported by the FSM. As the FSM aims to empower parents, and takes their upbringing and difficulties into account, it may be that parents feel less threatened and experience a more equal power balance. It is also important to hear parents feedback so that we can improve the care both for them and their children, and to give a voice (and therefore more power) to a group who are often not listened to or heard within practice and research.

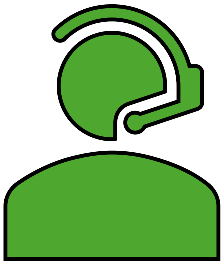
How we did the research

We used a **qualitative** approach to explore parents' experiences of being supported under the family safeguarding model and focused on power and threat within this.

Who took part and what did we do?



Participants: 17 parents were asked about taking part, with four being the final sample. The four mothers had an average age of 32. Some had finished their work with CSC and others were still being supported by CSC. All had been supported by social workers as well as other professionals such as clinical psychologists, substance use workers and domestic abuse workers. All had experiences of being in abusive intimate relationships.



Recruitment: Parents were recruited from one CSC service. Professionals involved in their care asked them if they would like to take part and they were given an information sheet about the research. With their permission, the researcher then contacted them to introduce herself and provide an opportunity for them to ask any questions. If they wished to go ahead, an interview was organised. Consent was carefully considered.

Interviews: Each parent took part in a one-to-one interview which lasted around one hour long. Two took place via video call and two were in person. All interviews were audio and video recorded and transcribed. Parents were asked questions about their experiences of being supported by the model. Parents were asked about power, for example, how involved and listened to they felt, including any experiences of feeling empowered or oppressed. Parents were also asked about how threatening the experience was, for example, any anxieties they faced, how supported they felt and how their wellbeing was looked after by professionals.

What happened next?

The researcher analysed the interviews using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022). This method allowed the researcher to look closely at how parents made sense of their experiences within the FSM, both individually and across all four interviews.

This method uses four steps to look at experiences:

1. **Diving into the data** – The researcher read the transcript of each interview multiple times.
2. **Making notes** – Then the researcher made notes about what seemed important to the participant and their experiences.
3. **Creating themes** – These notes were then made into themes which summarised each person’s experience. These three steps were repeated for each of the four interviews.
4. **Grouping themes together** -Themes from each individual interview were then compared to find similarities and differences in experiences to create overarching themes for the whole group (all four participants).

The researcher had regular supervision with both a university supervisor and one based in the team and went to regular group supervision with other trainee clinical psychologists. This helped to make sure that they were reflecting the parents’ experiences as closely as possible.

What was found?

The researcher found three themes across all four interviews:

1. Living in fear
2. Invisible and unworthy
3. A space to be seen

Theme 1: Living in fear

All four of the parents interviewed had experienced domestic abuse within their intimate relationships. Parents described how fearful they were of their partners, and how much control their partners had over them. The high level of threat and low level of power they already had made it difficult for them to engage with the FSM.

"If he wanted me to do something, I'd have to do it there and then. He'd starve me if I wasn't…you know…I couldn't. He made, he made the meals." – Michaela

Michaela's partner had power over even her basic needs, such as eating. Going against him and his wishes would mean that she would sometimes go without food.

Parents described how the fear of their partners made it difficult for them to build relationships with professionals and accept the right support. Rosie described how she was worried about making the violence worse if she accepted support, and how this delayed her accessing help.

""Yeah, I didn't reach out enough because, well, I was scared of him. So yeah, yeah, yeah, there was repercussions for everything that I did." - Rosie

"…because they've been manipulated for so long, they learn to be a manipulator as well. Not in a narcissistic way, but in a way of protection. Yeah. So, they do become good actors." – Michaela

Parents reflected on how this fear also made it difficult to build relationships with professionals. They often felt that they couldn't be honest and had to hide what was going on at home, due to fear of more violence and harm from their partner. Michaela spoke about being like an "actor" and learning to "manipulate" others to protect herself and her children from further harm.

Theme 2: Invisible and unworthy

Parents described feeling left out of their children's support and care. This included not being asked or told about decisions, not being able to understand professionals and their language, or being asked and then their input was being ignored. This led to them often feeling like they were invisible. Parents also described feeling judged and intimidated by professionals which made them feel unworthy.

"like they just thought, "Oh, Louise is in a shit situation. So we're just gonna remove the child" sort of thing. Without even my permission, without even my talking about my beliefs and everything like…" Louise, P8

Louise spoke about her child being removed from her care. She felt as if CSC had made no effort to support her and her family with their difficulties before removing her child. She reflected on how not being involved in this decision made her feel powerless.

Michaela felt that one social worker just wanted to "get the ticks" and was doing the bare minimum of her job. Michaela felt that this person didn't try to understand or care what was going on within her family. She felt that this meant that some signs of abuse were missed, and that opportunities to help her and her children break free from her partner and his harm were missed.

“but I think sometimes she saw, but she just thought there's too much hassle” Michaela P33

Louise felt that she was “always” being judged and that she was made out to be a “sh*t mum”. She spoke about this in relation to her history of using substances, and how one professional made strong judgements about her ability to stay abstinent. She felt stereotyped.

““and I was clean for several years. But I was still on methadone and then J, she was like “how long is long enough to be clean? like you're always going to revert back to drugs” – Louise P12

Theme 3: A space to be seen

All parents spoke about professionals who were warm, friendly, authentic and empathetic which made them feel comfortable, helped to build trust and allowed them to open up and feel seen. This then allowed them to rebuild and reclaim parts of themselves that they had lost along their journey.

*“And I actually cried in front of her, I'd not cried for years. Family members died and I didn’t cry. So when I did cry it was weird *laughter*, it was. So I said “this is your fault” *laughter*, but in the goodest, good way.” – Tina*

Tina spoke about feeling comfortable with professionals who treated her more “like a friend” and were not as formal as others. This allowed her to open up and she reflected on a very vulnerable moment which showed how safe she felt with one professional.

Rosie spoke about how her relationships with professionals helped her to understand that she was not alone in what had happened to her and not to

““Yeah, it was nice that they kind of got that out on my head that it wasn't my fault. It was his fault.” - Rosie

blame. She spoke about how powerful it was for her to realise that the abuse from her partner was not her fault.

Michaela described how her relationship with F, helped her to see that there was more to her and her life than her partner. F helped to boost her self-esteem and empowered Michaela to leave the relationship.

“But without F I would never have had the tools to do it. (…) she just opened my mind and let me know that I wasn't just K’s little bubble. I was a person. Yeah. Yeah”. Michaela, P17

What can professionals and services learn from these results?

Parents described how they were living in fear, and this made it difficult for them to access support from professionals and fully engage with the FSM. Some professionals were viewed by parents as intimidating and judgemental, which made it difficult to form relationships and build trust. Other professionals, however, were viewed as empathetic and kind, and parents built positive relationships with them. This allowed parents to open up, be vulnerable and reclaim parts of themselves.

Professionals…

- To help build trust and positive relationships, professionals should approach parents with a non-judgemental and empathetic stance. Being friendly, approachable and bringing parts of themselves to the relationship can help parents feel more comfortable and see the human side.

- Professionals should always seek the views and opinions of parents. This includes checking that they understand what is being planned for them and their family. This helps parents to be meaningfully involved in the planning of support for their family.

- To share skills and knowledge to support understanding a family's needs and how to build strong relationships, professionals from different disciplines should support one another by regularly engaging in consultation, reflective practice and joint-work where possible.

Services…

- Services can support by embedding attachment and trauma informed principles into practice. Parents who had a "secure attachment" to professionals in this study were able to open up and gain more from the FSM.

- Services could provide more training on the influence of power within the context of CSC, how to rebalance this and also empower parents. This should also include considering the parent's context, for example the influence of domestic abuse.

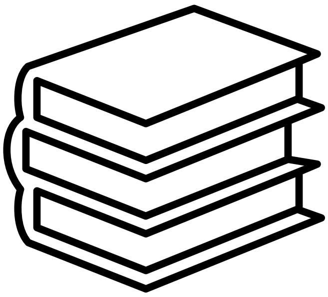
- Services could consider offering peer-led advocacy schemes to parents. Parents are matched with peers who have also experienced CSC to offer support and guidance throughout the process. This can help to empower parents and lead to better outcomes for families (Fitz-Symonds et al., 2024).

Strengths and things to improve on

Strengths of this research	What it could have done better
It is unique – no research has looked at power and threat within the FSM before. It therefore adds something new to the evidence base.	Only four people took part, all were female, and most had finished their involvement with the FST. Voices from fathers, and those still undergoing support from FST are not heard.
It raised voices of an understudied and often misunderstood and stigmatised group.	

What could future research focus on?

- Use a different way to collect data – If parents were able to remain anonymous, this might remove worries around information sharing relating to their children's care e.g. information being relayed to their social worker.
- Focus specifically on experiences of power within the lives of parents and how this effects how they access help and support and the relationship with professionals and services.
- Focus on the experiences of professionals working within the FSM, particularly looking at how the different disciplines work together to support families and whether they perceive a "split" in qualities as perceived by parents.



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