

Parents in treatment for substance use: using electronic records to understand Individual and treatment characteristics associated with childcare and parental outcomes

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Executive Summary

Considerable research has explored the implications of parental substance use on child well-being and health, including child maltreatment and abuse. In England, parental substance use is presented in almost two thirds of public family law proceedings cases ('care proceedings') (Pearson et al., 2021; Public Health England, 2018). The risk of involvement in care proceedings is intensified by the child's exposure to adversities associated with parental substance use, including domestic violence and parental mental health problems. Approximately 4% of all children in England are exposed to the co-occurrence of these problems (Chowdry, 2018). Socioeconomic adversities that are typically related to substance use (i.e., unstable housing and economic hardship) place additional stress on parents' abilities to provide the minimum care necessary to their children's development.

While a parental substance use problem is not always the primary reason for family court proceedings, it is a significant contributor. Mothers, as the primary caregivers, are more likely to be involved in child protection services and to manage the effects of their substance use while caring for the children. Worldwide, studies have demonstrated that maternal substance use is associated with a heightened risk of children being removed from the home, and with permanent loss of parental rights. However, not all mothers who use substances neglect and/or abuse their children and require care proceedings. Those who have lost the right to care for their children often have multiple and complex needs. In England, limited information on individual, treatment and childcare status of mothers receiving substance use treatment contributes to a lack of evidence-based practices to address the needs of these mothers during care proceedings.

In this research project we applied data science approaches to describe the individual and treatment characteristics of mothers attending South London and Maudsley NHS Foundation Trust (SLaM) substance use treatment services including their involvement with care proceedings. As the project progressed, we learned that we could apply a similar methodological approach to explore the characteristics of fathers in substance use services. Therefore, we expanded the scope of this project to identify who the fathers' receiving treatment for substance use are and the childcare responsibilities of those fathers who were involved in care proceedings.

Key findings

- Of all women attending SLaM treatment services, approximately 40% of female service users were mothers, with an average of nearly two birth episodes at the time of assessment. Of those female patients identified as mothers, approximately 80% reported being a mother of a dependent child aged <18 years and approximately

40% of mothers of dependent child reported that their children were not being cared for by them (i.e., in alternative care).

- Of all men attending SLAM substance use treatment services, approximately half of them reported being a father of a dependent child and 22% of them reported that the child was not under their care.
- Approximately half of mothers of dependent children did not disclose childcare arrangements (e.g., children under the care of the mother/in alternative care) during a routine risk assessment. A similar proportion of fathers did not disclose information about the child. The reason for this lack of disclosure is unclear (e.g., not being asked or patients own decision to not disclose).
- A range of paternal information that might impact parents' ability to look after their children are documented on clinical notes. However, information is lacking on how or what treatment and support is being offered to patients in response to the issues documented.
- Records of 480 mothers in SLAM substance use treatment services (30% of mothers of a dependent child) were linked to family court data. Mothers involved in care proceeding presented a distinctive profile from those mothers not involved in care proceedings. This included younger age, non-white background, social deprivation, housing problems, pregnancy at the start of treatment, problem with opiates and cocaine/crack cocaine use, lifetime history of domestic violence and poor mental health.
- Findings highlight that current substance use treatment services are not designed to support mothers in retaining the care of their children, as 82.1% had the child placed in out-of-home care. This prevalence is far higher than among the general population of care proceeding cases found in England, where around 50% of children are placed into out-of-home care under a care order.
- A focus on addressing substance use alone is not enough to improve mothers' ability to look after their children. Attending treatment for substance use during the proceedings is not a protective factor for out-of-home placement. In addition, the longer the mothers are in treatment, the greater is the risk for losing the rights to care for their children.
- There is pressing need for preventive strategies for mothers that are already known to substance use services prior to their involvement in care proceedings. In our study, 40% of the mothers were known to substance use treatment services before the start of the proceedings.
- Overall, 33% of care proceeding cases involved mothers that received treatment for substance use only after the completion of the proceedings.

- Almost three quarters of the care proceeding cases involved both parents and the participation of the child's father in the proceeding was a protective factor for not losing the care of the children only for those mothers that were receiving substance use treatment at the time of the proceedings.
- While there were more male service users who were fathers of a dependent child (49.6%) than female service users who were mothers of a dependent child (30.8%), the proportion of involvement in care proceedings was greater for mothers (30%) than fathers (5.1%). However, given that information of involvement in care proceedings for the fathers were from notes in electronic health records, we have no certainty in the size of this probability.
- It was common for both parents to have substance use problems in care proceedings involving fathers, and heightened the risk of having their child removed.
- More attention should also be paid to the quality of fathers' interpersonal relationships. Conflicts with the partner often led to substance use relapse and loss of contact with children, and substance use relapse often led to intimate partner violence, family break-up and children being removed from the care of the parents.
- Mothers were five times more likely to report lifetime domestic violence victimization than non-mothers and it increased the risk of the child being placed into care. Many fathers involved in care proceedings reported that the child's mother fled with the children due to their violent behaviours. Services aimed at improving family functioning cannot ignore the interconnection between intimate partner violence and substance use.
- Practitioners have little knowledge about what role men play as fathers. Different from mothers, there is limited information in the clinical notes about childcare responsibilities of the fathers (e.g., involvement in day-to-day care). Responses from the services about parental responsibilities tend to focus on whether the fathers posed a risk to their child.
- Practitioners in substance use services should not assume that the fathers do not care about their children. Most fathers (70%) were in contact with the dependent child and fathers involved in care proceedings clearly expressed their desire to be a better parent.
- Fathers were not informed on how their treatment plans were aligned with the care proceedings' goals and timeframe. Workers from across child protection and health services must communicate and collaborate with each other in order to keep fathers engaged with services.
- Almost three in every four mothers involved in care proceedings were likely to reappear in a subsequent set of proceedings within ten years after the completion of

the first case. Of the mothers who do return to court, 53% do so with a new born baby.

Recommendations

1. The high proportion of missing data about parental characteristics implies **a great need for staff training in substance use treatment services** to improve assessment and recording of key child related information.
2. **Mandatory assessments are not being undertaken.** For instance, the administration Alcohol Use Disorders Identification Test (AUDIT), Child and Need Risk (CNR) and Addiction Brief Risk Scale Assessment (BRSA-A) forms, which are all mandatory, was completed by 59.5%, 74% and 66.4% of the mothers' sample, respectively. It is imperative to address this issue, via regular audits and quality improvement projects, as it undermines the effectiveness of assessments and reflects a **critical oversight in supervision and management processes**.
3. Findings validate that substance use is not an isolated problem in women's lives, **with particular emphasis on the experience of trauma throughout their lives, and the challenges in preventing intergenerational violence from affecting their children**.
4. **There are immense barriers that many mothers experience in accessing substance use services in times of crises.** To this end, our findings question whether the current model of care is capable of adequately identifying and responding to the needs of mothers, and contribute to the ongoing calls for more investment in treatment approaches that comprehensively address the complex range of individual and family difficulties that might affect the ability of mothers with substance use problems to provide a safe and nurturing home environment for their children.
5. Findings also show **a decrease in the number of care proceedings** involving mothers attending substance use treatment in the study period, which is **not in line with the national increase in family court cases**.
6. In order to improve parental and childcare outcomes for parents in substance use treatment services **must not only identify problems, but recognise difficulties faced by these parents and support their needs**. The **integration of services is necessary to provide effective supports for these parents**. However, findings reiterate parents' negative views of child welfare systems involvement, and it is unclear how family-centred strategies are implemented across substance use services.
7. **The participation of the child's father in the proceedings was a protective factor** for maintaining care of the child for those mothers that were receiving

substance use treatment at the time of the proceedings. **Further research is needed to understand who the fathers are and to identify how service providers can better work with them** to support mothers involved in Family Courts.

8. Future studies and interventions should attend more to **the dynamics and external context of how substance using couples manage their relationships while figuring out how to be parents together.**
9. There is **a potential need for interventions to respond to fathers' intimate partner violence (IPV) perpetration** in substance use treatment settings.

Contents

Acknowledgement	II
Executive Summary	III
1 The research project and its context	1
1.1 Parental substance use and care proceedings	1
1.2 Identification of substance using mothers: our previous research experience	3
1.3 Using routinely collected administrative records	4
1.4 Study aims	5
1.5 Overall design	6
2 Parental status and characteristics of women in substance use treatment services (Study 1)	8
2.1 Objectives	8
2.2 Methods	8
2.3 Key findings	14
2.4 Limitations	14
2.5 Conclusions	14
3. Maternal and childcare information documented on clinical records of mothers presented to substance use treatment services (Study 2)	17
3.1 Objectives	17
3.2 Methods	17
3.3 Key findings	20
3.4 Limitations	24
3.5 Conclusions	24
4 Mothers in substance misuse treatments involved in care proceedings: characteristics, proceedings' outcome and recurrence rates to care proceedings (Study 3)	26
4.1 Objectives	26
4.2 Methods	26
4.3 Key findings	29
4.4 Limitations	30
4.5 Conclusions	31

5. Characteristics of fathers receiving treatment for substance use (Study 4)	32
5.1 Objectives	32
5.2 Methods	32
5.3 Key findings	35
5.4 Limitations	36
5.5 Conclusions	36
6. A qualitative study of clinical notes in substance use treatment services of fathers involved in care proceedings (Study 5)	37
6.1 Objectives	37
6.2 Methods	37
6.3 Key findings	38
6.4 Limitations	42
6.5 Conclusions	43
7. Implications	44
8. Bibliography	48
Appendices	56
Appendix 1	56
Appendix 2	58
Appendix 3	59
Appendix 4	61

1

The research project and its context

Parental substance use by parents is considered a significant risk to children's health, education, and social and biological development (Alati et al., 2013; Mirick & Steenrod 2016; Velleman & Templeton, 2016). It is also linked to general child maltreatment and neglect, often compounded by additional parental factors such as cycles of intoxication and withdrawal, socioeconomic difficulties, lack of appropriate parenting skills, and psychiatric comorbidities (Canfield et al., 2017; Kepple, 2018; Torrens et al., 2011). In the UK, approximately 162,000 children aged under 18 years live with a parent who is dependent on opiates and 200,000 live with a parent who is alcohol dependent (McGovern et al., 2018). While not all parents who use substances cause harm to their children, parental substance use is a common feature in public family law proceedings cases ('care proceedings').

1.1 Parental substance use and care proceedings

In England, parental substance use is presented in almost two thirds of care proceedings (Pearson et al., 2021; Public Health England, 2018). The risk of involvement in care proceedings is intensified by the child's exposure to adversities associated with parental substance use, including domestic violence and parental mental health problems (Douglas & Walsh, 2009; Mulder et al., 2018). Approximately 4% of all children across England live in a household with a parent who is struggling with the co-occurrence of these three vulnerabilities (substance use problem, domestic violence, and parental mental health problem; the so-called trio factors) (Children's Commissioner for England, 2022; Chowdry, 2018).

Mothers, as the primary caregivers, are more likely than fathers to be involved in care proceedings (National Children's Bureau, 2018) and to manage the effects of their substance use while caring for the children (Syed et al., 2018). Research has shown that women with substance use problems tend to differ from the general male population of substance users in terms of physical and psychosocial adversities (e.g., greater prevalence of both mental and physical morbidity, and history of physical and sexual abuse; Frem et al., 2017; Gilchrist et al., 2015; Simpson & McNulty, 2008), substance use patterns (e.g., higher severity of addiction, greater sharing of injecting equipment; Garcia-Guix et al., 2018; Iversen et al., 2015; Peters et al., 2019), and treatment utilization (e.g., less readiness for treatment, more relapses; Greenfield et al., 2007; Tuchman, 2017). In the past two decades, awareness of the distinct treatment needs of female service users has grown

(Greenfield, 2002; Simpson and McNulty, 2008; Tarasoff et al., 2018). However, there are still gaps in provision: despite the majority of women with substance use problems being of child-bearing age (Tarasoff et al., 2018; World Health Organization, 2008), it remains unknown whether substance use treatment services are addressing the specific needs of mothers (Canfield et al., 2017; Henderson et al., 2012; Lloyd, 2018).

Nevertheless, there is strong evidence suggesting that mothers and their children are more likely to have positive outcomes when substance use treatment integrates a wide range of services. Programs that include substance use interventions, parent/parenting classes, service linkages, and children's programs can reduce maternal substance use (Tarasoff et al., 2018) and mental health problems, and improve parenting and childhood development (Milligan et al., 2010; Niccols et al., 2012; Ofstead and Care Quality Commission, 2013). However, mothers with substance use problems tend to experience significant issues in accessing and engaging with supportive services (Lloyd, 2018; Best et al., 2004; Olsen, 2013), and face many barriers to seeking help, including feelings of guilt, high stigmatization, fear of losing custody of their children, and lack of transportation (Olsen, 2013; Radcliffe, 2011). For instance, women with children are less likely to attend residential treatment services than women without children (Lloyd, 2018).

Less is known about fathers receiving treatment for substance use and benefits of engaging them in care proceedings. Men account for approximately 70% of service users accessing substance use services in the UK, with estimates indicating 17% are fathers of children under the age of 18 (Office for Health and Social Disparities, 2022). While it is difficult to ascertain the child care responsibilities of these men, qualitative studies show that fathers in substance use services do hold an identity as a father even when they have uncertainties about their parental role (Stover et al., 2018; Taylor, 2012; Ward et al., 2017). However, while these men may have the motivation to provide a positive upbringing to their children, studies suggest that many fathers with substance use problems do not have the skills needed to engage in healthy relationships with their children. This includes poorer communication (Soderstrom & Skarderud, 2013), hostile-aggressive parenting (Stover et al., 2013), poorer emotion regulation (Moss et al., 2002) and tenuous attachment (Edwards et al., 2004). In addition, fathers with substance use problems often have hostile attitudes towards their partners (Stover et al., 2013) and had perpetrated violence toward their child's mother (Heward-Belle, 2015; Moore et al., 2011). Children that are exposed to the co-occurrence of parental substance use and intimate partner violence (IPV) are at a greater risk of abuse and neglect (Burlaka et al., 2017; Chowdry, 2018; McTavish et al., 2016). More men in substance use treatment services have perpetrated IPV in the preceding 12 months compared to men in the general population. This ranged from 42% (Canfield et al., 2019) to 60% (Fleming et al., 2015) of men in treatment having perpetrated IPV compared to 35% in the general population (WHO, 2013). Despite this, substance use treatment services do not routinely address fatherhood, intimate partner violence or the impact of these

concerns on children (Brandon et al., 2019; Radcliffe & Gilchrist, 2016; Stover et al., 2018).

There is an established literature on the positive and negative impact to children's wellbeing of having a father/father figure involved in their lives (Higgs et al., 2018; Lamb, 2013; Kubb et al., 2020; Sarkadi et al., 2008). Less clear is the views of birth fathers' involvement in care proceedings and whether involving them in tailored services will improve the outcomes for the children (Brandon et al., 2019; Scourfield 2015; Stover et al., 2018). This is due to the lack of evidence in this topic. Qualitative studies suggest that men are rarely acknowledged by child welfare services, even when they are present in the children's life (Brandon et al., 2019; Ewart-Boyle et al., 2015) and that child protection practitioners tend to describe them as insignificant or a threat in proceeding's cases (Scourfield, 2001; 2006). Over the past decade, there have been calls for greater inclusion of fathers in child welfare's practice and in research (Brandon et al., 2019; Critchley 2022). The inclusion of fathers is viewed as important to any assessment of risks and benefits they may bring to the child (Bandford et al., 2019). It is also viewed as important to prevent the sole parental responsibilities resting on mothers including views and attitudes towards mothers as accountable for the risks and difficulties in the family.

While many parents avoid seeking treatment for their substance use because they fear losing custody of their children (Broadhurst & Mason 2020), sustained engagement in substance use treatment may increase the probability of reunification (Canfield et al., 2017, Doab et al., 2015, Grant et al., 2011). However, these outcomes are more likely to happen when substance use treatment is part of a multidisciplinary integrated programme that meets the complex needs of these parents (e.g., medical, mental health, parenting services, education, employment assistance, case management) (Doab et al., 2015, Neo et al., 2021). These types of programmes are usually offered when a child is initially removed from the care of the parents. In England, limited information is known about the mothers and fathers receiving mainstream treatment for substance use that are involved in care proceedings and the subsequent outcomes of care proceedings. The lack of research in this area is partly due to challenges in engaging and retaining parents with substance use problems in research during care proceedings (Radcliffe et al., 2020).

1.2 Identification of substance using mothers: our previous research experience

Our previous Nuffield Foundation funded research demonstrated that identifying maternal problematic alcohol users during care proceedings involvement was challenging, as they were hidden and hard to reach by social workers and researchers (Marlow et al., 2017). The lack of a standardized substance use

assessment for social workers imposed additional identification barriers. By exploring the feasibility of using social service case notes to investigate maternal substance use, we found that when substance use was identified and connection with substance use treatment established, reports on engagement were not required for social worker's case notes (Marlow et al., 2017). Moreover, disclosure relied on self-report and information about substance use treatment engagement was subject to reporting biases. We therefore conducted another feasibility study to explore the use of electronic health records (EHRs) to examine patterns of substance use among patients attending substance use treatment with dependent children (Marlow et al., 2017). Our findings supported the use of linked EHRs as the only feasible way to conduct an anonymous retrospective cohort study of mothers attending substance use treatment.

1.3 Using routinely collected administrative records

England has a unique collection of electronic health records (EHRs) and administrative datasets that enable population analysis at a level of detail. Linkage studies of EHRs bring enormous benefits to research wishing to establish a common data model with reproducible data variables (Department of Health, 2012; Medical Research Council, 2011). In this study, we were able to access EHRs of patients attending South London and the Maudsley NHS Foundation Trust (SLaM) substance use services, which had been previously linked to Hospital Episodes Statistics (HES).

In addition, the study used a new linked dataset generated from a Nuffield Foundation study combining EHRs from women attending SLaM mental health services with records of women involved in care proceedings (Cafcass) (for further information visit [The Health Needs of Mothers and Children in Family Court Cases](#)). This resource provided a unique opportunity to identify mothers receiving treatment for substance use who were and who were not involved in care proceedings, and what maternal and clinical characteristics might increase the risk of a child's out-of-home placement in this population. Understanding care proceeding involvement status and outcomes according to the characteristics of the mothers is important, as there is no consensus on which aspects of the parents' characteristics and substance use behaviour are associated with childcare outcomes (Wall-Wieler et al., 2018). This lack of evidence-based information creates challenges for services to provide timely support. Information that could be used to assist services identify who requires support and when to target support is pressing, given that the unmet mental health needs of mothers remain the key contributor for child placement orders (Marmot, 2020; Masson et al., 2019, Morriss & Broadhurst, 2022). In addition, since 2014, Family Courts in England and Wales are required to complete proceedings within 26-weeks from the day of inception of the care proceeding. In some cases, an extension may be granted if justified. This 26 week timetable of court proceedings

makes it increasingly difficult for parents who entered treatment at the beginning of care proceedings to demonstrate engagement with services (Radcliffe et al., 2020), and contradicts the timeline of 52 weeks' abstinence from substances required by courts to allow mothers to retain/regain ongoing care of their child (Munby, 2014). These conflicting timeframes is problematic as it remains unclear how social services and substance use treatment services should work together to support mothers to start treatment prior to the commencement of proceedings.

1.4 Study aims

The original aim of this study was to use electronic health records (EHRs) to describe the individual and treatment characteristics of mothers attending substance use services – and specifically to investigate the relation between these characteristics and childcare status (i.e., living with the mothers, removed from maternal carer by family court mandate). To achieve this aim, we analysed a unique linked database formed between the SLAM Case Registry Interactive Search (CRIS) electronic health registry, Hospital Episode Statistics (HES) and family court dataset (Cafcass). The study objectives were:

- **Objective 1:** Describe the characteristics of mothers receiving substance use treatment.
- **Objective 2:** Investigate which maternal and childcare issues are reported and addressed in substance use treatment.
- **Objective 3:** Explore which mothers receiving treatment for substance use and involved in care proceedings are most likely to retain or lose care of their children.
- **Objective 4:** Examine individual and treatment outcomes for mothers after involvement in care proceedings according to the care order outcome.

As the study progressed, we learned that we could apply a similar methodological approach to explore the characteristics of fathers in substance use services including those who are involved in care proceedings. We then proposed to Nuffield Foundation an extension of the project to conduct a supplementary study on fathers. However, due to the CRIS-Cafcass linked dataset being restricted to women, our study on fathers only used data from the SLAM substance use services.

There were several reasons for conducting this supplementary study. Presently, there is no information on individual, treatment and childcare characteristics of fathers receiving substance use treatment in England. Nor is there information on who these fathers are in substance use services that are involved in care proceedings. As explicitly highlighted in the Nuffield Foundation's review on fathers reappearing in family courts (Philip et al., 2021), research is needed to build a

clearer picture of who the fathers in family courts are. In addition, in our analysis of the CRIS-Cafcass dataset of mothers in substance use treatment services we found that father's participation in the proceedings is a protective factor for mothers to retain the care of the children. This finding adds to an emerging body of studies calling for more attention to couples in the context of interventions to prevent first and repeat episodes of care proceedings. To be able to develop such interventions, we must firstly understand who these fathers are and their needs.

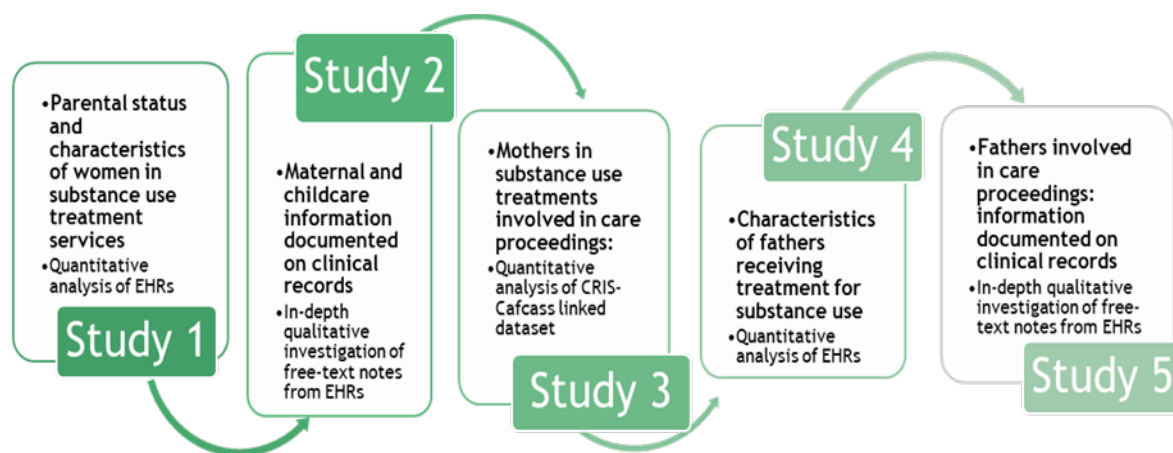
The objectives of the supplementary study on fathers were to:

- **Objective 5:** Describe the sociodemographic, psychological, and clinical characteristics of fathers and men without children.
- **Objective 6:** Examine potential differences in fathers of dependent children involved in care proceedings to those not involved.
- **Objective 7:** Explore which factors in the father's lives that may have an implication on care proceedings are being reported by health professionals.
- **Objective 8:** Identify the care responsibility of the fathers after involvement in care proceedings (e.g., type of contact with the child/ care proceedings' outcome).

1.5 Overall design

The study comprised an extensive programme of quantitative and qualitative research using administrative datasets. Five linked studies were conducted according to the study objectives. The research design is summarised in Figure 1 and each study is discussed in more detail in the next chapters.

Figure 1 Overall design



Study setting

The study population consisted of patients who attended Tier 3 (i.e. community-based drug assessment and structured treatment including community prescribing, psychosocial interventions, and day programmes) and 4 (i.e. residential treatment, such as NHS inpatient units and voluntary sector rehabilitation centres) structured treatment interventions for their alcohol and/or drug use within the South London and Maudsley (SLaM) National Health Service (NHS) Foundation Trust addiction services between 1st January 2013 and 31st January 2020. SLaM provides substance use treatment services to people resident in the South London boroughs of Croydon, Lambeth, Lewisham and Southwark covering roughly a population of 1.4 million. SLaM additionally delivers substance use treatment services to four neighbouring local authorities (Bexley, Bromley, Greenwich and Wandsworth).

Data were extracted using the Clinical Record Interactive Search (CRIS) system (Perera et al., 2016), which contains anonymized electronic health records (EHRs) from SLaM services recorded during routine clinical practice. CRIS is a secure data repository for SLaM services which operates strict governance controls with external service user led oversight (for further information about CRIS please see Downs et al., 2019; Perera et al., 2016; Stewart et al., 2009). In addition to structured fields (e.g. dates, diagnoses and medications), CRIS includes anonymised unstructured, free-text fields (such as clinical progress notes, discharge reports and other correspondences).

CRIS has linked mental health data to hospital data. In 2020, a new linked was established between CRIS and Children and Family Court Advisory and Support Service (Cafcass). The case management system used by Cafcass captures information on all relevant adults and children involved in a public family law application. This includes demographic information such as age, gender, and ethnicity, as well as case information such as who was involved in the case and key dates. The Cafcass records also contain information on final legal orders made family court data via Cafcass. Records of 3226 women attending SLAM services between 2007 and 2019 were linked to Cafcass (Pearson et al., 2021).

Ethics

CRIS was approved as a dataset for secondary analysis by Oxfordshire Research Ethics Committee C (reference 23/SC/0257) and CRIS oversight committee approved all the five studies of this project study. Additional approval was granted by the Cafcass to analysed the CRIS-Cafcass linked dataset.

The authors do not own the data and are not permitted to share it, except in aggregate form for publication. Access to the data can be requested through submitting a data request through the CRIS Request Service.

2

Parental status and characteristics of women in substance use treatment services (Study 1)

Methods and results from this descriptive study have been published in

[Canfield M, Norton S, Downs J & Gilchrist G \(2021\). Parental status and characteristics of women in substance use treatment services: Analysis of electronic patient's records. *Substance Abuse and Treatment*, 127](#)

2.1 Objectives

- i) Explore differences in socio-demographic, psychological, patterns of substance use and treatment characteristics between mothers and women without children.
- ii) Examine potential differences in those mothers whose children were in alternative care, compared to those whose children were under their care.

2.2 Methods

Records of all female service users who received care from SLaM substance use treatment services between 1st January 2013 and 31st January 2020 were extracted. This comprised of 4370 women. The date of the first Treatment Outcome Profile form (TOP) completed closed to the completion date of the Child Needs and Risks (CNR) form was used as 'point of assessment'. We used these two forms due to the first providing information about substance use patterns and the later providing information about childcare and maternal characteristics. However, in cases where the CNR form was not completed, the earliest TOP assessment date during the study period was used (N=1155, 26% of total sample). Given that there is a 6 months window period for the CNR to be completed after the TOP assessment, it might be that CNR was not completed by those service users who dropped out/ended treatment between assessments' time. In addition, while the CNR form was part of the service assessments before the observation period of this study, its administration only became mandatory from January 2013, therefore not all women who entered treatment before 2013 had CNR completed.

Identification of maternal status

We used the Hospital Episodes Statistics (HES) data on reports of 'ever given birth' before the first date of the TOP assessment being completed within the observation

period of this study. These data were matched with reports of having a dependent child on the CNR (defined as having a dependent under the age of 18 years). There were some cases (N=239) where women reported having a dependent child in the CNR but had no reports of giving birth in the HES data. We then looked at CNR free-text data which suggested that this discrepancy was largely due to these women being originally from another country and thus birth might have occurred outside England.

The term 'mothers' in this study refers to patients who ever gave birth, whereas 'mothers of a dependent child' refers to mothers of a child/children aged <18 years independently of living together. The flow diagram of the study participants is illustrated in Figure 2.

Measures

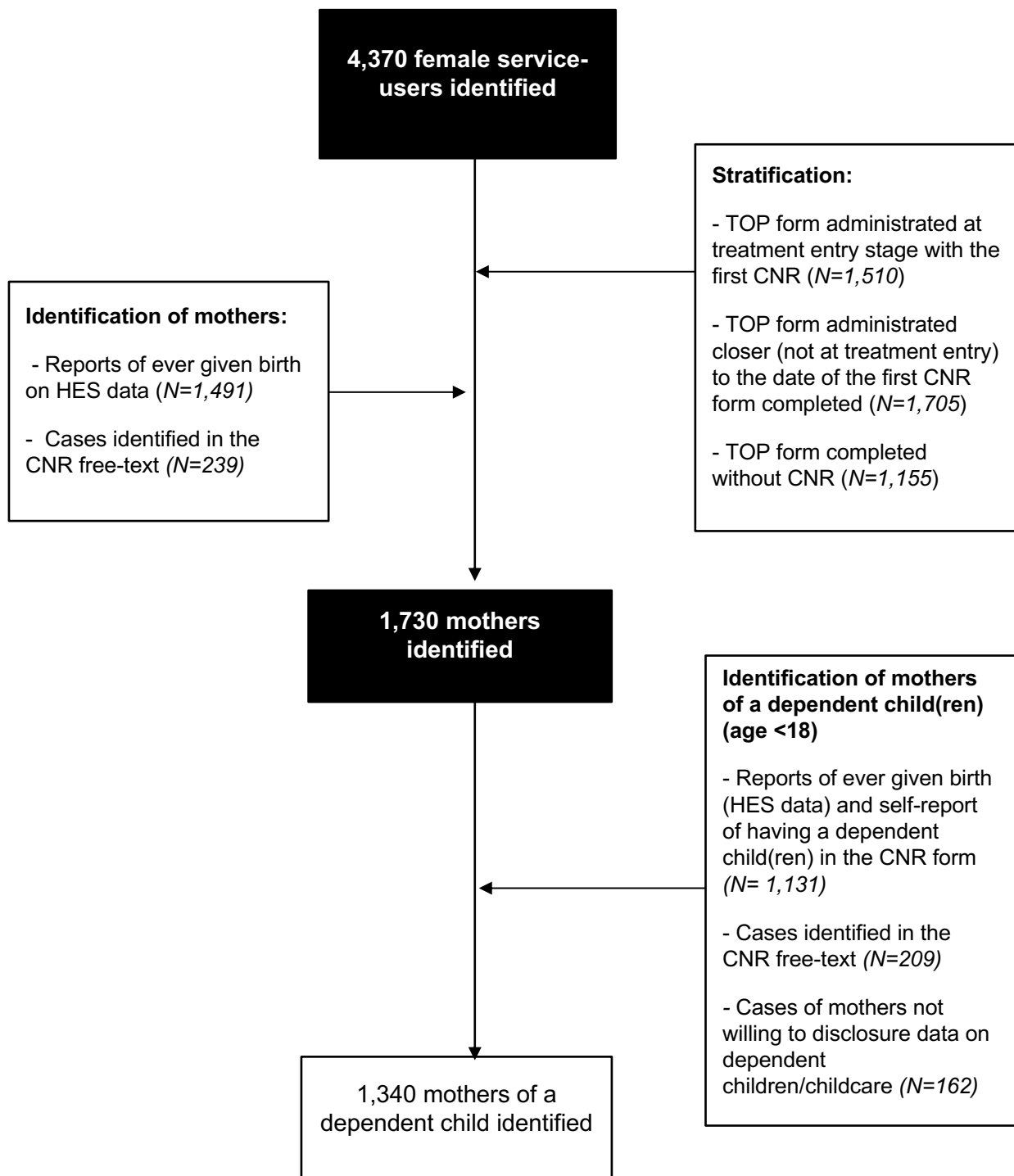
We extracted information from the following assessment forms which are compulsorily administered by staff to all patients attending substance use services. Figure 3 illustrates the time points of assessments of each clinical form.

- *Treatment outcome profile (TOP)* (Marsden et al., 2018): This form is administered at treatment entry and re-administered every 6 months during the treatment journey and when patients leave treatment. The TOP contains a set of questions on the frequency that the following on each of the past 4 weeks: alcohol, opioids, crack-cocaine, cocaine, amphetamines and cannabis. Weekly average use was calculated for each these items and a score of 1 was assigned if alcohol was consumed mostly every day of the week (>3 times) and if any other substance was used at least once a week. Additional information extracted from the TOP includes an interval measure ranging from 0 (poor) to 20 (good) where patients rate their own levels of 1) physical health; 2) psychological health and 3) quality of life in the past 28 days.

- *Alcohol Use Disorders Identification Test (AUDIT)* (Babor et al., 2001): Frequency and quantity of alcohol consumed in the past 12 months was extracted from the AUDIT, which is completed at treatment entry. It consists of a ten-item measure and provides an indication if person's drinking is lower risk (scores < 7), increasing risk (scores 8-15), higher risk (scores 16-20) or possibly dependent (scores > 20).

- *Addiction Brief Risk Scale Assessment (BRSA-A)*: This form is completed as part of the patient's initial assessment to the treatment. The following information were extracted (yes/no responses): currently having a blood borne virus infection, lifetime history of suicide attempts, lifetime history of overdose, hospitalization due to mental health problems in the past 12 months, reports of social isolation, risky sexual behaviour and self-neglect in the past 12 months.

Figure 2. Study sampling flow diagram



- *Child Needs and Risks form (CNR)*: This form is completed as part of a clinical assessment within a six-month window following the completion of the TOP form regardless of being a parent of dependent children. Data from the CNR was used to identify those patients who have a dependent child/ren and childcare arrangements (under the care of the mother/in alternative care). In addition, this form provides self-reported information on pregnancy status and lifetime history of domestic violence (ever in life), whether the patients' substance use, mental health or learning disability impacts on their capacity/ability to meet the needs of the child/ren (i.e., high risk to children, yes/no responses) and whether safeguarding referrals were made by the substance use treatment services to the Multi Agency Risk Assessment Conference (i.e., referral to social services, yes/no responses). However, given that parental status is self-reported and focuses on having any dependent children rather than being a parent or ever giving birth, it is possible that data from these forms lack information on those women that decide not to disclose their parental status or those mothers who had their right to care for their children terminated by child protection services.

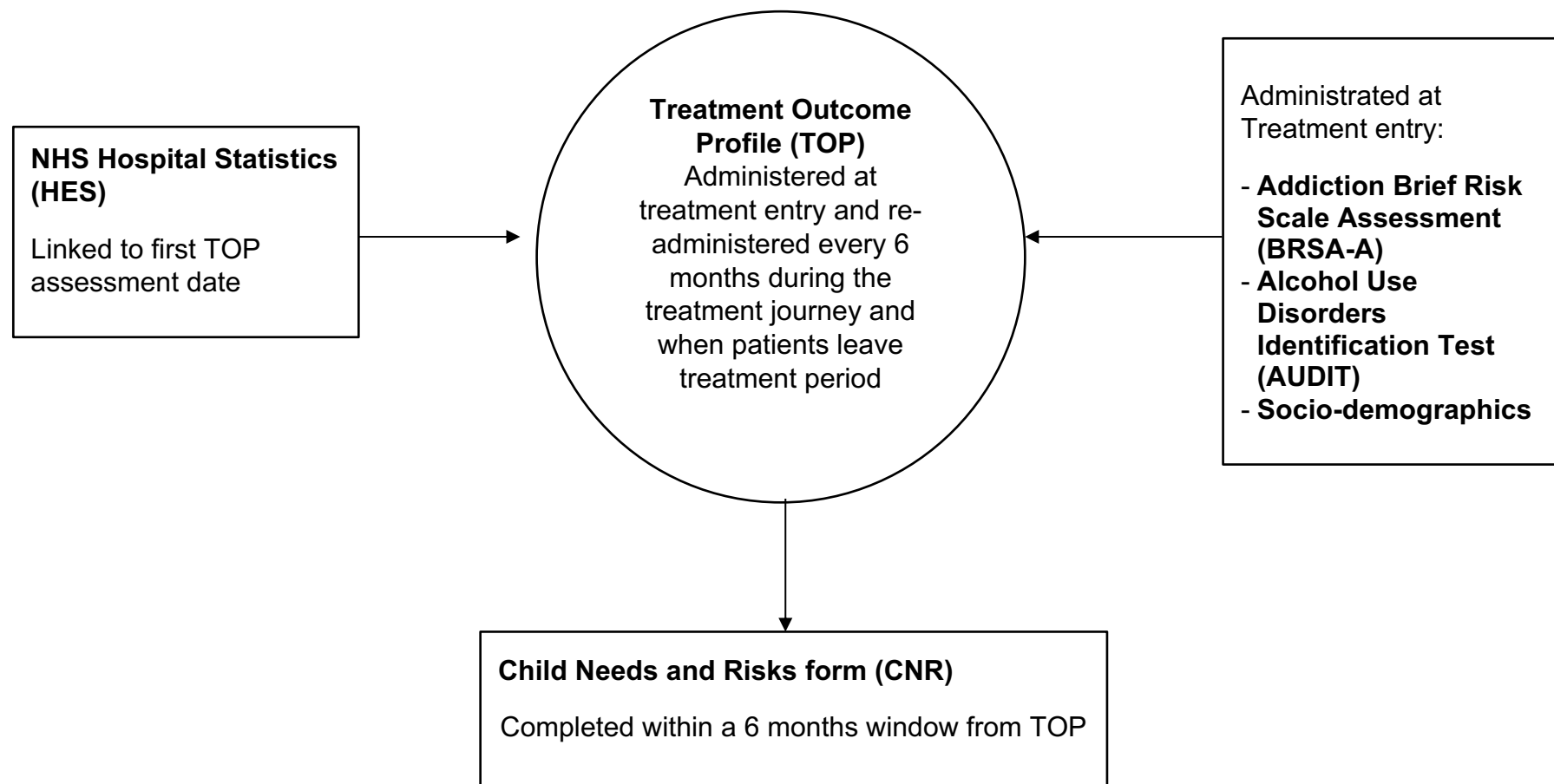
- *Hospital Episode Statistics (HES)*: Data from HES was used to ascertain the number of women who were mothers and had given birth. We also extract the number of deliveries before the first TOP assessment was administered within the observation period of the study.

- *Sociodemographic information*: Information on ethnicity was extracted from SLaM electronic patient records in their designated fields. We condensed ethnicity classification into "White British" and "Others" (British minoritised ethnic groups). Age was calculated on the date on which women completed their first TOP form within the observation period. Information on homelessness/unstable housing and receiving an employment salary were extracted from the TOP form.

Analysis

Bivariate analyses using *t*-tests and chi-square tests compared women who are mothers and those who are not mothers. Effect sizes (odds ratios and 95% confidence intervals) of factors associated with mother status was calculated using logistic regression. A series of univariable analyses using logistic regression were used to identify possible factors associated with those mothers whose children are under their care, compared to those whose children were in alternative care.

Figure 3 Time points of assessments of each clinical form



2.3 Key findings

Mothers comprised of 39.6% of the cohort (1730/4350), of whom 1340 (77.4%) had dependent children.

Compared to women without children:

- Mothers were younger, more likely to have housing problems, and less likely to be in paid employment.
- More mothers had experienced domestic violence in their lifetime.
- Fewer mothers reported social isolation.
- Fewer mothers in substance-use treatment met AUDIT criteria for alcohol dependence or reported drinking alcohol mostly every day of the week in the past 28 days.
- Mothers in treatment had higher reports of opioid and crack-cocaine use in the past 28 days

Characteristics of mothers

There was a large amount of missing data for several maternal characteristics:

- A third of identified mothers had missing data on their number of children.
- Over half of identified mothers had missing data on childcare arrangement.
- Reasons for the missing data is unclear (e.g., not being asked or patients own decision to not disclose) and so we would advise some caution around the representativeness of the data.

Of the reported data:

- The average number of births for mothers receiving substance-use treatment was between 1 and 2.
- 40.0% of female service users were mothers. Of these, 77.4% were identified as mothers of a dependent child.
- Where childcare arrangement data was available (N=790), 82.1% of mothers reported their child was in alternative care (i.e., foster care, adoption, kinship care)
- A small proportion of mothers were considered to be high risk to their children (3.5%) and there was a small number of referrals to social services by substance use treatment services (2.8%).

Of the mothers of dependent child/ren who reported childcare arrangements, compared to mothers whose children were under their care, mothers with children in alternative care were:

- Over 3 times more likely to report lifetime domestic violence (ever in life).
- More likely to report drug overdose, but less likely to report opioid and crack-cocaine use in the past 28 days

- Other factors such as age, paid employment status, housing status, and alcohol consumption was similar across mothers with children in alternate care and those whose children were in their care.

2.4 Limitations

EHRs are not collected for the purposes of research, which might have influenced missing data. Although the administration of all the assessments was mandatory, in practice we found that information from the AUDIT, CNR and BRSA-A forms was completed by 59.5%, 74% and 66.4% of the sample, respectively. It is therefore possible that in some cases, important psychological and childcare information including domestic violence was missing. Only TOP and AUDIT measurements were previously evaluated as a measurement in terms of psychometric constructs (e.g., discriminant validity, reliability). In addition, only the first TOP assessment information within the observation period was accessed, which does not necessarily mean it is the first TOP assessment conducted in a patient's lifetime. Patients who have had previous TOP assessment conducted, might have had different reports of substance use in the past 28 days. Similarly, we do not know if any new birth episode and/or change in childcare arrangements occurred in subsequent TOP assessments.

2.5 Conclusions

Several sociodemographic and clinical characteristics differed between mothers and women without children. Such factors (such as housing problems and employment status) in combination with substance-use may reduce mothers' abilities to sufficiently care for their children. Mothers were shown to have higher rates of lifetime experiences of domestic violence, and higher rates of opioid and crack-cocaine use. Integrated support and interventions addressing and/or preventing experiences of domestic violence may be beneficial for mothers in substance-use treatment. Future research should investigate how crack-cocaine use and treatment may affect mothers' abilities to care for their child(ren).

Over half of identified mothers of dependent child(ren) did not disclose childcare arrangements, and the type of alternative care or contact mothers had with their dependent child(ren) could not be identified from the EHR data. This missing data could mean that alternative care was underreported, and/or that mothers are less able to report childcare issues to health services. It is important to better understand and develop ways to provide support and adequate childcare screening to mothers. The six-month timeframe provided for completing the CNR form from the time of the first clinical assessment indicates that parental status and the needs of children in numerous families may have remained unattended for several months after the commencement of the mother's treatment. Moreover, the current timeframe for completing the CNR form implies that services could have potentially missed the

chance to address childcare concerns in mothers who dropped-out or terminated treatment before the six-month period.

3

Maternal and childcare information documented on clinical records of mothers presented to substance use treatment services (Study 2)

Methods and results from this study have been published in

[Canfield M, Brown A, Nelson A, Downs J, Gilchrist G, Norton S \(2023\). Documenting maternal and childcare information of mothers presented to substance use treatment services: a qualitative study of reports in a clinical case register. *Substance Abuse and Treatment*, 47](#)

3.1 Objectives

- i) Explore the feasibility of using free-text notes from EHRs to conduct a qualitative analysis of clinical records of mothers receiving substance use treatment.
- ii) Identify what maternal-related information and factors that might impair mothers' ability to care for their children is being documented by practitioners in clinical records.

3.2 Methods

To the best of our knowledge, this was the first study to conduct an in-depth investigation of free-text notes from EHRs of mothers attending substance use services. Typically, studies analysing EHRs have relied on structured data ("coded data"); however, clinical information is often missing from structured fields. Reasons for this missing information include motivations around clinical uncertainty, stigma, loss of information between services, time pressures or poor clinician training in the coding structure (Ford et al., 2020). Findings from Study 1 showed that approximately half of mothers of dependent children did not disclose childcare arrangements when an assessment of a range of childcare related factors was administered through the CNR. From discussions with the project advisory group which includes a service user, it was highlighted that women with dependent children might be more comfortable disclosing childcare-related information to substance use service professionals during routine consultations rather than during a risk assessment. Within the EHRs it also possible to access a range of case note communications between different health care practitioners and services (e.g.,

communication between substance use services, psychiatric services, and child protection services). However, given the rigid data governance applied to the use of such data for research purposes, analysing free-text notes from EHRs can be time consuming and difficult to navigate. Thus, to be able to address objective 2 of this study, we first conducted a feasibility study of analysing free-text notes within CRIS.

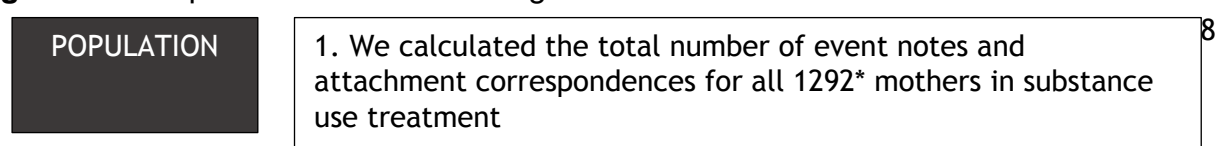
Sampling

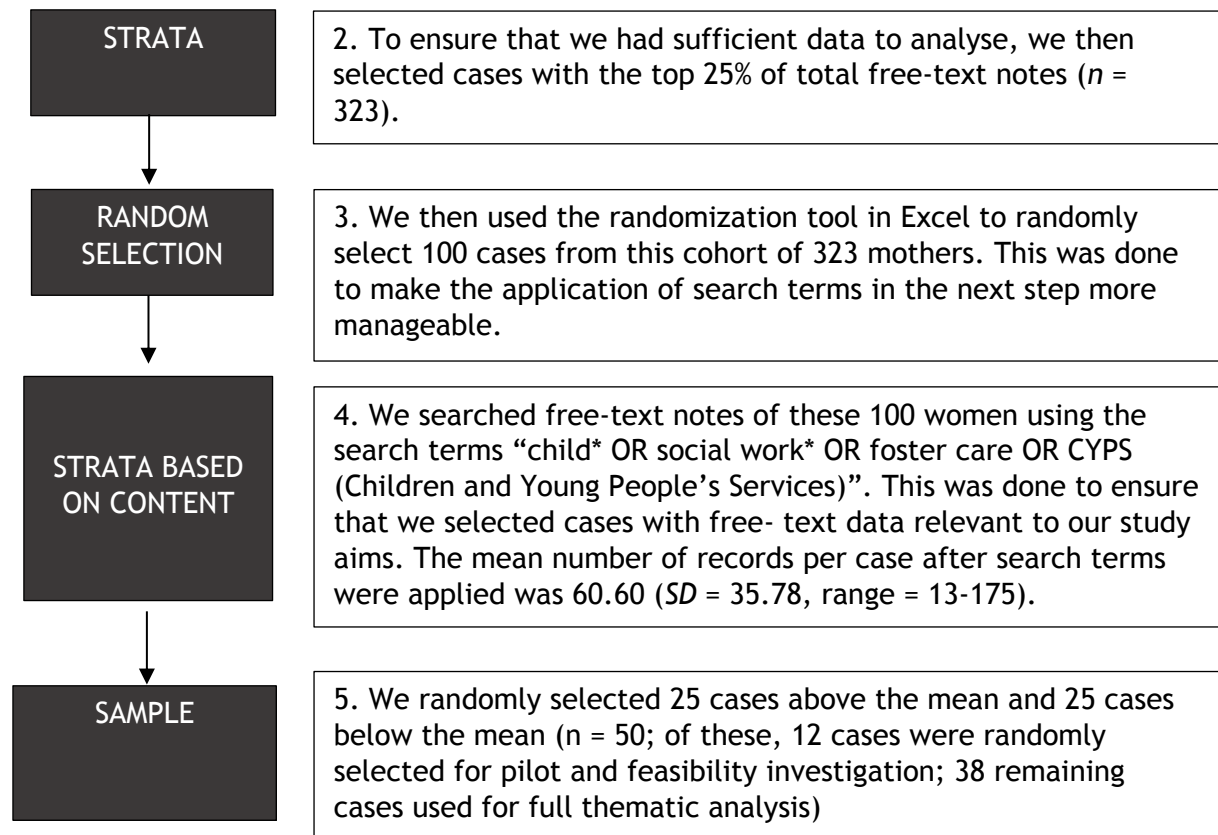
From Study 1 cohort, we stratified a subsample of 50 mothers of at least one dependent child (defined as mothers of children aged <18) whose data were extracted for this study. Information about a suitable sample size for the analysis of free-text notes in EHRs does not exist, however previous studies which collected qualitative data through interviews demonstrated that sample sizes of 20 to 40 participants are adequate to reach data saturation in less homogeneous samples (Chilman et al., 2021; Hagaman & Wutich, 2017). Similarly, no consensus exists in the literature of what is “good enough” for case selection in EHRs (Ford et al., 2016). We developed a sampling stratification process based on a random selection and number of records per case to ensure that the study analysed an adequate volume of data per case. Specifically, the purpose of this sampling stratification approach was to 1) provide some diversity in terms of overall case notes, while still having enough data with which to draw conclusions and 2) make data handling more representative by not only selecting those cases with the most notes. The sampling stratification process participants is illustrated in Figure 4

Data extraction and analysis

Data extraction for each case began at their first attendance to substance use treatment recorded on the CRIS system and ended on June 30, 2021. Patient notes were accessed and read through the CRIS user interface. This included analysis of free-text notes, which recorded details of patients’ contact with practitioners and letters and other documents (e.g., referrals to the multi-agency risk assessment conference, multi-agency public protection arrangements, or new referrals and plans for children’s social care). The data extraction and analysis took place in two stages.

Figure 4. Sample stratification flow diagram





First stage: pilot study

We conducted a pilot study with a subsample of 12 randomly selected 50 cases to understand the type of information available in free-text notes and the feasibility of being able to qualitatively analyse them. This pilot study involved the following steps:

- 1) Two researchers independently read all free text of six of the twelve cases and generated codes with the goal of identifying types of information being recorded in EHRs, with a particular focus on reporting child and mother outcomes.
- 2) Preliminary coding framework emerged with 12 codes (see Appendix 1) and the researchers identified common terms used to refer to information about children and childcare (e.g., “daughter”, “neonatal”, “twins”, “adoption”; see supplementary material TS2 for the full list of terms identified).
- 3) A set of search terms was established by determining how many search terms could be entered before errors occurred on CRIS interface. This led to seven search terms being applied to all remaining cases; terms were selected based on relevance and frequency of use (see Appendix 2).

- 4) To ensure that these search terms allowed for appropriate data saturation, we re-coded the six cases using the records available after limiting by the identified search terms. Doing so allowed us to complete a sensitivity analysis to ascertain whether the volume of data and data from notes related to maternal care/issues remained similar after applying search terms.
- 5) We extracted notes using the search terms for the remaining six cases and analysed them through an open-coding process. This process allowed for exploring the richness of the data by assessing if there were sufficient data to be coded within each case using the preliminary coding framework.

Second stage: A full deductive thematic analysis (Braun & Clarke, 2012) was conducted with the remaining 38 cases. All notes were extracted using the search terms identified in phase two of the pilot study.

Quantitative analysis: Throughout the pilot study and thematic analysis, we kept track of variables that would help us to determine feasibility and usability of CRIS and EHRs: number of records, time to search CRIS for individual cases, and time to code each case. We extracted information on the sociodemographic, clinical, and childcare characteristics from the Study 1 cohort.

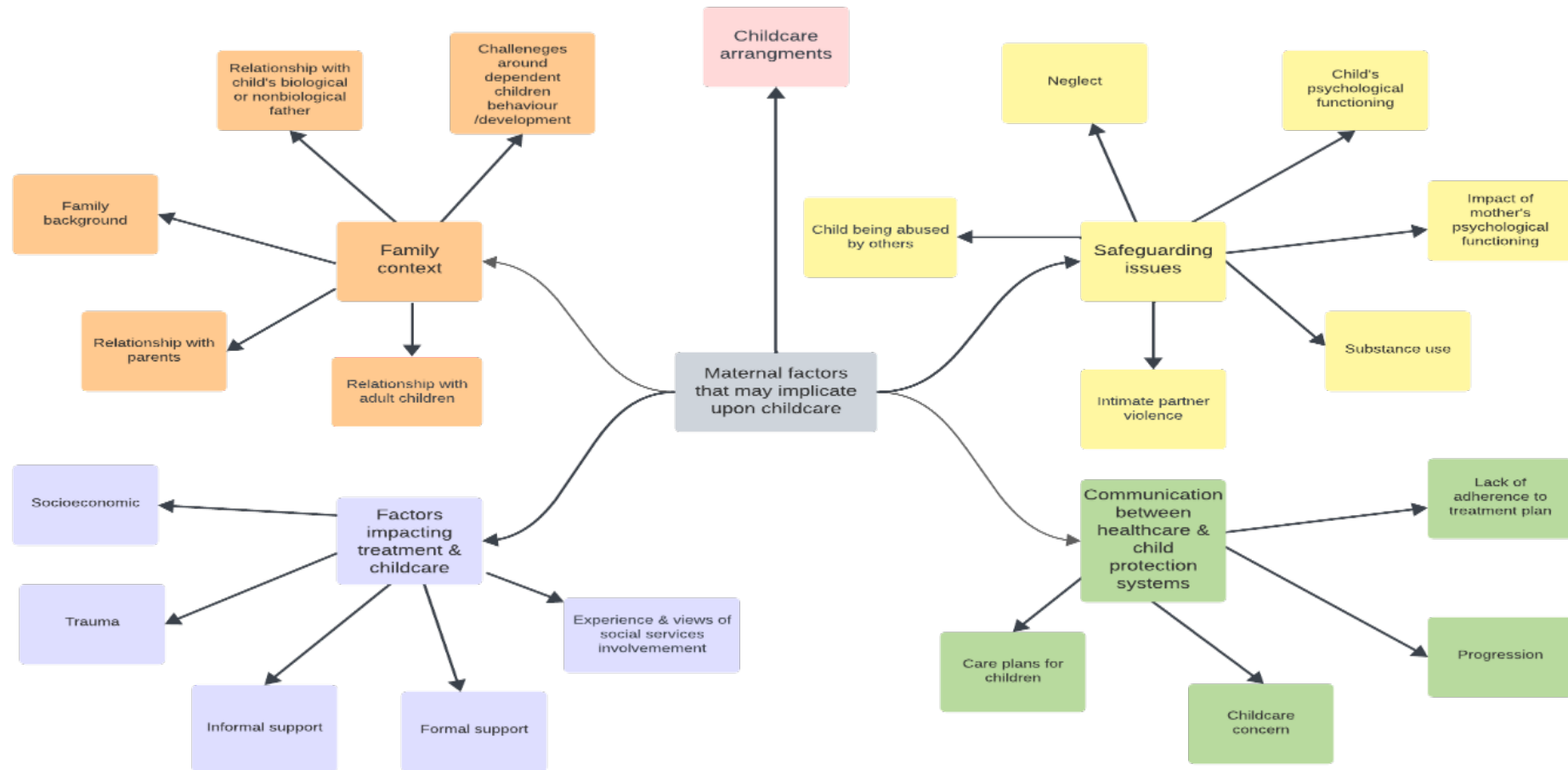
3.3 Key findings

Addressing objective 1: The pilot study demonstrated that there was sufficient data for further analysis using search words. This was indicated by:

- Of the 823 text extracts coded from the initial search of six cases, 170 (20.7 %) were missing after application of search terms (median of 49 extracts missing per case). However, when reassessing the amount of missing text extracts that had a direct reference to children (using related terms, e.g., son, daughter), 6.3 % (56 of the 823 text extracts) of these extracts were missing (median of 8 missing per case).
- Exploration of the remaining six cases found that all cases had information in at least nine of the 12 codes from predefined categories.

Addressing objective 2: Analysis of the remaining 38 cases yielded five themes with subthemes, which are illustrated in Figure 5. The key findings for each theme are described below. Further description of the themes and subthemes with examples of quotes are presented in Appendix 3.

Figure 5. Themes and subthemes identified from EHR



1) *Childcare arrangements*

- A variety of formal and informal childcare arrangements were identified, such as where mothers had primary carer responsibilities, if they were single mothers or had relatives, such as the child's grandmother or aunt, assisting with childcare.
- However, there was no information on who was caring for the child while the mother attended substance use treatment.
- Case notes frequently detailed if a child had been removed and the type of removal, such as temporary or permanent, as well as the mother's contact with the child.
- Changes in childcare arrangements were frequently communicated to practitioners.

2) *Family context*

- The nature of mothers' relationships with their parents, particularly with their mothers, was thoroughly described. Some women reported having tense ties with their families. For most mothers their family relationships were a beneficial element, particularly when it came to childcare assistance.
- Mothers frequently provided an open account of their personal past, including any family history of substance use, poverty, or mental health issues.
- The relationship with the partner at the time, such as the child's father or the acting father, was sometimes a beneficial factor, but it was also a stressor and a barrier to treatment in certain situations.
- Mothers frequently talked about difficulties with their children's emotional and behavioural development, such as aggression, sibling conflicts, and school achievement.
- A number of mothers had children above the age of 18. They frequently spoke about the nature and quality of their connection and emphasised the difficulties of coping with adult children. Practitioners did not identify this as a risk factor for mother's recovery and the safety of her other dependent children.

3) *Safeguarding issues*

- Practitioners occasionally included speculative notes indicating that the child may have been neglected, but they frequently lacked sufficient information to describe the type or extent of the neglect.
- It was evident from the notes that women did their best to satisfy their children's daily care requirements, but it was commonly the case that they did not completely comprehend the impact of their parenting style and drug use behaviour on their children's mental health.
- It was typical for mothers to have drug use in addition to other mental health disorders. Several mothers reported experiencing postpartum depression,

which contributed to their continued substance use. The records documented communication within mental health services about barriers and progressions in the mother's treatment.

- Practitioners usually inquired about how mothers stored their substances at home and the strategies they used to keep substances away from their children.
- Practitioners documented instances of mothers being intoxicated in the presence of their children.
- IPV victimisation was common among mothers and was documented in the majority of cases. This included reports of any type of violence (physical, emotional, sexual, or coercive control) in previous or current relationships. IPV victimisation from current partners seemed to be a major factor in removing the child from the mother's care or prolonging the children's stay in foster care. The child's safety had generally improved in cases where mothers ended their relationship with the perpetrator.
- There were some reports of children being abused by other adults, particularly daughters being sexually abused. These revelations were more common among mothers who had children in alternative care.

4) *Factors that impact the treatment plan and care of the child*

- Many mothers were experiencing social and economic insecurity, particularly in terms of housing, which was a direct barrier to treatment and childcare. Mothers were assisted in completing their allowance applications and directed to the welfare system.
- Many mothers were experiencing or had experienced traumatic events, as well as ongoing trouble and threats from drug dealers. These occurrences frequently resulted in a mental health crisis, a relapse in substance use, and the loss of childcare.
- Due to childcare responsibilities, mothers had difficulty attending appointments due to a lack of support from friends and family.
- Practitioners frequently communicated openly about mothers' needs, and concerns about child safety were reported to social services. Some documents indicated referrals for additional support services, but it was not stated whether mothers attended and received assistance from them.
- Mothers held negative views towards social services such as hostile opinions and feelings of fear which were not challenged by practitioners.

5) *Communication between healthcare and child protection systems*

- When a child protection plan was opened, practitioners were notified, and there was regular communication with the child protection system, which requested updates on the mother's treatment progression.
- Other information shared across services included mothers' appointment attendance, reports on relapse and the situation surrounding it, and the

- mother's preference for alternative care for the child, such as a family member, rather than an unknown foster parent.
- Practitioners advocated to child protection social workers on the mother's behalf in cases of isolated relapse(s) to consider the overall progress made.
- When practitioners became aware of situations affecting child safety, they openly informed child protection systems.
- The childcare system always kept practitioners up to date on the outcome of care proceedings.

3.4 Limitations

We conducted a sensitivity analysis and found that the use of search terms had only a minor impact on the volume of relevant maternal and childcare information extracted from free-text notes. This finding provided us with confidence that the chosen search terms were appropriate and practical for information extraction. However, we recognise that the use of search terms might have impacted full data saturation. Additionally, we encountered technological limitation for accessing data with CRIS's online platform, which limited the number of search terms we could employ (i.e., discovering the limit of seven search terms before errors occurred). The CRIS interface also presents other limitations as a platform for qualitative research, including the lack of text analysis tools and frequent errors in processing lengthy queries. These limitations impacted the time needed to undertake this work and the number of cases selected for the feasibility study. A larger sample size during the pilot phase would have provided a more robust bases for comparison in the sensitivity analysis.

Furthermore, it is important to acknowledge that the information documented primarily reflects the practitioners' interpretation of mothers' reports. Mothers might choose to not share certain information with professionals because of concerns about child safeguarding. Moreover, the absence of information in the notes does not necessarily imply that relevant conversations between practitioners and mothers did not occur.

3.5 Conclusion

Our study demonstrates the methodological approach to, and the feasibility of, identifying maternal information using free-text notes from a large-scale electronic clinical register of mothers attending treatment for substance use. The available EHR data encompassed a diverse sample of mothers and covered a wide range of information. This data on maternal characteristics can be used to improve understanding of the needs and experiences of women in substance-use treatment. However, notes can be lacking in some detail. Practitioners in substance use

treatment services are presented with, and document, a wide range of information regarding the difficulties these women face, but there is little documentation about the treatments and support that is then offered to patients.

The 5 identified themes from this study validate that substance use is not an isolated problem in women's lives, with particular emphasis on the experience of trauma throughout their lives, and the challenges in preventing intergenerational violence from affecting their children. In order to improve maternal and childcare outcomes for women in substance use services, practitioners must not only identify problems, but recognise difficulties faced by these mothers and support their needs. Integration of services is necessary to provide effective supports for these women. However, this study reiterates mothers' negative views of child welfare systems involvement, and it is unclear how family-centred strategies are implemented across substance use services.

4

Mothers in substance use treatment services involved in care proceedings: characteristics, proceedings' outcome and recurrence rates to care proceedings (Study 3)

Methods and results from this study addressing objectives 1 & 2 (below) have been published in

[Canfield, M., Norton, S., Downs, J., Wijlaars, L. PMM., & Gilchrist, G. \(2023\). Risk factors for involvement in care proceedings for mothers receiving treatment for substance use: a cohort study using linked and administrative data in South London. *Children and Youth Services Review*, 155](#)

Methods and results from this study addressing objective 3 (below) is under review for publication.

4.1 Objectives

- 1) Explore possible individual and clinical differences between mothers involved in care proceedings with those mothers of dependent children not involved in care proceedings.
- 2) Investigate the individual and care case characteristics of mothers involved in care proceedings and the court decision about out-of-home placement or not.
- 3) Estimate the prevalence and estimate time for returning to care proceedings as well as the profile of mothers that returned.

4.2 Methods

A retrospective observational design study was employed to analyse an existing linked dataset between Family Court (Cafcass) and SLAM data (Pearson et al., 2021). Data was extracted from women attending SLAM addiction services between 2007 and 2019.

Sampling

Mothers involved in care proceedings: Records of 480 mothers attending substance use treatment were linked to care proceedings data. For each of these mothers, the index case was defined as the first set of care proceeding case where a final legal

order was made. In cases where more than one set of care proceeding case was opened simultaneously, the set of care proceeding case of the youngest child was used as the index case. The 'point of assessment' within addiction services was defined as the date of the first treatment outcome profile (TOP) assessment completed closest to the open date of the index case (detailed information about TOP assessment is reported in Chapter 2, page 9)

Mothers not involved in care proceedings: Records of 1,107 mothers of a dependent child that were not involved in care proceedings were identified using the Child Needs and Risk (CNR) form (for further information about the CNR form, see chapter 2, page 11). Free-text notes from practitioners' additional comments on the CNR form were read to ascertain if the dependent child reported was the patient's own child. Where it was clear that the child was not from the patient, we excluded the case from the cohort. The "point of assessment" for each mother was defined as the date of the first TOP assessment completed.

Measures

Care proceeding case index characteristics and outcomes

The following information was extracted from Cafcass records: mother and child age at start date of index care proceeding case, two or more cases opened at the same time of the index case (yes/no), start and completion date of the proceeding (duration of the proceeding in weeks), child's father is party to the proceeding (yes/no). Information on final legal orders made were also extracted from Cafcass records. We used the following framework to extract legal order outcomes (Bedston et al., 2019, Pearson et al., 2020): remaining or returning home (case dismissed or Order of No Order), placed at home (Family Assistance Order or Supervision Order), placed in out-of-home care (Care Order or Secure Accommodation Order), placed with extended family (Special Guardianship Orders or Child Arrangements Orders (known as Residence Order prior to April 2014)), and placed for adoption (Placement Order or Adoption Order). A binary variable was created to indicate whether a parental responsibility was curtailed or terminated (out-of-home placement): 1 = Care Order, Special Guardianship Order, Child Arrangements Order, Placement Order or Adoption Order; 0 = any other legal order or no legal order. Lastly, we recorded cases of mothers who appeared in at least one different set of proceedings during the study period (yes/no) and defined '*recurrent care proceedings*' to any new application that was made after the completion date of the index cases regardless of closure.

The following variables were extract from SLaM clinical forms (detailed information about each form is reported in Chapter 2, page 11).

- *Substances consumed in the past week* (from TOP form): score of 1 was assigned to those who consumed alcohol almost every day of the week (>3

times), to those who consumed opiates at least once as well as cocaine/crack-cocaine. Possibly alcohol dependence was extracted from the AUDIT.

- *Time of the treatment:* dates of TOP forms completed were extracted and two variables were created: treatment started before the care proceeding starting date (yes/no) and receiving treatment during care proceeding (which include cases started before or during the start date of the care proceeding where treatment was ongoing during the time of care proceedings; yes/no). In addition, the length of time in treatment was calculated by the number of weeks between the first and last TOP form completed.
- *Psychological characteristics:* Information about poor quality of life and poor psychological health was extracted from TOP. Information about suicide risk (previous attempts and/or plans) and reports of social isolation in the past 12 months was extracted from the Addiction Brief Risk Scale Assessment (BRSA-A). Information about lifetime history of domestic violence victimisation was extracted from the CNR form.
- *Sociodemographic characteristics:* Information about homelessness/unstable housing in the past 4 weeks was extracted from TOP. Data on ethnicity and Indices of Multiple Deprivation (IMD) 2010 quintiles (Ministry of Housing Communities & Local Government, 2010) were extracted from SLaM EHRs. Women's ethnicity was presented in the following four categories: White/White British, Black/Black British, Mixed Heritage and Other. The IMD quintiles ranges from 1 (most deprived) to 5 (less deprived).

Analysis

To determine the association between potential risk factors and involvement in care proceedings, logistic regression models were run with involvement with care proceedings (yes/no) as the outcome regressed on sociodemographic and clinical characteristics. Separate models were run for each predictor first unadjusted for potential confounders and then adjusted for potential confounders (i.e., age, ethnicity, and area level index of multiple deprivation). Further logistic regression models were run for the subsample of mothers involved in care proceedings where the outcome was out-of-home placement (yes/no). Separate models were run for each predictor. Similar to the previous approach, unadjusted and adjusted models for potential confounders (age, ethnicity, and area level of index multiple deprivation) were conducted. Lastly, the logistic regressions were expanded with interaction terms to ascertain factors associated with out-of-home placement according to the treatment status of the mother at the time of the care proceedings. Specifically, models included each predictor, the binary variable receiving treatment during care proceedings (i.e., cases that started treatment before or during the care proceeding where treatment was ongoing during the time of care proceedings) and an interaction term to estimate the differential effect of the predictor on the odds for out of home placement for those concomitantly receiving treatment. Unadjusted and

adjusted odds ratios (95 % CI) were reported. Multiple imputations by chain equations (MICE) (Sterne et al., 2009) were performed to preserve statistical power while accounting for missing data uncertainty (vann Buuren, 2012). Variables with completed cases were used for imputations, resulting in 40 plausible data versions.

Survival analysis was used to estimate the time probability of return to care proceedings over time (yearly) and rate of recurrence (from the end date of the index case to start date of first repeat). Kaplan Meier time-to-event analysis was applied to account for censoring due to incomplete observation and variable follow-up (Lovric, 2011). For instance, the observation window of our dataset is 2007 and 2019, and so it has not been possible to follow up all mothers for the same period. For example, mothers that appeared in the dataset in the most recent years may not yet have had time to return. We used Cox proportional hazards regression models to examine the association between characteristics of the index care proceeding case and recurrence to care proceedings.

4.3 Key findings

- Compared to mothers who were not involved in care proceedings, mothers who were involved, were more likely to be younger, from a non-white background, to be socially deprived, to experience housing problems, to be pregnant, to have a longer duration of treatment for substance use, to use opioids and/or crack-cocaine and to report lifetime domestic violence victimisation, be at risk of suicide, and report poorer quality of life and psychological health.

Characteristics of care proceeding cases (N=480)

- The majority of cases involved a child under 4 years old: 175 index cases involved a child under four weeks old (36.5%) and 139 involved a child between 1 and 4 years old (29.0%). There were 200 cases (41.7%) where the index case child was part of a sibling group (two or more cases opened at the same time of index case). For 70.0% of cases, the child's father was involved in the index case.
- The number of care proceeding cases decreased during the study period. Since the implementation of the Children and Families Act 2014, the number of orders in our study cohort dropped by almost half (from 354 to 126 cases).
- Many mothers involved in care proceedings (40.4%) were known to SLaM substance use services before care proceedings began. Receiving treatment for substance use during the time of the care proceedings was identified in 67.7% of the cohort.
- Most care proceeding cases took more than 26 weeks to be completed (72.0%), with a median average of 37 weeks (25% quartile: 25.3, 75%

quartile: 52.9), which was slightly higher than the national average case duration of 34 weeks in 2019–2020 (Cafcass).

Care order outcome

- Most mothers involved in care proceedings had the care of their child curtailed or terminated (82.1%). Regarding the types of placements, 32.3% of their children were placed for adoption, 31.7% were placed with a family member (kinship care), and 23.5% were placed into foster care. Only 5.4% of the cases were dismissed and 12.3% received a supervision order.
- Mothers' younger age, housing problems, use of opiate and/or cocaine/crack-cocaine and poorer quality of life increased the odds of out-of-home placement of the children. In addition, risk of out-of-home placement was associated with mothers' longer period of time in treatment.
- The participation of the child's father in the proceedings was a protective factor for maintaining care of the child for those mothers that were receiving substance use treatment at the time of the proceedings.
- Attending treatment for substance use during the proceedings was not statistically associated with the child placement outcome.

Reappearing in care proceedings

- One quarter of mothers reappeared in a subsequent set of proceedings (N=119). Of this, 62 cases (52.0%) involved returning to care proceedings with a new baby.
- Results from the survival analysis shows that almost one in every four mothers was likely to reappear in a subsequent set of proceedings within ten years after the completion of the index case. The risk of a first repeat episode is greatest within the first five years (25.0%).
- The following risk factors for returning to care proceedings were identified: mother's younger age at the start of index care proceeding, multiple cases opened at the same time of index case, and mothers not receiving substance use treatment during the index care proceedings.

4.4 Limitations

It was not possible to ascertain the parental status of women who entered treatment before 2013 as the CNR form became mandatory from January 2013. In addition, the self-report nature of this form means that some women might decide to not disclose their parental status and it is not possible to ascertain if they were the biological mothers of the children. The small number of clinical cases linked to the family court database was a restricting factor for analysis of associations when exploring out-of-home placement. It is possible that, with a larger sample, more subtle patterns of association may have been detected specially in models adjusted for confounders. While we have used an appropriate data imputation method to address the incomplete information in some variables (e.g., domestic violence and

alcohol dependence), we acknowledge that this limitation may have led to an underestimation of prevalence. Length of time in treatment was estimated by the date between first and last TOP completion. It is not possible to ascertain possible gaps in treatment participation. Similarly, it was not possible to ascertain the reasons why a mother was not receiving substance use treatment during the time of the care proceeding (e.g., mother's own decision, lack of referral, or previously discharged by the service). A further limitation is the potential source of bias associated with the CRIS-Cafcass linkage process, where women from black and minority ethnic groups were less likely to be matched between datasets than women from White backgrounds (Pearson et al., 2021). Hence, the real prevalence of women from non-White backgrounds may be under-reported.

4.5 Conclusions

Our findings raised questions about the provision of substance use treatment for mothers involved in care proceedings. Findings show that the majority of mothers in our cohort had their children placed in out-home care and that attending substance use treatment during the proceedings is not associated with proceedings' outcome. The fact that 33% of mothers involved in care proceedings in our cohort only received treatment after the completion of the care proceeding case, further demonstrates the barriers that many mothers experience to access substance use services in times of crises. To this end, our findings question whether the current model of care is capable of identifying and responding to the needs of mothers, and contribute to the ongoing calls for more investment in treatment approaches that comprehensively address the complex range of individual and family difficulties that might affect the ability of mothers with substance use problems to provide a safe and nurturing home environment for their children.

Findings also show a decrease in the number of care proceedings involving mothers attending substance use treatment in the study period, which is not in line with the national increase in family court cases. It also shows that that almost one in every four mothers in our cohort were likely to reappear in a subsequent set of proceedings within ten years after the completion of the index case. The risk of a first repeat episode was greatest within the first five years. These figures are in line with previous findings reported in England and Wales (Broadhurst et al., 2015, 2017; Alrough et al., 2022).

Lastly, the participation of fathers in Family Court as found to be a positive factor for those mothers that were receiving treatment during the proceedings. Further research is needed to understand who these fathers are and to identify how service providers can work with them to support mothers involved in Family Courts.

5

Characteristics of fathers receiving treatment for substance use (Study 4)

Methods and results from this study are in preparation for publication.

5.1 Objectives

- Estimate the prevalence of fathers in substance use treatment services.
- Describe the sociodemographic, psychological, and clinical characteristics of fathers and men without children.
- Identify fathers involved in care proceedings and potential differences in fathers of dependent children involved in care proceedings to those not involved.

5.2 Methods

Data from all men attending SLAM addiction services between 1st January 2013 and 30th September 2022 were extracted from CRIS. This comprised records of 8,125 male service users.

Identification of paternal status

The CNR and National Drug Treatment Monitoring form (NDTMS) were used to identify fathers of dependent children (under the age of 18 years old). Firstly, we explored data from the CNR about being a parent of a dependent child (see chapter 2, page 11, for further information on the CNR). Secondly, we explored data from the NDTMS on cases that had not reported the parental status on the CNR form. It was possible to identify the parental status of 7,308 (89.9%) service users (responses yes/no from the CNR/NDTMS). Of these, 3,625 (49.6%) men were identified as fathers of a dependent child (birth and not-birth fathers). The “point of assessment” for each father was defined as the date of the first TOP assessment completed during the study period window within the completion of the CNR form.

To determine which of identified fathers had been involved in care proceedings, a free text search was carried for the terms "care proceedings", "care order" and "family court" from identified fathers. Searches of the CRIS database returned details of 334 fathers involved in care proceedings. Of this, 146 cases were excluded during

screening (for example, because they related to the father themselves being a child of care proceedings, not being a father, or the patient had other types of judicial orders). The final sample included 188 fathers whose records indicated that they were involved in care proceedings (5.2%; 188/3,625). Figure 6 illustrates the flow diagram of the cohort.

Measures

Data from the same clinical assessments used in Study 1 and 3 were extracted in this study. This includes:

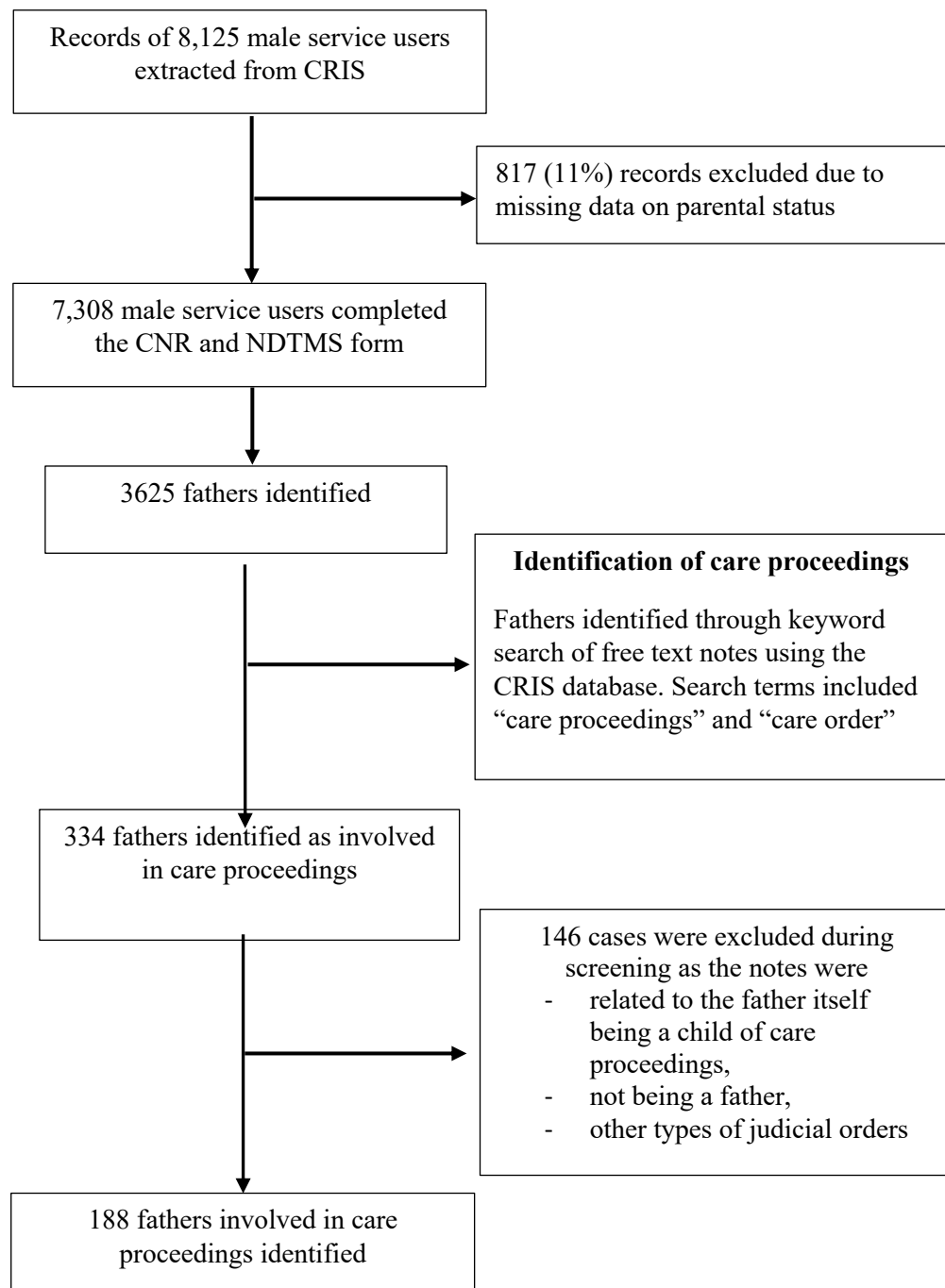
Childcare characteristics: The CNR form was used to identify those men who have a dependent child, the number of children, whether the father had contact with the child (yes/no) and childcare arrangements (under the care of the father/in alternative care). In addition, this form provides self-report of partner's pregnancy status, whether the patient's substance use, mental health, or learning disability impacts their capacity/ability to meet the needs of the child (i.e., high risk to children, yes/no responses).

Substances consumed in the past week (from TOP form): score of 1 was assigned to those who consumed alcohol almost every day of the week (>3 times), to those who consumed opiates at least once as well as cocaine/crack-cocaine. Possibly alcohol dependence was extracted from the AUDIT.

Psychological characteristics: Information about poor quality of life and poor psychological health was extracted from TOP. Information about suicide risk (previous attempts and/or plans), blood-borne viruses, social isolation, and criminal activity in the past 12 months the BRSA-A.

Sociodemographic characteristics: Information about homelessness/unstable housing in the past 4 weeks was extracted from TOP. Data on ethnicity and Indices of Multiple Deprivation (IMD) 2010 quintiles (Ministry of Housing Communities & Local Government, 2010) were extracted from SLaM EHRs. Men's ethnicity was presented in the following four categories: White/White British, Black/Black British, Mixed Heritage and Other. The IMD quintiles ranges from 1 (most deprived) to 5 (less deprived).

Figure 6 Study participation flow diagram.



Analysis plan

Bivariate analyses using *t*-tests and chi-square tests compared men who are fathers and those who are not fathers. A series of univariable analyses using logistic regression were used to identify factors associated with those fathers involved in care proceedings to those not involved. Results were reported as effect sizes as odds ratios (and 95% confidence intervals) .

5.3 Key findings

- Fathers of a dependent child (birth and not-birth fathers) comprised approximately half of the study cohort (49.6%, 3,625/7,308).
- It was not possible to identify the parental status of 11.2% of the cohort (817/7,308).
- Almost half of identified fathers did not disclose the number of dependent children and whether they had contact with them (41.9%; 1520/3,625). In addition, one quarter of identified fathers did not disclose the care arrangements of the child (under his care or in alternative care) (24.1%; 875/3,625).
- Of those fathers that had disclosed children information almost one quarter of them reported to having only one child (46.5%; 978/2105) and 22.3% reported three children or more (22%; 468/2105). Most of the identified fathers reported that they had contact with the child (69.9%; 1472/2105).
- Nearly one quarter of the fathers that disclosed care arrangements 21.7% (597/2750) reported that the child was not under their care (i.e., formally removed under a public law order/solely under the care of the mother). A small minority of fathers (2%) said that their partner was currently pregnant.
- Compared to men without a dependent child, those who had a child were younger, more likely to be from a non-white British background, homeless, to use cocaine, to smoke cannabis, and to be at risk of alcohol dependency. Fathers were less likely than men without children to report a blood borne virus.
- We were able to identify 188 fathers involved in care proceedings while receiving treatment for substance use. This represents 5.1% of the population of fathers of a dependent child (188/3650).
- Compared to fathers not involved in care proceedings, those who were involved were more likely to not be in paid employment, reported higher levels of social deprivation, to use crack-cocaine, opioids and amphetamines, to report poor quality of life and to have committed theft in the last 28 days.

5.4 Limitations

Many forms were missing or incomplete, especially regarding paternal characteristics. For instance, 817 men were excluded as father status could not be identified. In addition, the self-report nature of this form mean that some men might decide to not disclosure their parental status and it is not possible to ascertain if they were the biological fathers of the children. Therefore, this sample likely underestimates fathers in substance misuse services. Even amongst identified fathers, the CNR forms were incomplete for many service users. This form is expected to be completed during treatment; why many are incomplete is unclear. There is no structured data in the EHRs about the care arrangements of fathers. For example, it is not known whether the children of fathers in substance abuse services who are in alternative care have been adopted or removed by the court. Another important limitation of this study is the estimation of fathers involved in care proceedings. We have not tested the feasibility of applying search terms. A more rigorous methodology such as Natural Language Processing (NLP) applications could help address the exigencies of quantifying key information about paternal and childcare characteristics within EHR.

5.5 Conclusions

This study provides evidence about who the fathers of dependent children in substance use treatment are. It has also provided initial evidence about the characteristics of those fathers in treatment who are involved in care proceedings. The study highlights the need for substance use care providers to better engage with the service users when asking information about the children. Future qualitative research guided by the factors found in this study could help untangle the range of factors leading to involvement in care proceedings for these men.

6

Exploring individual characteristics and childcare responsibilities of fathers involved in care proceedings through their clinical notes in substance use treatment (Study 5)

Methods and results from the study are under review for publication.

6.1 Objectives

- i) Determine the fathers' care responsibility following involvement in care proceedings (e.g., type of contact with the child/care proceedings outcome).
- ii) To understand what health professionals are reporting in relation to the factors in the father's lives that might have an impact on care proceedings.

6.2 Methods

A qualitative analysis of free-text notes from Electronic Health Records (EHRs) was conducted. The Clinical Record Interactive Search (CRIS) system was used to extract records from men who attended addiction services at South London and Maudsley NHS Foundation Trust.

Identification of involvement in care proceedings

The CRIS database was searched using free text search terms for fathers of dependent children (under the age of 18) who were receiving treatment for substance use between 2013 and 2020 and whose records documented involvement in care proceedings. This included the terms "care proceeding," "family court," and "care order." From this process, we identified 188 fathers involved in care proceedings while receiving substance use treatment. Further information about this study cohort is reported in Chapter 5, page 30.

Data extraction

Each case's data extraction began with the first record recorded on the CRIS system. The CRIS webserver was used to access and read free text notes for each case. This included an examination of notes containing details of patients' interactions with practitioners, as well as letters and other documents (for example, referrals to the multi-agency risk assessment conference, multi-agency public protection arrangements, or new referrals and plans for children's social care). All notes were read and text sections relevant to the study's objectives were manually extracted. These text sections were placed in an Excel spreadsheet for analysis on the SLaM server.

Analysis

A directed content analysis approach was used to address the study's first objective. Contact between fathers and their children, as well as the outcomes of care proceedings, were categorised, and the frequency of each occurrence was recorded in an Excel spreadsheet.

To address the second objective of this study, a thematic analysis was conducted in three stages (Braun & Clarke, 2012). First, a random subsample of 15 cases were selected, and full notes were read and analysed using an inductive approach. In the second stage, preliminary codes were redefined to address the study's first objective. As a result, a codebook was created, which provided a standardised procedure and baseline for organising and analysing data. In the third stage, all free-text notes of the remained 173 cases were read, themes were extracted from the data and iteratively checked and refined using the identified codes.

6.3 Key findings

Addressing objective 1: Care responsibilities of fathers after involvement in care proceedings

- The care proceeding outcome could not be determined for 39% of the sample.
- 19% of the fathers had at least one of their children placed in foster care or adopted.
- 16% received a special guardianship order.
- 20% had their children placed at home under a supervision order.
- 6% retained custody of their children.
- The majority of fathers had the care terminated by the court (57%).
- Many of the fathers in this study had no contact with the children (35%) suggesting that a significant proportion of the fathers were absent in their children's lives.

- Findings also demonstrate that co-substance use between both parents was common and seemed to heighten the risk of having their child removed. 44% (n=60) of fathers had at least one partner that used substances.

Addressing objective 2: Paternal factors that may impact on care proceedings' outcomes.

The main themes that emerged from the analysis of case notes of fathers involved in care proceedings are depicted in Figure 7. Individual challenges, challenging relationship dynamics, safeguarding issues, and engagement with services were among the key themes (see appendix iv on theme definitions and quotes).

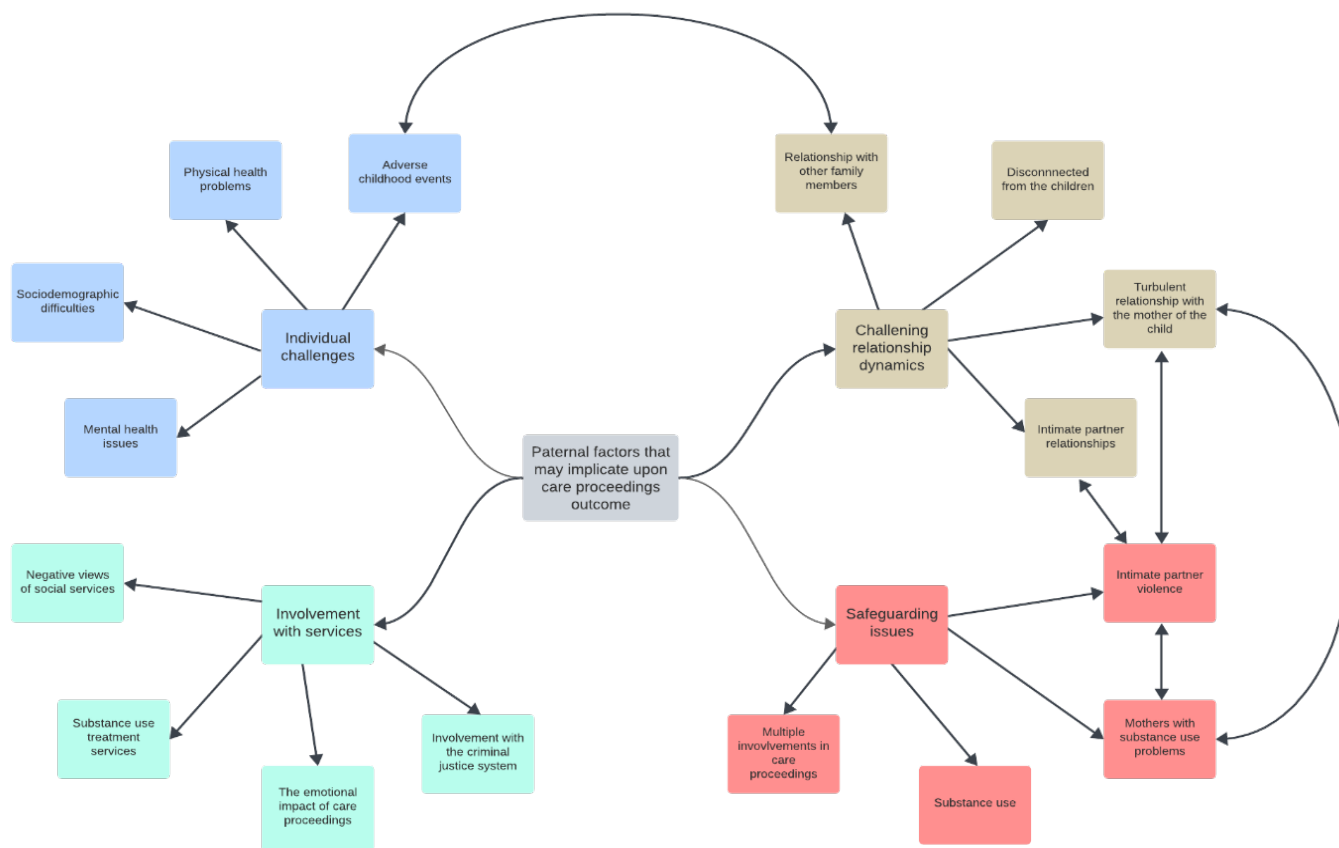
1) Individual challenges

- Many fathers were documented as living in situations of social and economic instability, particularly in terms of housing.
- The majority of the fathers had a psychiatric comorbidity, including schizophrenia and post-traumatic stress disorder.
- In some cases, health professionals explicitly stated that substances were used by patients to cope with psychiatric symptoms. The presence of these symptoms was usually exacerbated by difficulties in gaining access to their children.
- Fathers were frequently characterised by poor physical health, including mobility issues and injuries, as well as other ailments that required care in addition to their addiction.
- Adverse childhood events were heavily documented in all case notes, with reports indicating that fathers frequently had turbulent upbringings and had experienced traumatic occurrences, as well as being victims of emotional, physical, and sexual abuse and witnessing domestic abuse against their mothers.

2) Individual challenges

- Many fathers were documented as living in situations of social and economic instability, particularly in terms of housing.
- The majority of the fathers had a psychiatric comorbidity, including schizophrenia and post-traumatic stress disorder.
- In some cases, health professionals explicitly stated that substances were used by patients to cope with psychiatric symptoms. The presence of these symptoms was usually exacerbated by difficulties in gaining access to their children.

Figure 7. Themes and subthemes identified from EHR of fathers in substance use services who are involved in care proceedings



- Fathers were frequently characterised by poor physical health, including mobility issues and injuries, as well as other ailments that required care in addition to their addiction.
- Adverse childhood events were heavily documented in all case notes, with reports indicating that fathers frequently had turbulent upbringings and had experienced traumatic occurrences, as well as being victims of emotional, physical, and sexual abuse and witnessing domestic abuse against their mothers.

3) Challenging relationship dynamics

- Fathers' relationship with their children were often documented as restricted by the children's mothers or the authorities.
- Many fathers did not play an active parenting role in their children's lives.
- Practitioners often reported fathers' feelings of guilt and remorse surrounding this as well as fathers desire to be better role models for their children and to be more involved in their lives.
- Fathers frequently stated that the desire to regain custody of their children drove their motivation to achieve abstinence.
- The fathers' and mothers' relationship was marked by mutual substance abuse, violence, and childcare conflicts.
- The documents contain reports of fathers committing sexual and/or physical assault and/or controlling behaviours against the child's mother, which were sometimes the primary reason for social services' initial involvement with the family.
- These men frequently had multiple relationships aside from the mothers of their children, or had children with multiple women, making their family and relationship dynamics complex.
- The dynamics of the fathers' relationships with family members varied greatly. At times, the family was a positive influence in these fathers' lives, serving as a support network throughout treatment and care proceedings. However, many fathers had negative relationships with some of their family members and wanted to distance themselves from the relatives, often due to their caotic lifestyle. Family members often put themselves forward to formally take on the care of the children

4) Safeguarding issues

- Reports of safeguarding concerns with regards to safe storage of substances as well as being intoxicated around the children were discussed with the fathers. It was not uncommon for fathers to live with family members, such as his parents, who were responsible for their children's care.
- Reports indicate that many fathers were in a relationship with the child's mother who also used substances. However, while fathers openly reported

mutual parental substance use to practitioners, there was no evidence of a discussion between fathers and practitioners about how this problem was affecting parenting practises.

- Children were frequently exposed to intimate partner violence. Reports of fathers being violent towards partners were frequently related to the reason for not having contact with the child.
- Records also revealed a negative cycle of repeated removals that some fathers were caught up in, with fathers returning to care proceedings with a new child after losing custody of another child.

5) Involvement with services

- Most of the fathers understood that abstinence from substances was an important factor in the care proceedings. In cases of relapse, a lack of contact with children was frequently cited as the primary cause.
- The practitioners frequently discuss a wide range of topics, including the father's motivation for achieving abstinence and the plan of action to be followed between sessions. However, there was no documented evidence of how the father's treatment plan aligned with the goals and timeframe of the care proceedings.
- The majority of these men had difficulty fully engaging with the treatment plan, which was reported to social services.
- The fathers had negative feelings towards social services. This includes mistrust and a lack of understanding about the importance of social services involvement, as well as a lack of understanding about court rulings.
- Fathers often felt that social services were being unduly difficult towards them which often caused feelings of anger. In such situations, the fathers often sought guidance from practitioners on how to deal with social services.
- The emotional impact of the care proceedings and having limited access to their children were widely reported in the notes, and it was often the case they precipitated stress and substance use relapse. Less documented was how the practitioners addressed the negative emotional impact of care proceedings in the fathers' lives.
- The vast majority of the fathers had a history of criminal activity. During the care proceedings, some of these fathers were on probation. In such cases, there were no reported documentation on how health, social and criminal systems were communicating with each other to address the fathers' issues.

6.4 Limitations

Our study is limited by data from practitioners' interpretations of men's accounts, with no triangulation via observation of interviews with fathers. The findings must also be interpreted within the context of the study and the nature of clinical notes. For

example, the fact that fathers were involved in care proceedings might result in feelings of being under constant surveillance and evaluation. They may have decided not to reveal much information in order to avoid losing custody of the child. While all records attached to each father were analysed, it was not possible to draw a timeline for pre and post care proceedings. Many fathers had been involved in multiple care proceeding cases and the notes presented several nuances regarding which child was reported and time events. In addition, due to the search strategy used, it is possible that some fathers who would be involved in care proceedings were missing from the sample because practitioners did not enquire about or document their parental information accurately.

6.5 Conclusions

Fathers in substance use services are defined by a number of factors that influence the outcome of care proceedings. Our findings show that, despite the fact that such factors are documented in clinical notes, fathers' need for assistance is not being recognised by substance use services. Findings also show that practitioners in substance use services may lack the skills to have an open conversation with fathers about their parental responsibilities. Our research contributes to a growing body of work advocating for future research and intervention programmes to take into account the paternal role of men undergoing substance use treatment. Better care proceeding outcomes will arise from providing these fathers with additional support in managing their relationships with their partners and families.

7

Implications

In this project, we have demonstrated that electronic health records provide opportunities that enable identification and analysis of a potentially hard-to-reach research group at a high level of detail with low risk of selection bias. We have also demonstrated a novel methodological approach to, and the feasibility of, identifying a range of information that might impact the ability of parents to care for their children using free-text notes from a large-scale clinical register (CRIS). This project also helped progress the work of a recent Nuffield Foundation's project (for further information see [The Health Needs of Mothers and Children in Family Court Cases](#)) beyond the lifespan of the project grant by expanding their initial analysis of the CRIS-Cafcass linked database. Therefore, the methodological approach in this study can inform future studies on how different data sources and collaborative approaches can be used to anonymously explore maternal substance use and children welfare in a highly efficient and cost effective way.

Our findings link with the wider research, policy and practice on parents with substance use problems within the protection services. Our project is in line with calls for a better integrated policy across health and social sectors. It compliments earlier published research on mothers with mental health problems and fathers involved in care proceedings. We summarise below the key implications of our project:

- Parents in substance use services are characterised by a compilation of factors impacting up on care proceedings. They are hampered in their treatment and care proceedings process due to numerous social, psychological, physical as well as economic disparities. To mitigate an already difficult process, these **services must collaborate more effectively to build trust with these parents and reduce the challenges they face in their engagement**. These parents will benefit from additional assistance in managing their relationships with their families and partners, which will result in better care proceeding outcomes.
- **There are immense barriers that many mothers experience in accessing substance use services in times of crises**. To this end, our findings question whether the current model of care is capable of identifying and responding to the needs of mothers with substance use problems and contribute to the ongoing calls for more investment in treatment approaches that comprehensively address the complex range of individual and family

difficulties that might affect the ability of mothers with substance use problems to provide a safe and nurturing home environment for their children.

- **Workers from across child protection and health services must communicate and collaborate with each other in order to impact on several service mechanisms that currently work as barriers to positive substance use achievement in parents.** Nonetheless, collaboration can be difficult, especially in the face of conflicting missions, goals and priorities between child welfare systems and treatment providers. There have been promising evidence-based tools developed elsewhere for conceptualising the delivery of complex multi-agency systems that should be considered in the UK such as the “Comprehensive Framework” in the US (Children and Family Future, 2022) and the “Safe & Together” model in Australia (Humphreys et al., 2021).
- **Collaborative approaches across services could also be facilitated by encouraging shared funding resources between agencies and by developing joint committees that would ensure that parents’ different needs are met within different points of the substance use treatment pathway** (from referral to treatment entry and to treatment completion). The implementation of evaluative frameworks could assist these joint committees in determining, for example, when substance use services should address mental health problems, prioritize socioeconomic support, refer to parenting workshops and provide childcare support.
- **Substance use treatment services need to improve the assessment of childcare issues, including when and how to assess it.** Approximately half of mothers of dependent children in SLAM substance use treatment services did not disclose childcare arrangements (e.g., children under the care of the mother/in alternative care) and similar proportion of fathers did not provided information about the child (i.e., number of children, contact, childcare arrangement) during a routine mandatory risk assessment (CNR). In addition, the current six-month window for completing the CNR assessment following the start of treatment suggests that parental status and the needs of children for many families may not being addressed for several months.
- **Mandatory assessments are not being undertaken in substance use treatment services.** The administration AUDIT, CNR and BRSA-A forms, which are all mandatory, was completed by 59.5%, 74% and 66.4% of the mothers’ sample, respectively. **This is a major supervision and management issue.**
- **There needs to be far greater training of practitioners in substance use services on how to engage in an open conversation with fathers about their parental role.** Men in substance use services are interested in parenting

interventions and improving the dialogue about fatherhood is an important step for referring to and supporting their engagement in family-oriented interventions. In addition, engagement with men about their parental role is important to any assessment of risks and benefits they may bring to the child. It is also viewed as important to prevent the sole parental responsibilities resting on mothers including views and attitudes towards mothers as solely accountable for the risks and difficulties in the family.

- While there is compelling evidence for methadone treatment improving mothers' ability to care for their children, there is less convincing evidence for the protective role of treatment for mothers who use stimulants such as crack-cocaine. The treatment of crack-cocaine dependence has unique challenges: there is no drug replacement treatment available, dependence is characterized by highly uncontrollable craving, and high frequency of relapses, and evidence-based information on the effectiveness of psychosocial approaches to reduce clinical patterns of its dependence is limited. Our findings emphasize the need for **further research to investigate how clinical patterns of crack-cocaine and treatment utilisation might impact, in their own right, the ability of mothers to care for their children.**
- **Critical to improving the provision of care for mothers in substance use services are the need for low-barrier substance use treatment strategies,** such as assertive outreach, flexible appointments, and accessible clear information on all the complex systems (social, health and welfare systems) they must access to gain the necessary types of support. Such strategies must be incorporated with an effective and timely manner given that longer substance use treatment duration has been identified as a risk factor for children being in placed into care.
- Many mothers in our study only received treatment after the involvement in first set of care proceedings, suggesting that they were not receiving appropriate support in time of need. In addition, these mothers were more likely to return to a subsequent set of care proceedings. Evidence from previous studies shows that the lack of standardized substance use assessment tools for social workers is a key barrier to quick access to treatment. **There is a need to develop standardized tools that are culturally sensitive and linguistically appropriate to the communities they serve to assist social services conversation with mothers about substance use and they need for support.** A quick entry into and completion of substance use treatment is also crucial for mothers that are working against the 26-week time limit to complete proceedings.

- **Future studies and interventions should attend more to the dynamics and external context that interplay on how substance using couples manage their relationships while figuring out how to be parents together.** Attention should also be paid to the quality of fathers' interpersonal relationships. Conflicts with the partner often led fathers to substance use relapse and loss of contact with children. Likewise, relapsing into substance use often led to family break-up, intimate partner violence and children being removed from the care of the parents.
- **Substance use services must emphasize the importance of establishing a sound therapeutic relationship with mothers based on respect, nonjudgmental attitudes, and patient empowerment.** This is particularly pertinent in the context of incidences of intimate partner violence, where women are often held responsible for the care of the children and are then blamed for the incidences of violence in the home and the consequent failure to protect their children. For instance, mothers might delay leaving their abusive partners due to fear of the social stigma associated with being a single mother and a substance user or because they worry about the safety of their children if they leave them in the care of an abusive partner or because they are dependent on the abusive partner for drugs and/or finances.
- The high number of reports of intimate partner violence (IPV) perpetration by fathers highlights **need for interventions aimed at responding to fathers' IPV perpetration in the context of substance use.** There are some initiatives to simultaneously address male IPV perpetration in the context of substance use in treatment settings that show some promise to enable behaviour change among abusive men who uses substances (Gilchrist et al., 2021;2024; Easton et al., 2018; Stover et al., 2018).

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Appendices

Appendix 1

Preliminary Coding Framework from Pilot Study.

Code Name	Description
Relationship with child and background	Information about the mother's relationship with her children and life history/background for mother and child (e.g., mother's history of abuse)
Risk to child	Description of the potential or actual risks to children reported by the mother, clinician, social services, law enforcement, or family (e.g., substance use around child)
Risk to mother	Description of the potential or actual risks to the mother reported by herself, clinicians, law enforcement, or family (e.g., safeguarding concerns about sex working)
Child support network	Description of external formal child support networks, including formal support by Children and Young People Services (CYPS), social services, and foster care
Family support	Description of support the mother or child receives from family or friends (e.g., childcare)
Children as protective factors	Information about the ways in which children act as protective factors for mothers in treatment either reported by the mother or clinicians (e.g., daily structure due to children's needs)
Health deterioration or relapse	Description of the mother's health issues, deterioration, or substance use relapse. This included both substance-related health deterioration (e.g., alcohol induced psychosis) and other health concerns (e.g., COPD)
Clinical judgement	Reports by clinicians' professional opinions/judgements on the mother and children's wellbeing and the mother's engagement (or lack thereof) in treatment services (e.g., noting that the mother continues to put herself in situations that encourage substance use)
Emotional responses and disclosures	Reports of reactions/responses and personal disclosures from the mother during contact with health or legal services (e.g., abusive reactions towards staff, disclosure about sexual assault)
Progress in mother and child health	Description of positive changes to the mother or children's health and wellbeing (e.g., substance use cessation, improvement in children's social functioning)
Treatment plans	Reports of formal treatment plans proposed by clinicians and the mother's reflections on her ability to

	engage in these plans (e.g., referrals to psychiatric services or detox centres)
Barriers to treatment	Reports of barriers to adherence to treatment plans (e.g., inability to find childcare)

Note. Codes were derived from $n = 6$ cases with free-text data that was not limited by search terms application.

Appendix 2

Search Strategy Using Search Terms.

Search terms	
child*	foster
daughter*	CYPS
son*	school
kid*	parent*
baby	maternal
teenager*	into care
pregnan*	youngest
social work*	eldest
social services	safeguarding

Note: in bold, final search terms used to extract the notes

Appendix III

Description of themes and sub-themes with quotes - mothers' study

Themes	Sub-themes	Definition	Quotes
1. Childcare arrangements	-	Description of who looks after the children on a daily basis	<p>ZZZZZ has a daughter under 5 and is the primary carer, however ex-partner takes an active role with daughter (case notes, ID 10)</p> <p>ZZZZZ has one child under 16 - a daughter who resides with her ex-partner and his parents (case notes, ID2)</p> <p>ZZZZZ has contact but no full-time caring role. (case notes, ID43)</p>
2. Family context	Relationship with any (biological, in-laws, step-parents) of her parents	Reports of relationship dynamics between the mother and her parents	<p>ZZZZZ turned up at the team base this morning without an appointment. She was very tearful. Said she was feeling very bad. Said her mother has been with her for almost a week and has made her life a misery. They keep arguing with each other and this makes ZZZZZ very sad. Said her mother was very controlling. This she does not like. I advised her to speak with her mother and explain how their arguments affect her and the children (case notes, ID2)</p> <p>There are considerable relationship difficulties between Ms ZZZZZ and her mother (whom the children currently reside with) (letter of referral to social services, ID2).</p>
	Relationship with children's biological or non-biological father	Reports of the type of relationship the mother has with the biological/non-	She is presently separated from her partner of many years after giving birth and also the father of her new baby. She told us that, by his

		biological father of her children	<p>actions, he is not acting responsibility; he is an alcoholic and 'plays mind games with her'; he has put her through a lot (mental anguish and verbal abuse- shouting; swearing and constantly putting her down); and said that his behaviour towards her is robbing her of her confidence and therefore, her self-esteem is very low. In addition, she said that she is disappointed in their relationship and would have wished to have had her baby in a normal family environment. (initial contact assessment case notes, ID23)</p> <p>She reported that she has been [having a] low mood triggered by a violent relationship. Relationship ended a few years ago following a series of physical violence where she even lost a tooth and also believes that this has had an effect on her young children (case notes, ID2)</p>
	Family/mother's background	Reports of family history of substance misuse, poverty, mental health difficulties, etc.	<p>She reports that her child's father introduced her to drug use and by her late 20s she was injecting heroin and crack cocaine. She reports a difficult childhood in an environment of domestic violence that she witnessed between her parents. She also described domestic violence in her first relationship with her child's father, whom she dated intermittently for nearly 10 years. This relationship was unstable, with both Ms ZZZZZ misusing drugs and her partner spending periods of time in prison. - (case notes, ID20)</p> <p>We discussed her family set up and some historical family events such as her father</p>

			leaving, her mother having serious physical health problems and her having her son when she was very young (Case notes, ID 12)
	Challenges around dependent children's behaviour/ development	Mother's report of challenges around her children's behaviour and/or development	<p>ZZZZ reports that she is struggling with her two children, as they are mischievous. She says that they swear at her, hit her, break things in the house, broke a car window, [and were] expelled from school for a day for slamming the door and refusing to go to class. Children & Families Services are involved. ZZZZ has also been informed that one of her children might have ADHD (case notes ID2)</p> <p>Informed me that her drinking as increased to 6 - 8 cans of 9% [alcohol by volume; ABV] daily - due to stress & [domestic abuse] from teenager son - discussed Solace again & encouraged to continue with this, she wants her son to leave, but he [will] not - Son on Youth Offending - arrested again this week for smoking cannabis (case notes, ID2)</p> <p>ZZZZ attended Court due to her child's absenteeism from school. She said the Judge spoke to her child and made it clear ZZZZ could go to prison if the child did not go to school. ZZZZ has to attend further court hearings. ZZZZ feels she has done all she can to encourage her child to attend school and it is now up to her child to take responsibility. She said the child has been attending school since the hearing. - (case notes ID11)</p>

	Relationship with non-dependent children	Description of the relationship in cases where the mother also has older children (>18 years old)	<p>She said that her older son (in his 20s) who was also staying in the same house threatened to commit suicide because his grandmother (ZZZZZ 's mother) was always yelling at him for not finding a job. She said that her son is now sleeping out of the family home and seeking help to find a job. (case notes, ID 17)</p> <p>Her eldest daughter is now mid 20s. They have built up a good relationship; [her daughter] is independent and regularly visits her (case notes, ID 15)</p> <p>ZZZZ's adult daughter called and asked me to provide contact for rehab where ZZZZ could go now. I said that this is possible to arrange through our service and I hope to see her mum next week for the key work session and to discuss it with her. ZZZZ's daughter said that it is too late - "they are taking her kids now and she wants to go somewhere now." I said that I don't have any contacts to give them now. Daughter became angry and hung up (case notes, ID34).</p>
3. Safeguarding issues	Neglect	Reports of children's needs that are not being met	<p>Her teenage son's mental well being appeared to be deteriorating. Mother appeared frustrated with the process and despondent so they were kept on plan under emotional neglect. Recovery issues presented at the conference. Mum's continued drug use and dropping of script during the last month was highlighted. Key worker report and discussed at the conference (letter of communication with social worker, ID 12)</p>

			When unwell; neglects her children not getting them to school on time or tending to their needs (letter of communication with social worker (ID 29)
	Children's psychological functioning	Reports of mothers not understanding the impact that they are having on their children's mental health	<p>She does not believe that her drinking has anything to do with her child's issues (case notes, ID39).</p> <p>She had a meeting with her son and the Social Worker at the son's request. The boy has some anger issues and asked a lot of personal questions. eg - Why didn't she leave her husband, and when did she start to use drugs and did she use when she was pregnant etc etc. She tried to be honest but obviously this was quite upsetting. However, she seemed to feel that it was a necessary event for her son and helped her to come to terms with the impact of her drug taking (case notes, ID15)</p>
	Impact of mother's psychological functioning	Description of mother's mental health impacting the care of the children	<p>Phone call from ZZZZZ 's friend and reported she is concerned regarding ZZZZZ 's mental health. She reported that ZZZZZ has been drinking and also self harming (cut her arm). Police were called in and she was taken to an A&E. Her daughter was looked after by ZZZZZ's sister for one day. Daughter is back with her now (case notes, ID 28)</p> <p>She denies any thoughts of harm to the children but when Dr QQQQ spoke to her brother he said that she has reported to him hearing voices commanding her to harm her</p>

			children (letter of communication with social services, ID 29)
	Substance use	Description of substance use exposure to the children	<p>Staff received a call from the children and family social worker stating that he has been to ZZZZZ's house and that she has not been taking care of the children and that she has been using drugs in their presence, neglecting them and he will discuss the case with his manager (case notes, ID29)</p> <p>ZZZZZ has an under 10 year old child. She had another child who is now in her 20s and was taken into care under the age of 10. Extensive verbal and written information regarding the risk of death to children associated with medication including methadone and buprenorphine and the safe storage of medication [information was] given to the patient. Metal lockable box provided, she told me she has a medicine cabinet at home as well. There is an open referral to Children and Families. ZZZZZ tells me her husband doesn't use drugs and that he is aware of her drug problems. She was using drugs in the family home bathroom. Child reported to be attending school. - (email to social services, ID33)</p>

	Intimate partner violence (IPV)	Description of mother's or children's experience or exposure to intimate partner violence	<p>Phone call with children's social worker who gave a detailed verbal history of significant events in ZZZZZ 's life. These relate to current domestic violence issues (past psychological/ emotional abuse from ex-partner and more recent sexual abuse from child's father where risk is considered current) (letter of communication with social services, ID8)</p> <p>There was a change in situation as social services no longer sought to remove the children at the moment but were willing to give ZZZZZ another chance to attend for hair strand test. This was because her situation was now different with partner now out of the family home following the incident of violence against ZZZZZ a fortnight ago. She was now expected to attend signpost fortnightly, contact women's aid for support and do other things such as staying as far away from her partner as possible considering that he now lives a few flats away from her (case notes, ID6)</p>
	Children being abused by others	Description of children's experience of being abused by other adults	<p>Her ex-husband's friend was involved in sexually abusing her daughters. This friend is currently in prison for that. ZZZZZ often blames herself for not been able to protect her daughters (medical review case notes, ID34).</p> <p>Client has mentioned that her youngest son was sexual bullied online to do disgusting things. She says the police are involved in the case and they are making investigations. She reports that this child lives with foster parents and she</p>

			has contact every other month (case notes, ID15)
4. Factors that impact the treatment plan and care of the children	Socioeconomic	Social and economic factors, such as housing, ability to get additional support, benefits/income, and education	<p>ZZZZZ told me she lives in a hostel with 20-30 others and that she only moved in there a couple of months ago. She said she was homeless for nearly two years prior to that and could not remember where else she had lived. She said [...] that she finances [the hostel] through prostitution. 'I sleep all day and work all night'. (duty doctor assessment case notes, ID50)</p> <p>She is now homeless. Social services has taken her children and are now with her mother. She has moved in with her mother because she has no where to go. She can not afford to live on her own. At home she is arguing with mother and her eldest son. (case notes, ID15)</p>
	Trauma	Description of the mother's experience of adverse events that might have caused traumas (e.g., abuse by non-partners, assaults, robbery)	ZZZZZ explained that she had been raped by two cousins who were in their 20s and 40s. Said that they had been imprisoned but that her Mum had got them released. Spoke of when the doctor examined her he could get his whole hand up her vagina and said that she had been damaged and doesn't know if she can have children. Said that her Mum didn't believe her and that is why she hates her (nursing case notes at detox, ID50).

			ZZZZZ presented very tearful and scared. Drug dealers are threatening to harm her and her family, including her Autistic son. Threats of violence and kidnapping them (letter of communication with social services, ID12)
	Informal support	Description of social support (or lack thereof) from friends, family, or others that affect childcare	<p>ZZZZZ said that her sister stopped supporting her when the baby was taken into care. Shared that part of the plan of care of getting her child back rests on support from her family. - (case notes, ID46)</p> <p>Drinking has increased, concerns at the school and a meeting to be held. Issues may now be escalated as child [is] affected and this is showing throughout the day. ZZZZ has expressed interest in detox, although afraid. This may now be a safeguarding matter. Thoughts needed as to if ZZZZ was admitted as inpatient who would take care of her child (case notes, ID24)</p>
	Experience and views of social service involvement	Descriptions of mothers' experiences in working with and/or views of social services	<p>ZZZZZ spoke regularly about her child and how disturbed she is by social services involvement and the guilt associated with this. She kept stating 'I'm going to lose him'. I pointed out that the best way to avoid losing her child is to fully engage in the treatment process; for the child and herself (case notes, ID42)</p> <p>She expressed frustration at social services in regard to her teenage children in foster care-wanting more access, finding it difficult as she doesn't feel social services are including her fully. She wants more access (case notes, ID15)</p>

	Additional formal support	Description of clinician or mother's plans/suggestions for treatment or maintenance of sobriety	<p>Psychology session - ZZZZZ was referred to psychology for help on how to deal with panic without relying on methadone, crack cocaine and alcohol. Presenting problems - Panic Disorder (psychology session case notes, ID16)</p> <p>ZZZZ says that she would like to have a baby in the future and has some questions related to pregnancy and methadone and if social services would be involved. I advised her I was unable to answer many of her questions but that I could ask colleagues or arrange for her to see the doctor. ZZZZ also talked about feeling lethargic and tired and she recognises that starting a pregnancy at the moment would not be a good move. I advised her to see her GP regarding this (case notes, ID6).</p>
5. Communication between healthcare and child protection system	Lack of adherence to treatment plan	Description of mother attending/missing appointments and relapse	<p>ZZZZZ has recently spent twenty-eight days in rehab for her alcohol abuse but relapsed within twenty-four hours of leaving. Her mum stated that recently ZZZZZ has been drinking heavily and her mental health had deteriorated. ZZZZZ's two children arrived at the address, they stated that ZZZZZ threatening to self-harm or commit suicide is becoming a regular occurrence, she is refusing all help and is continuing to drink heavily. (ID37)</p> <p>Client's attendance is very poor and as I am on duty I could not do a full keyworker session. Pharmacy has already confirmed that she missed 2 days and today will be her 3rd day.</p>

			Due to her poor engagement with the services, and she has been spoken to before about this, I discussed with primary care doctor and I have given her a shorter prescription so that she can attend for a keyworker session next week (ID15)
	Progression	Description of mother meeting the treatment plan/ mental health improvement/general functioning improvement	<p>Again, this cannot be pre-determined, especially if the client is on a low dose of medication. The urine analysis for the last three tests are all negative for amphetamine and all other drugs. I am concerned that Ms ZZZZ 's efforts are being undervalued and that whilst I understand that the primary concerns are with regard to the children, and that is as it should be, the mother's efforts need to be noted. I would like to draw your attention to how Ms ZZZZ was two years ago and the progress that she has made since that time. It was agreed at the Case Review meeting by all concerned that Ms ZZZZ had made progress. However, this is not reflected at all in the letter regarding court (email to safeguarding worker, ID49)</p> <p>Attended ZZZZ's child protection meeting today. ZZZZ has proved herself competent as a mother and her children are both thriving and happy. No concerns, panel all agreed ZZZZ's children no longer need to be under child protection (case notes, ID11)</p>
	Childcare concerns	Concerns raised by healthcare services about the ability of the mother to look after the children	I had received information that ZZZZ was saying at the centre that she has been using cocaine and several men have been staying at her house overnight. She told one of the other

			<p>mums that one of the men was her supplier. This is very concerning and raises issues about the safety of the children (email to social services, ID41)</p>
			<p>ZZZZZ reported that as a result of our referral, the police went to her sister's house with Social Services and found herself and her under10 year old daughter living in a shed. The police removed her daughter and arrested ZZZZZ. Her daughter is subject to a Police Protection Order and is in temporary foster care. ZZZZZ was held in the police station overnight and released this am (email to safeguarding worker, ID48)</p>
	Care plans for children	Changes in childcare decided by career proceedings	<p>ZZZZZ will have supervised access three times a week when her baby is in hospital and twice a week when the baby is in foster care. ZZZZZ will be introduced to a person who will supervise the visits. This supervising person will also take notes of how ZZZZZ interacts with her son. (case notes, ID50)</p> <p>Her daughter has been taken off the Child Protection Register and so she is no longer in need of social services input. (email to social workder, ID28)</p>

Appendix IV

Description of themes and sub-themes with quotes - fathers' study

Themes	Sub-themes	Definition	Quotes
1. Individual challenges	Sociodemographic difficulties	Reports of fathers social and economic instabilities	<p>"Some of the current stressors include living in a one-bedroom rented flat with young children and the council not listening to his need of being in a different accommodation."</p> <p>"ZZZZZ is waiting for his universal credit claim to be processed. He is currently homeless. He reported that he has children in foster care but he has not had contact with them for a few months."</p>
	Mental health issues	Reports of psychiatric comorbidities and learning difficulties	<p>"His symptoms on admission were consistent with a paranoid psychotic episode precipitated by ongoing relationship difficulties and limited access to his child."</p> <p>"ZZZZZ said that he had been suffering from anxiety and depression. He reported that these were mostly linked with his alcohol dependency and the lack of access to his children."</p>
	Adverse childhood events	Reports of traumatic occurrences in childhood	<p>"..when he was younger he experienced extreme sexual violence which he has never come to terms with... ZZZZZ described DV in the family (from father towards mother) when he was a child, and during his early years, ZZZZZ described witnessing lots of violence."</p>

			<p>“... he reports numerous experiences and events which reflect severe neglect and extensive physical and emotional abuse sustained from biological mother and father throughout childhood. Both parents appeared to suffer from various forms of psychopathology (e.g., substance dependence and major depression). He also suffered multiple ruptures in attachment with primary caregivers and spent frequent episodes in various children’s homes. He further reported antisocial behaviours in early childhood such as stealing, fighting, lying, running away, truanting characteristic of childhood onset (before 10 years old) Conduct Disorder. He also engaged in drug and alcohol use from early age.”</p>
	Physical health problems	Reports of physical health comorbidities	<p>“He mentioned that pain stops him in doing some physical activities with his boys. He also mentioned that his social life has reduced because of the pain and responsibility of being a single parent.”</p>
2. Challenging relationship dynamics	Disconnected from the children	Description of fathers relationships with their children	<p>“Displayed remorse for his behaviour and is keen to recover and provide a good role model for his children and family.”</p> <p>“ZZZZZ states that his motivation is to work at getting his son back and that completely outweighs the need to use again.”</p>

	Turbulent relationship with the mother of the child	Description of the relationship between the fathers and the child's mothers	<p>"There was severe domestic violence and controlling behaviour between ZZZZZ and his ex-partner hence her fleeing to another city. This was witnessed by our service. ZZZZZ was also banned from our service after threatening behaviour to one of our staff."</p> <p>"The children use to spend some weekends with him but these contacts were terminated. He apparently argued with one of his children who then called the mother and the police were involved. Since then, he is only allowed supervised contact and the children's' mother is trying to stop these contacts too."</p> <p>"ZZZZZ has been having a problem with his ex-girlfriend with regards to having access to his child. He is seeking legal advice from his lawyer"</p>
	Intimate partner relationships	Description of fathers relationships aside from the mothers of their children	<p>"He reports that he has physically hit his girlfriend in the past and that she has physically attacked him. However he reports that there have been no recent incidents. She also has a long and current history of substance misuse. He reports that they abuse drugs together."</p> <p>"ZZZZZ reported that there is a conflict between ex and current partner when ex-partner comes to ZZZZZ to visit his child. I encourage him to discuss with social worker on how to manager this process."</p>

	Relationship with other family members	Description of fathers relationship dynamics with their immediate family	<p>"Has a supportive family who will also assist him if he has a community detox."</p> <p>"ZZZZZZ opened a letter regarding a court date and found this a huge trigger, he was supported from his mum and child to not relapse and instead phoned his solicitor to discuss the letter."</p> <p>"ZZZZ does not have a very good relationship with his mother and step father. His under 5 year old child is living with other family members. ZZZZZ has three-five visits a year."</p>
3. Safeguarding issues	Substance use	Reports of safeguarding concerns with regard to safe storage and intoxication around the children	<p>"I spoke with ZZZZZ again about his illicit drug use and his childcare responsibility. ZZZZZ stated that he uses at his friend's house and that he does not use around his child. He stated that he is aware of the risks and only looks after his child until his father comes back from work."</p> <p>"ZZZZZ reports that children will not have access to their room and that he has portable lockable storage. He was reminded of the risk to children posed by buprenorphine."</p>
	Mothers with substance use problems	Reports of mutual substance use and dependence with the child's mother	<p>"Expresses guilt and remorse around recent events, particularly the removal of his child to foster care, and the affect this has had on his partner....he has accepted that he needs to leave the family home, to give his partner time to address her own illicit drug use without his influence, and to allow both of them time to reflect on their relationship."</p>

			<p>“Strongly advised ZZZZZ to think about kinship carers, and to talk to his partner about returning to abstinence and using relapse prevention skills to manage cravings and triggers. Asked client and his partner to attend tomorrow for full care-plan review and to discuss strategies for remaining drug free. He then disclosed that he and his partner had relapsed over a period of few weeks.”</p> <p>“Reports using a large quantity of heroin and crack injected IV into arm on Friday with partner. Reported that both himself and his partner were feeling fed-up and so binged.”</p>
	Intimate partner violence	Description of mother’s or children’s exposure to intimate partner violence	<p>ZZZZZ has a history of assaulting the mother of his child and is now only allowed to contact his child via a solicitor. ZZZZZ does not know where his ex-partner and child live. This matter is with children and family services, as well as with Family Court.”</p> <p>“ZZZZZ has no current contact with his children following past issues of domestic violence when he was in a relationship with their mother. Since they split several years ago, ZZZZZ has had no contact with his children.”</p>
	Multiple involvements in care proceedings	Description of fathers going through multiple sets of care proceedings at the same time for their children	<p>“ZZZZ previous wife used drugs during pregnancy and the child was taken by social services. His drug use got worse after their split. ZZZZ then met another women who also used drugs, and they had a child who was placed into care after the partner died. He later had another child with someone else who also uses</p>

			<p>drugs. The child lives with a family relative. ZZZZ is in touch with the youngest child through social media”</p> <p>“He does not know how long he must get clean before proceedings begin (newborn child). His other children from the same partner, who were all under the age of 4 years old have already been adopted.”</p>
4. Involvement with services	Substance use treatment services	Description of fathers engagement with substance use treatment services	<p>“Mr ZZZZZ said that he relapsed few months ago and the factors that contributed to him relapsing were not having contact with his family, feeling quite bored and being in contact with peers that were drinking a lot of alcohol.”</p> <p>“One of his motivations to provide clean urine samples, is that this is part of the conditions imposed by children and families’ social services for him to have access to his child. He is not dealing with social services directly but apparently has a solicitor who liaise for him. He does not know how long he has to get clean before proceedings begin. His other children from the same partner, who are all young have already been placed into care.”</p> <p>“I have been involved with ZZZZZ ’s overall treatment care plan and OST (opiate substitution treatment) for more than a year. During this time he has remain stable in treatment and committed to making progressive change in his life. This is the final stage of his medical intervention for treatment which he feels he requires additional support based on past</p>

			<p>experiences in coming of medication and struggling with at the final stage. He is punctual for his appointment with a brilliant attendance record. He communicates well and remains confident in expressing how he feels. He has good insights in to his personal experience of addiction and has worked hard to get to this stage in his recovery. Over the last years ZZZZZ was working full time managing a security team.”</p>
	Negative views of social services	Reports of fathers negative experiences and feelings towards social services	<p>“ZZZZZ is finding things difficult without the routines of looking after the children and being in the flat on his own. He misses the walk to school. ZZZZZ said he was annoyed that the social services saw things differently from him. Says he understands our reasons for contacting social services, but he got heat up and feels angry about it. For him and the children are his life and now that has been taken away and he's not caused them any harm. He felt anxious around being judged.”</p> <p>“He'd also like support around the issues of social services. Feels he has been hard done by. States he has only missed or been a little late for a few meetings and because of this is being treated harshly.”</p>
	The emotional impact of care proceedings	Reports of the impact of care proceedings and having limited access to their children	<p>“Drinking up to 8 cans cider daily, now beginning to cut down. Finding it difficult coping with the prospect of losing contact with his child, using alcohol to deal with this.”</p>

			<p>"ZZZZ reports his mental health has been declining for the past few months. He feels this started with the news that his child, who is in care, may be being adopted. Since this incident he reports suicide attempts prior to his attempt resulting in this admission."</p> <p>"Mr ZZZZZ complains of ongoing low mood. This is mainly related to his youngest child being placed for adoption. He blames himself for this to a degree due to the fact he was dealing with the criminal justice when this was ongoing. He finds that he is angry with himself and thinks that he has let his children and himself down. He has a negative view of himself and his future, although no suicidal ideas. He has difficulty in leaving his house as he fears the judgement of others."</p>
	Involvement with the criminal justice system	Reports of fathers criminal activities	<p>"ZZZZZ said he'd been to prison more than one time due to alcohol related problems. He was released from prison last week after being there for few weeks for assaulting somebody whilst intoxicated. Currently on probation."</p>