An Exploration of Engagement in Child Protection Contexts: Investigative and Forensic Approaches are a Key Barrier

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Summary

The rates of child removal across Anglophone countries have continued to rise, despite calls to move towards public health models of child protection. In Australia, more infants are being removed at or close to birth, and this age group are those least likely to be reunified to the care of their parents. Under a public health model of child protection, more support is to be provided to families to reduce the risks of harm posed to a child, and to reduce child removals. However, underpinning these models is a focus on early intervention, which has the dual aim of early detection and protection of a child and the provision of support to families. I suggest, throughout this thesis, that services that carry this dual early intervention aim can defer to the protective aims – which involve more forensic and investigative approaches – to the detriment of the supportive aims. I suggest that these approaches can lead to service provision that lacks transparency with pregnant women, that often does not offer support, and that can lead clinicians to take approaches that may jeopardise their engagement with parents. In this thesis, I used a mixed methods approach to explore the engagement between child protection clinicians and parents, and service providers and parents, to better understand the nature of service provision, engagement, and support provided to pregnant women and mothers both pre- and post-child removal.

Chapter 1 provides an overview of contemporary child protection systems as well as the issue of parental engagement. Chapter 2 explores the provision and uptake of support to and by pregnant women in a South Australian public hospital via an early intervention program with the dual aim of detection and support. In Chapter 3, I conduct a systematic review on the barriers to and facilitators of engagement with support by pregnant women at risk of child removal. In Chapter 4, I adopt a social interactionist lens to provide an analysis of engagement between mothers and clinicians during Parenting Capacity Assessments. In Chapter 5, I use an experimental paradigm to examine the perceptions and appraisals made by clinicians of a mother's presentation during child protection proceedings, and the consequences of these perceptions. Finally, in Chapter 6, I provide general discussions on the thesis' findings.

Declaration

I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university

2. and the research within will not be submitted for any other future degree or diploma without the permission of Flinders University; and

3. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Additionally, I confirm that I received an Australian Government Research Training Program Scholarship to support the completion of this thesis (2022-2024).

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Statement of Co-authorship

Chapter 3

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CHAPTER 1. Introduction and Literature Review

Since the turn of the 21st century, the rates of children being removed from their families by statutory child protection services and who remain in out-of-home care for the duration of their childhoods have risen exponentially (Parton, 2017). This is the case across Anglophone countries that have adopted more forensic and investigative orientations to child protection (Lonne, 2009). At the same time, there have been increased calls from researchers and practitioners to reduce the rates of child removal due to the significant harms associated with this practice for children, for families, and for communities (Chamberlain et al., 2022). In Australia, for almost the last two decades, national frameworks have highlighted the need to move towards a public health model of child protection (Child Protection Systems Royal Commission, 2016; Commonwealth of Australia, 2021; Council of Australian Governments, 2009). These frameworks each communicate in various ways that forensic and investigative models of child protection are no longer fit to respond to the majority of child protection cases that now result from complex social issues related to the often-intergenerational disadvantage and marginalisation of families and communities. However, despite calls to move towards more supportive models of child welfare, the rates of child removal have only continued to rise (Child Welfare Information Gateway, 2019; Department for Education, 2023; U.S. Department of Health and Human Services, 2024; AIHW, 2024).

In this thesis, I demonstrate how investigative and forensic approaches to child protection continue to influence service provision and creates a significant barrier to the provision of early intervention support to families that may reduce the rates of child removal. I suggest that currently, early intervention is a phrase that carries a dual meaning encompassing both (a) the early detection of risk or harm and removal of a child (intervening earlier in the life of a child), and (b) the early provision of support to families (early intervention in the life of a family). This dual meaning allows for the deference to the former, more forensic, and investigative child protection practices whilst still technically advancing an effective early intervention response. I demonstrate that this approach influences clinicians' decision-making, including their referral provision and approaches towards

assessment. Further, this dual focus in early intervention exacerbates the omnipresent threat of removal and experiences of shame that exist within child protection and broader service contexts, and often causes parents to resist or avoid services in the cases where they are offered, or have access to, support.

The High Rate of Child Removal in Contemporary Child Protection Systems is Causing Harm to Children, Families, and Communities

The number of children across Australia who receive child protection services intervention (including child protection investigations, care and protection orders and out of home care) has risen slightly for the last 5-year recording period (2018-2023; AIHW, 2024), following a steady increase over the last two-decades (AIHW, 2004, 2014). Rates of children in out-of-home care have followed this trend. Infants (children under 2-years-old) are most likely to receive child protection services intervention and are the age group most likely to be removed from the care of their parents (AIHW, 2024). In South Australia, children are being removed from the custody of their parents and entering the care of the Department of Child Protection (DCP) younger, and less children are being reunified with their families once entering care (Department for Child Protection, 2024). These trends mirror those of Anglophone countries – New Zealand, England, Canada and the United States – that adopt a 'child protection' orientation to child welfare, whereby the rates of children being removed from the care of their parents was increasing steadily towards the end of the 20th century, and has either continued to rise over the last decade, or has maintained relatively stable (Department for Education, 2023; U.S. Department of Health and Human Services, 2024; Parton, 2017). Taken together, this suggests that efforts towards reducing or reversing these rates of removal in a significant way have so far been unsuccessful.

Child custody loss and out-of-home care arrangements have wide and longstanding consequences for children, parents and families. Children in out-of-home care have poorer outcomes in mental health and wellbeing (Bürgin et al., 2025), education and employment (Gypen et al., 2017; Maclean et al., 2016; Orri et al., 2021), incarceration (Brownell et al., 2024; Forsman &

Brännström, 2024), suicidality (Baldwin et al., 2024), physical health and cognitive functioning (Batty et al., 2024; Brownell et al., 2024; Goemans et al., 2016) and early mortality (Sørensen, 2023). While much of this is related to experiences of disadvantage and maltreatment, some studies (Baldwin et al., 2019; Maclean, 2018; Sariaslan, 2022) and systematic reviews (Dubois-Comtois et al., 2021; Maclean, 2016; Javdani et al., 2023) that have compared outcomes between children in out-of-home care and matched samples have found children in out-of-home care to fare no better in health, wellbeing, and social outcomes. Moreover, these outcomes appear worse for children who entered out-of-home care at a younger age (Conn et al., 2015; Wade, 2024). With the potential for placement terminations, abuse in care, and high levels of social isolation when children leave care (Mendes & Chaffey, 2023), it has become commonly accepted that providing more support to families to enable children to remain in the care of their parents is in the best interest of the child (Commonwealth of Australia, 2021).

For parents, the effect of child removal is profound. The grief, loss, and trauma associated with removal is sometimes described as akin to the grief of the death of a child (Marsh, 2017). Studies about the experiences of mothers suggest that shortly following child removal, women experience an exacerbation of the issues that were often cause for removal in the first instance. In combination with a loss of maternal identity, self-esteem, and high levels of shame, this compounding of issues then impacts their capacity to work towards reunification (Broadhurst & Mason, 2019; Collings et al., 2021; Grant et al., 2023; Otterlei et al., 2021). While there is much less research on the experience of fathers (and none on gender non-conforming parents), fathers are found to similarly experience disenfranchised grief and a loss of paternal identity (Baum & Negbi, 2013). Of significant concern, is the higher rates of unintentional drug overdose (Thumath et al., 2021), suicide deaths (Wall-Wieler et al., 2017), and other mortality (Devaney, 2024) amongst mothers following the removal of a child by statutory child protection services.

On a societal level, the forced removal of a child from their family is one of the most intrusive and drastic forms of state intervention. Child removal served as a function of colonialism

in Australia, New Zealand, Canada, and the United States, and nations are, since the turn of the 21st century, attempting to reconcile with this dark history. This is likewise the case for the forced adoption of children born to unwedded mothers that occurred throughout the 1940s-1980s in England and Australia (Joint Committee on Human Rights, 2022; Moor, 2006). Formal apologies were offered on behalf of the Australian Government in 2007 for the forced removal of Indigenous children, otherwise known as the Stolen Generation, and in 2013 for the forced adoption of children born to unwedded mothers. Such apologies highlight the societal level impacts and recognition of the harms associated with child removal. While these are historical matters, a recent report conducted by the South Australian Commissioner for Aboriginal Children and Young People (Lawrie, 2024) has warned that if the current rates of Aboriginal child removal continue, that the state and country risks enacting another Stolen Generation. The enduring loss, grief, trauma, and subsequent harms of child removal and family separation are intergenerational and continue to be felt across families and communities.

Aboriginal and Torres Strait Islander children and families are vastly overrepresented in all aspects of statutory child protection services intervention – from reports of maltreatment, investigations, substantiations, rates of removal, and rates of children in out-of-home care. The increasing rates of intervention have prompted a group of 33 prominent researchers and professionals in the child protection field to publish an urgent call of action to address what they consider a crisis in Aboriginal and Torres Strait Islander infant removals (Chamberlain et al., 2021). In South Australia, 1 in 2 Aboriginal children are subject to a child protection investigation, and 1 in 10 are in out-of-home care (Abdul Rahim et al., 2023). This is roughly ten times the rate of non-Indigenous children in out-of-home care (Abdul Rahim et al., 2023). This over-representation is consistent with Australian national data (AIHW, 2024) and is consistent with the over-representation of Indigenous children in New Zealand, Canada, and the United States, and with the over-representation of Black children in the United States and Canada (Cénat, 2021; Edwards et al., 2023; Fallon et al., 2021; Te Aho, 2022; Quinn et al., 2022). While part of this is over-

representation is due to the effects of intergenerational trauma, disadvantage, and marginalisation, another key contributor is the effects of systemic racism within support services and within child protection reporting and decision-making (Antwi-Boasiako, 2022; Cénat et al., 2021; Krakouer, 2023).

Investigative Approaches to a Broadening Scope of Harm Have Led to High Rates of Child Removal

Contemporary child protection systems throughout Anglophone countries emerged from widespread concerns of the 'battered child syndrome', a term coined in the early 1960s amongst American paediatricians (Kempe, 1962). The battered child syndrome became a medicalised term for the intentional physical abuse of children that was observed by health and social welfare workers. Proposed as a diagnosable syndrome, a key diagnostic feature was said to be a discrepancy between clinical findings such as fractures, lesions, or bruising to a child, and the explanations of their occurrence by the child's parents (Kempe, 1962). Parents responsible for this abuse were understood in terms of their psychopathology, and were described by Kempe et al. (1962) in their seminal paper on the battered child syndrome as "psychopathic or sociopathic characters… they are immature, impulsive, self-centered, hypersensitive, and quick to respond with poorly controlled aggression" (pg. 106). Resulting from this paper was a growing consensus that, given the discrepancy in parents' explanation for their children's injuries, there must be methods to investigate, to charge parents for this harm, and to remove children from their care. From this, came methods for the reporting, surveillance, and investigation of parents – most notably the introduction of mandatory reporting – and the creation of statutory child protection agencies (Raz, 2020).

As the formalisation of contemporary child protection systems occurred in response to the intentional physical and sexual abuse of children, the methods adopted were investigative and punitive in nature. These were abusive acts that parents would attempt to hide and were seen to therefore warrant discrete tactics for surveilling families, for identifying abuse, and for the criminal punishment of parents in addition to the removal of children from their care (Raz, 2020). However,

it wasn't soon after contemporary child protection systems were formalised, that the definition and understanding of child harm and abuse was broadened to include issues of neglect and emotional harm, which relate to more complex social issues often exacerbated by poverty and marginalisation. Raz (2020) argues that this broadening definition of harm, alongside a sustained focus on theories of child abuse that situated the issue within the individual psychopathology of parents, saw punitive and investigative interventions applied to poor and marginalised families. She suggests that individualising, psychological explanations of child harm led to the invisibalisation of issues related to class, race, and disadvantage – issues that warranted support over investigation – and contributed to the current inequalities within child protection systems.

Australia, as well as Canada, England, and New Zealand, in adopting the approach to child welfare that was developed in the United States following concerns of the battered child syndrome, are understood to have a 'child protection' orientation to child welfare. This contrasts with many European countries that have a 'family service' orientation (Price-Robertson, et al. 2014). While both approaches share similar aspects, the child protection orientation is suggested to have a narrower focus on protection and risk – the consequence of which being a service system that is more forensic and investigative – while the family service orientation has a primary objective of prevention and support (Kojan & Lonne, 2012). This child protection orientation, paired with a broadening definition of child harm to include issues of neglect and emotional abuse, is understood to have contributed to increasing rates of child removal over the last few decades, and an overwhelming reliance on statutory child protection services. At the core, is that issues related to, or compounded by, broader societal inequalities – for example, poverty, homelessness, gendered violence, parental mental ill-health, disability, drug and alcohol use and addiction, incarceration, and intergenerational trauma, child loss, and institutionalisation – have been met with an investigative response that has favoured surveillance and removal over the provision of support (Lonne, 2009). Accordingly, the vast majority of children in Australia are now removed from the

care of their parents due to emotional abuse (which includes issues such as parental drug use, mental ill-health, and domestic violence) and neglect (AIHW, 2024).

A Stated Shift Towards a Public Health Model of Child Protection

In an attempt to remedy the issue of increasing rates of child removal and the high demand on statutory services, Australia's national and state child protection policy frameworks now advocate for a public health model of child protection (Commonwealth of Australia 2021; Council of Australian Governments, 2009; Department of Child Protection, 2020). This is consistent with recommendations of the need for earlier, targeted support listed in the South Australian Royal Commission into Child Protection Systems (Child Protection Systems Royal Commission, 2016). It is likewise consistent with child protection frameworks globally, whereby there is a consensus that more supportive approaches are needed to shift the tide in growing child removal rates (Child Welfare Information Gateway, 2019; Education Department, 2006; Ministry of Children, Community and Social Services; 2021). Underpinning this proposition, is an acknowledgement that the issues driving most of the statutory child protection system intervention with children and families can and should be mitigated by the provision of universal preventative initiatives as well as targeted supports. If parents are provided with the support to ameliorate the issues that pose harm to a child, the role of statutory services, as well as the rates of intervention and child removal, can be reduced. The public health model of child protection is visually represented in the shape of a pyramid, whereby universal preventative initiatives and early-intervention services sit at the bottom two layers and base of the pyramid, indicative of the foundation and entry point, and indicative of where the most resourcing and service utilisation should occur. Statutory child protection services then sit at the top, 'pointy end' of the pyramid, and are seen as a last resort response for those for whom universal initiatives and targeted supports have been unable to meet the needs of, and who then 'travel up' into statutory services (Council of Australian Governments, 2009).

However, despite a theoretical shift in orientation from child protection to a public health model of child welfare, Higgins et al. (2019) argue that the working reality of Australia's current

child protection systems are still a far reach from a public health model. Indeed, the vast majority of resourcing is still targeted towards statutory child protection services (Lawrie, 2024; National Family Matters Leadership Group, 2024). What this means, is that it is often still the case that statutory child protection agencies are the first point of contact in the lives of vulnerable families (Higgins et al., 2019; Lawrie, 2024; National Family Matters Leadership Group, 2024), that this contact is forensic and investigative, and that offers of support are made following an investigated and substantiated (confirmed) case of child abuse or neglect (which include cases of *risk* of abuse or neglect). This suggests that parents are often not receiving preventative support services before encountering the statutory child protection system. To reference the public health model pyramid, this process continues to mean that the top end of the pyramid – what should be the point of last resort – is the primary entry point for families into the child protection system. Families may then flow down, rather than up, into targeted supports depending on the capacity of an overwhelmed statutory system to respond and refer (Bromfield & Holzer, 2008).

The Role of Early Intervention

If Australian child protection frameworks began to promote a public health model of child protection from 2009 (Council of Australian Governments, 2009), it is perhaps a pertinent question as to why rates of child protection intervention and child removal have increased so significantly since this time (AIHW, 2010; 2015; 2020; 2024). Included within the proposed public health model of child protection, was the promotion of 'early intervention' responses and prenatal reporting. While early intervention is oftentimes promoted as a mechanism to provide earlier, targeted support to families, early intervention in the child protection context is also concerned with intervention early in the life of a child and has therefore been responsible for the earlier detection and removal of infants at or proximal to birth (Featherstone et al., 2014). Early intervention in child protection has been advanced as a proactive response to reducing child harm and is specifically concerned with short timeframes for detection and removal, and for limiting the timeframe between child removal and permanent decisions regarding long-term custody arrangements (Wilson, 2002). This is

proposed as necessary to avoid harm to a child, and to achieve care permanency early in a child's life. The introduction of prenatal reporting, as a primary mechanism for early intervention, is understood as a key contributor to the increased rates of child protection intervention and removal over the past two decades (Featherstone et al., 2014; Marsh et al., 2017). In a study conducted by Marsh et al. (2017), the authors found that, in the decade following 2008, and following legislative changes in New South Wales that strengthened prenatal reporting, there was over a 400% increase in the removal of infants at birth. Concerningly, only 6% of those infants were restored to the care of their parents, and the remaining 94% were placed under state guardianship until they reach 18 years of age or were, in a minority of cases, placed for adoption (Marsh et al., 2017). The short timeframes provided for reunification, guided by the early intervention approach, and coupled with the significant psychological toll of infant removal on mothers in particular, is suggested as a reason for the significantly low rates of family reunification (Featherstone et al., 2014). Indeed, overcoming the immediate and profound grief and loss of child custody while making changes to what are often longstanding social, economic, situational, and psychological issues is no easy feat for parents, particularly those who are under-resourced.

The relative ambiguity of the practices that constitute early intervention in the child protection context, due to its dual aims of protection and support, makes it difficult to assess its effectiveness against certain aims. Moreover, it makes it difficult to determine whether services are in fact moving towards the more supportive aims listed under the current national child protection framework (Commonwealth of Australia, 2021), or whether they are continuing to enact more investigative, early intervention methods. For example, to take a lens that focusses on the immediate risks to the child, to the child in isolation of their family, and without consideration for the longer-term consequences of child removal, early intervention as it relates to the earlier detection of risk and the removal of a child would seem an appropriate response. These practices would be most common within services that view the child as their primary client, and whose role is to assess and respond to immediate risk above all else. The effectiveness of early intervention in

these contexts would most likely be measured in terms of the accuracy of early detection methods and the reduction in rates of maltreatment, no matter the method used. To take a lens that considers the child and family together, and that considers the longer-term consequences of removal, early intervention as it relates to the early identification and provision of support to families would seem more appropriate. The effectiveness of early intervention in these contexts would most likely be measured in terms of the ability of services to engage with families, to provide support, and to reduce risks and incidences of removal.

The Role of Effective Engagement in the Provision of Support to Families at Risk of Removal

To reduce the number of children being removed from the care of their parents, and to increase rates of family reunification, child and social welfare systems must move away from more forensic and investigative methods (including those that sit behind an early intervention banner) and must effectively engage with families (Featherstone et al., 2016; Hyslop & Keddell, 2018). How clinicians and services do this, however, holds significant consequences for the motivations of parents. Research on the experiences and perspectives of parents involved with statutory child protection services highlight a sense of powerlessness that parents experience when complying with plans and with services that they do not agree with (Davis, 2019; Robbins & Cook, 2018; Syrstad & Slettebo, 2020). Such experiences can often lead to a sense of compliance in absence of a more intrinsic motivation to engage with support or can lead to more active forms of resistance or avoidance (Dumbrill, 2006; Gibbons & Connolly, 2020, Smithson & Gibson, 2016). At best, engaging with parents who are at risk of child removal can foster a sense of shared understanding between parents and clinicians, can increase the motivation of parents to engage with support and to make positive change, and can aid in the provision of support that can prevent the risk of harm and removal (Damiani-Taraba, 2017). At worst, it can increase feelings of shame (Gibson, 2020; Monheim, 2019), powerlessness (Schoch & Aaby, 2022; Smithson & Gibson, 2016), moral injury (Haight et al., 2017), re-traumatisation (Mason et al., 2020), and reduce perceptions of self-efficacy

(Bekaert et al., 2021) – all of which can cause parents to disengage and to avoid further contact with services.

What is Effective Engagement?

In a therapeutic context, client engagement is a key determinant of therapeutic outcomes and is therefore a key consideration in psychotherapy and case work practice. Despite this, operational definitions of engagement are lacking and there is significant variability in the ways that client engagement is measured. Holdsworth et al. (2014) reviewed 79 studies that operationally defined or assessed engagement, and that reported the client characteristics, therapist characteristics and/or treatment factors associated with client engagement. They found significant variability in the ways that engagement was defined or assessed, and that the studies reviewed often cited factors that they argue, are better understood as engagement determinant variables (such as clients' motivation or the therapeutic relationship), or engagement outcome variables (such as treatment satisfaction or the amounts/degrees of change), as a measure or proxy for engagement itself. Likewise, they found several studies that defined or assessed engagement by what they argue is just one component of engagement, the most rudimentary, and the most common, simply being attendance at appointments. Based on this review, they proposed a model of client engagement that defines engagement – constituting what they have termed engagement process variables – as the efforts that clients make during treatment to achieve change. They consider these efforts to involve attendance, participation and/or involvement during session (observable, voluntary and active efforts) and homework or practice (voluntary, active efforts between sessions). Participation and involvement during session includes a client's open and honest disclosure of thoughts, feelings, experiences, as well as their willingness to try new tasks and to work towards collaboratively set goals.

The therapeutic alliance between a client and clinician is often described as the most integral element of client engagement. This alliance has been broken down into two important aspects; task alliance, which describes the extent to which the client and clinician agree on the reason for and outcome of their work together, and relationship alliance, which describes the rapport and trust built

between the client and clinician (Pinsoff et al., 2004). Social identification with one's clinician has been found to be a strong predictor of the therapeutic alliance (Cruwys et al., 2023; Lee et al., 2022; Lee et al., 2024). Cruwys et al. (2023) tested the relationship between social identification with one's clinician, the therapeutic working alliance, and aspects of therapy engagement and satisfaction. Across 2 studies with over 500 psychotherapy clients, they found social identification with one's clinician to account for over 50% of the variance in therapeutic alliance, and to be positively related to therapy outcomes. Importantly, is that social identification is not measured via the identities shared with one's clinician (i.e., it is not necessary for clients and clinicians to be of the same demographic), but the extent to which clients feel connected with their clinician and feel connected in working towards a shared goal. Extending this research, Lee et al., (2022, 2024) have found social identification, identity leadership, which relates to the extent to which clinicians are seen to create and promote a shared sense of identity, and client 'voice', which relates to the extent to which client feel that they have a say and have influence over the therapeutic process, accounts for over 70% of the variance in the therapeutic alliance. Taken together, this line of research suggests that collaboration between a client and clinician, whereby a client feels heard and feels well connected to a clinician who they feel is advancing their shared goals, is key to the therapeutic alliance, and to client engagement.

Engagement in Child Protection Research and Practice

Engagement in the child protection context is often mandated or coerced, which creates significant challenges for the development of a therapeutic alliance, and to engagement. It is most often the case that statutory intervention is unwelcomed by families, and that engagement with statutory services is either mandated via state legislation or is coerced via the threat of further intervention or removal. South Australian examples of this are in parents' mandated attendance at assessments, legislated under the *Children and Young People (Safety) Act 2017* (SA), or in parents being coerced to engage with and follow safety plans prescribed by the DCP, to maintain child custody. These mandates extend to parents' engagement with assessment, treatment, and support

services that sit outside of statutory services, and within the wider social services field. Due to the oftentimes mandated nature of engagement in child protection contexts, engagement in child protection research can sometimes be conflated with compliance, and can oftentimes be measured in rather rudimentary ways, such as attendance at appointments or as completion of assessments or treatment programs.

In the child protection field, compliance is sometimes used interchangeably with engagement, whereby both are seen as desirable actions of parents (Leigh et al., 2020). Conversely, compliance can also be understood as an undesirable action of parents, and one in absence of the internally motivated, voluntary, and active efforts towards change (i.e., engagement). This distinction is evident in the use of the term disguised compliance in child protection practice and research (Hart, 2017; Leigh et al., 2020; Reder et al., 1993). The traditional view of disguised compliance suggests that clinicians must look out for signs of disguised compliance from parents, which is conceptualised as parents pretending to comply with child protection authorities. A common example provided of this, is parents engaging with support services in a superficial manner, to reduce the concerns of statutory services (Reder et al., 1993). In this case, compliance is understood as desirable, and clinicians are warned to look for signs of non-compliance. However, Hart (2017) argues that this term explains the opposite of what it tries to convey. He argues that the term disguised compliance is in more literal terms, describing compliance in action, whereby parents are complying while disguising their disagreement or resistance with their treatment or intervention plans. In their discourse analysis of the term disguised compliance within the social work child protection field, Leigh et al. (2020) suggest that the term identifies compliance from parents as desirable, situates parents and their manipulation of clinicians as the problem, reinforces the power and authoritative approach of clinicians, and increases clinicians' distrust of parents. Rather than seeking compliance, they suggest that clinicians should seek engagement from parents by focusing on building respectful relationships and should be curious as to why parents may resist certain aspects of intervention. Whilst compliance is perhaps easier to obtain in mandated contexts

in which there are consequences for non-compliance, to foster the meaningful provision of support, and to promote parents' motivation and voluntary efforts towards change, instead requires engagement built on a strong alliance.

Engagement as a Triadic Process

While parental compliance may be achieved via coerced or mandated interventions, parental engagement – that is, the voluntary, active efforts made towards change that are supported by a strong therapeutic alliance – cannot. Rather, engagement can be fostered by the approaches of clinicians, and can be impacted by clinician factors, client factors, and by the broader service context. In this way, engagement is not only relational, but dynamic; it can change over time, based on the actions of either party in relation to one another, and to their context. For example, client disclosure during sessions is dependent on the therapeutic working alliance, but can also affect it (Farber & Hall, 2002; Kelly & Yuan, 2009). Whether practitioners perceive that their clients are withholding information may affect the assessments that they make, their approach with clients, and the subsequent alliance they form. As another example, client motivation, which is often understood as a distinct client-level determinant of engagement, can be harnessed and shaped by the relational skills of practitioners and by the therapeutic approach taken (Frey et al., 2021). It is also the case that, despite the efforts of both clients and clinicians, child protection context specific issues such as mandatory reporting influence the willingness of clients to openly engage with clinicians (Falletta et al., 2018). In considering the dynamic, relational nature of client engagement, it would therefore be an oversight to consider just one actor – client *or* practitioner – when considering the mechanisms that influence client engagement, as it would be to consider this relationship in absence of its context. Likewise, to consider engagement as relational and dynamic requires research on engagement to look beyond attendance rates, and into the interactions between clinicians and clients.

Summary and Thesis Overview

In this thesis, I aim to explore the engagement between clinicians and parents in a child protection context that is stating an aim to move towards more supportive approaches towards families, but where rates of statutory intervention and removal are still rising. I start this exploration in an applied context, to first provide an observation of what is occurring within an early intervention service located within a South Australian public hospital that is tasked with detecting infants at risk of harm, providing support to pregnant women and their families, and assessing parents regarding the potential for reunification following the removal of their children. Based on the findings of this study (Chapter 2), and in the three empirical chapters that follow it, I aim to explore the barriers that pregnant women face in accessing support services (Chapter 3), clinicians' approaches to assessments with women who have had their children removed (Chapter 4), and the effect of assumptions of responsibility on perceptions of women's defensiveness and resistance to intervention (Chapter 5). This thesis uses a mixed-method approach in adopting quantitative observational designs, qualitative designs, and an experimental paradigm, to explore the issue of engagement from the perspective of pregnant women, by considering the approaches of clinicians, and by testing psychological processes involved in the attributions of others. Taken together, and by taking a multidimensional approach to the exploration of engagement in child protection contexts, this thesis contributes to a dynamic and interactive understanding of engagement that is influenced by parents, clinicians, and the service context.

In the second chapter of this thesis, I begin with a case file review to explore the identification of infants deemed at risk of harm during antenatal appointments, the provision of referrals to support to the mothers of those infants, and the uptake of referrals by women. The findings from this study suggest that many pregnant women are not being offered support despite being given high risk birth alerts, and that rates of referral uptake amongst pregnant women are low. In this chapter, I also explore the engagement of women in parenting capacity assessments following the removal of their children and find that engagement in this process appears particularly

challenging for women and often leads to a break down in engagement between women and clinicians.

In the third chapter of this thesis, and after observing that rates of referral uptake by pregnant women are low, I explore the barriers experienced by pregnant women in engaging with support during pregnancy and when at risk of child removal. Exploring this question via a mixed-method systematic review, I find that fear of consequence – particularly fear of removal, stigma, shame and judgement – are amongst some of the most pronounced barriers reported by women. By including qualitative and quantitative studies, as well as studies that report the perspectives of women and of clinicians, I suggest variability in findings across methodologies and variability in understanding between clinicians and women and provide implications for practice and research.

In the fourth chapter of this thesis, and after observing that engagement during parenting capacity assessments is both challenging for women and often breaks down throughout the process of assessment, I explore the approach taken to these assessments by clinicians. I suggest that clinicians take a confronting approach to assessments that seeks responsibility and blame from women, that women appear to explain, share blame, deny, or withdraw during these assessments, and that these responses are appraised negatively and in absence of the relational context, which holds negative consequences for reunification efforts.

In the fifth chapter of this thesis, I use an experimental paradigm to test how approaches to individual responsibility and blame impact perceptions and assessments about a mother's defensiveness during parenting capacity assessments. I find that instructing one to take an approach that considers a mother to bear full responsibility and blame for the issues that pose harm to her child leads to perceiving her as more defensive when she provides explanation of her situation. I find that perceiving a mother as defensive makes clinicians more likely to endorse taking a more confrontational approach to the interaction with her, and more likely to recommend child removal. The findings from this chapter, and combined with the findings of Chapter 4, suggest that

assumptions rooted in more forensic and investigative approaches to child harm may influence assessment processes and outcomes regarding reunification recommendations.

Finally, in the sixth chapter, I integrate the findings of this thesis and identify the common thread found throughout the preceding four empirical chapters. This thread, I propose, is that forensic and investigative approaches are pervasive in an early intervention context – during pregnancy and after the removal of a child – and that these approaches pose a significant barrier to the engagement between clinicians and pregnant women that is necessary for the provision of support and for the work towards reunification. I discuss the implications of these findings for research and practice and suggest future avenues for research based on the work of this thesis.

Positionality and Reflexivity Statement

Throughout this thesis, I use a mixed methodology to explore the engagement between child protection practitioners and clinicians, and pregnant women and mothers. While it is an expectation of qualitative researchers to critically reflect on their positionality and how their positionality influences the subjectivity of the research process, Jamieson et al. (2023) suggest this to be an equally important process for quantitative researchers. This is because – despite quantitative research being understood as a more objective method of research – the way that research questions are posed, studies are designed, data is collected and analysed, and results are framed and concluded upon, involve subjective decisions, particularly in the social sciences (Jamieson et al., 2023). I therefore offer this positionality and reflexivity statement prior to this thesis' empirical chapters, and as it relates to all work within it.

My approach to this research is influenced by my social identities and experiences; specifically, my upbringing, my training and work experience as a social worker, and my training and research experience in social and clinical psychology. I come to this research as a White, able-bodied, (now) middle-class, cis-gender woman. I was raised by a single mother who loved and nurtured me and my siblings dearly. In binary terms, I do not consider myself a lived experience researcher. However, I do have a lived understanding of the apprehension involved in seeking

support but limiting my disclosures for fear of consequence. I have redacted part of this statement due to the sensitivity of personal disclosures, particularly for researchers with experiences that remain highly stigmatised. However, I can still share how my personal experiences have shaped the way that I have thought about, engaged with, and conducted this PhD and thesis. When I started this PhD, in collaboration with Child Protection Services, a clinician at the service told me of an undocumented practice where clinicians may admit an infant into the neonatal ward if the Department of Child Protection wish to have extra time to gather information and to observe the parents. Having been on the other side of this experience with a loved one, more than anything, this interaction led me to feel that I was in this research position in disguise. That experience undoubtedly shaped the way that I defined the research questions within this thesis. More than anything, it was a reminder that practices within services – particularly when those services shape the research agenda – are often hidden while the subjects of analysis, in this case, parents, become the problem to be solved. It was a reminder of this for me, because I had, albeit to a small extent, a lived experience of those practices, and while they are often presented as neutral and perhaps only shared with those on the inside (as I then found myself), in my experience, they were not hidden nor neutral. They were felt, along with the sense of judgment and shame that accompanies them. This experience led to a shift in my research question to include not only the issue of why parents are not engaging with early intervention services, but to the issue of how early intervention services are engaging with parents.

My experience as a social worker has seen me work mostly as a drug and alcohol counsellor, in the youth homelessness sector, and in the youth and adult prison system. I have worked with parents who have had their children removed, and I have heard from them of the significance of those experiences. Having developed therapeutic relationships with parents, I'm aware that I may hold a different perspective to clinicians who have instead been met with resistance from parents. I'm aware that I likely hold different perceptions and beliefs regarding parents' presentations or behaviours, and that it is this difference that would have influenced my

decision to explore clinicians' assessments. Were it not for this difference, the issue of clinicians' assessments would likely not have stood out to me as I was pulling data from the reports for the case file review in Chapter 2. That it did stand out to me, then shaped the studies in the latter half of this thesis

CHAPTER 2. A Case File Audit of the Engagement Between SA Health Clinicians and Parents of Children Removed by Statutory Child Protection Services

Infants between 0-2 years of age now have the highest rates of child protection involvement in all states within Australia. They are the age group most likely to be removed from the care of their parents, and least likely to be reunified with their parents and families once entering out-of-home care (AIHW, 2023; O'Donnell et al., 2023). As child protection policies aimed at early intervention have increased rates of infant removals, they have seemingly been less successful in the provision of early, targeted support to parents to prevent child harm and removal. In South Australia, clinicians within SA Health have two critical early intervention points with families that bear influence on the support provided to parents, and on infant removal and reunification practices. These are during routine antenatal appointments with parents of infants deemed at-risk of harm, and during parenting capacity assessments with parents following the removal of their child(ren) by statutory child protection services. However, the engagement between clinicians and parents during these contact points is often poor, which may negatively influence removal and reunification outcomes. The aim of this chapter is to explore the engagement between clinicians and parents at these two critical time points, to identify if and how issues of engagement may impact the provision and receipt of support to and by parents who have had their infants removed by statutory child protection services.

Child protection services in Australia and throughout Anglophone countries have, over the last three decades, adopted an early intervention approach to child protection. At the core, is the proposition that intervention needs to occur early to prevent harm caused to infants and children, rather than to respond to harm once it has occurred. A key policy and legislative area in early intervention child protection work has been prenatal reporting and the management of unborn infants deemed to be at high-risk of harm. In Australia, prenatal reporting was introduced in most states throughout the early 2000s. Since this time, the rates of infants being removed at or close to birth has increased at a steady rate (O'Donnell et al., 2023). While this is a concerning trend, less is

known about the other arm of early intervention – that is, the support that is offered and received by parents during the prenatal period, and as a result of prenatal screening and reporting.

While some states in Australia have explicit provisions for statutory child protection intervention during pregnancy, in South Australia, statutory intervention often occurs after the birth of a child. This is because state legislation does not allow for statutory child protection services to mandate the engagement of parents before a child is born. This means that the efforts made by statutory and other support services to engage with parents during pregnancy when there are concerns of harm to an unborn baby are variable. With no mandate to engage with parents, it is likely that efforts to do so are influenced by organisational contexts and policies, as well as the individual practices of clinicians.

SA Health Engagement with 'At-risk' Infants and their Families

SA Health, as an antenatal care provider and key stakeholder in prenatal child protection work, has several policy directives and programs aimed at the management of infants at risk of harm (termed 'high-risk infants' within SA Health documentation) and their families. The Early Links program, managed by Child Protection Services (CPS) and operating out of a metropolitan public hospital, is an early intervention program aimed at the identification of high-risk infants and their families. A screening protocol was developed by the hospital social work department and is universally administered to pregnant people by midwives during antenatal appointments. The screening includes the Antenatal Risk Questionnaire (ANRQ), Edinburgh Depression Scale (EPDS), and several questions related to psychosocial risk, such as the presence of domestic violence, homelessness, and adverse childhood experiences. Pregnancies deemed high risk following screening are referred to CPS for case management. This case management involves CPS staff liaising with the Department of Child Protection (DCP) regarding their plans for intervention either during pregnancy or after birth, and liaising with hospital staff to continue to monitor risk and to identify supports to offer to the pregnant person and their families. Referrals are to be made by midwives to hospital-based social work, mental health, and drug and alcohol services. Consistent

with SA Health policy for the management of high-risk infants (SA Health, 2019), a 'high-risk birth alert' is placed on the pregnant person's file, and an unborn notification is made to the Child Abuse Report Line (CARL) at the DCP. SA Health policy stipulates that in the case of high-risk birth alerts, pregnant people should be referred to appropriate supports aimed at "strengthening parenting capacity" (SA Health, 2019, p. 15). The responsibility to inform the parents of case planning and discussions for intervention at birth is that of the DCP and is expected to occur between 25-35 weeks gestation "unless safety concerns exist" (SA Health, 2019, p. 15).

An evaluation of the Early Links program was conducted in 2007, 2 years after the implementation of the program in 2005. The evaluation reported relatively low referral rates to hospital-based support services for pregnancies enrolled in Early Links (Power et al., 2007). The evaluation noted that midwives believed that they required more training in the administration of screening tools and in discussing issues of risk with pregnant women. Whilst pregnant women reported acceptability of screening questions, they reported that they were unaware that they had been enrolled in the Early Links program, the outcomes of their enrolment, or that the referrals that they had been offered had come from their enrolment with the program. A pilot study conducted of Early Links more recently (Beall et al., 2018), reported poor uptake of referrals by pregnant women to hospital-based support services. As a program that has the dual aims of monitoring risk and reporting high-risk infants to statutory child protection services, and in providing support to pregnant people and their families to ameliorate this risk, the extent to which this latter aim is being actualised is of key importance. In the context of rising child removals at birth, it is necessary to identify whether programs are effective in engaging with and providing support to families identified as needing support during pregnancy.

In addition to the Early Links program, CPS, as an outpatient service within SA Health, has an additional contact point with parents of high-risk infants. Following the birth of a child, and following intervention by the DCP, parents can be directed (and often times mandated) to undertake a Parenting Capacity Assessment (PCA) to support DCP investigations. The aim of PCAs is to

assess the capacity of parents to either retain or regain custody of their children, and to make recommendations of the changes required of parents – including their engagement with support services – to maintain or regain custody of their children. In this way, PCAs are a pivotal point in efforts to reunify children with their families; if parents engage well in this process and commit to recommended actions and service engagement, reunification becomes more likely (Cunningham et al., 2021). The engagement between parents and clinicians during PCAs is therefore an important avenue for exploration that may provide insight into both the challenges to reunification efforts, as well as avenues for improvements within this process.

The Current Research

The main aim of the current studies is to explore the engagement between clinicians and parents at the two intervention points – during antenatal appointments and during PCAs – that CPS has with parents of infants deemed at-risk. By linking case file data of antenatal appointments and PCAs, the studies were conducted on the same cohort of parents at both time points. This research therefore allows the examination of engagement at time points that are critical in influencing both child removal (during antenatal appointments), and reunification rates (during PCAs). Utilising a mixed-method approach, these studies allow the exploration of not only static attendance rates and trends, but the qualitative aspects of engagement between parents and clinicians. The first study is a quantitative case file analysis of trends in antenatal screening, referral to, and attendance at, hospital-based support services by birthing parents who went on to have their children removed within the first two years following birth. The second study is a qualitative case file analysis of the engagement between this same cohort of parents and clinicians during PCAs, and of the self-reports of parents regarding their engagement with services, as described in PCA reports.

Study 2.1

The objective of Study 2.1 was to examine the engagement between antenatal services, child protection services, and birthing parents during routine antenatal care at a public hospital managed

by SA Health, and with an imbedded early intervention program managed by CPS. Specifically, the study had the following aims:

1) To examine the screening and patterns of referral provision to hospital-based services made by midwives during routine antenatal care for pregnant people prior to the removal of their child(ren) by statutory child protection services.
2) To examine patterns of referral uptake to hospital-based services by pregnant people prior to the removal of their child(ren) by statutory child protection services.

Method

Sample of Case Records

This study was reviewed by the relevant South Australian Clinical Human Research Ethics Committee (SA HREC) and was found to meet the criteria for a clinical audit. Parenting Capacity Assessments (PCAs) conducted at an outpatient Child Protection Service (CPS) in metropolitan Adelaide, during a five-year period between 01/01/2015 and 31/12/2019, and for children aged 2 or under were retrieved. A period ending prior to the start of the COVID-19 pandemic was chosen as service provision was significantly affected throughout the hospital during this time. Children aged 2 and under were chosen as this matches the age bracket used by the Australian Institute of Health and Welfare to report on child protection data and trends throughout Australia. This age bracket also includes the upwards end of what is considered the perinatal period.

Two-hundred and twenty-eight PCAs conducted for children under 2 years of age, between 01/01/2015 and 31/12/2019 were retrieved from the CPS database. If more than one PCA was conducted for the same parent and child coupling, second and subsequent PCAs were excluded, as these are generally follow-up assessments and differ in content to the first PCA process. This left two-hundred and seven PCAs for retrieval. The hospital patient database was used to match antenatal records to the 208 PCAs retrieved. A further 72 PCA's were excluded as they related to children who were not birthed at the hospital, and whose birthing parent did not receive antenatal care at the hospital. A further 1 PCA was excluded as it related to a child that was still in parental

custody at the time of the PCA. This left 135 PCA's that were matched with antenatal record forms from the hospital database that were included as individual cases for analysis.

Data Collection

Antenatal appointment records were obtained from the FMC online database for the 135 cases included for analysis. All available data included within the antenatal screening forms were extracted. These data were recorded on the forms with a check-box, and included; pregnant person's age, ethnicity, history of child protection intervention, history of child sexual abuse, history of child abuse, history of domestic violence, un/stable housing, intellectual disability, Edinburgh Depression Scale (EDS) score, Antenatal Risk Questionnaire (ARQ) score, Early Links Alert, Early Links Alert Status, Early Links Plan, and referrals offered/accepted/declined for hospital-based social work, drug and alcohol, and perinatal mental health services. Data extracted from the FMC database included appointment attendance records for social work, drug and alcohol, and perinatal mental health services.

Data extracted from PCA reports included the child protection concerns, birthing parent's own child protection history (investigations, care placements, GOM18 orders), child protection history for other children, history of domestic violence and child abuse (sexual abuse, physical abuse, emotional abuse), and the presence of intellectual disability. These variables were chosen to closely match those recorded in the antenatal screening forms.

Data Analysis

For descriptive analysis of the sample of birthing parents, data from the antenatal record forms and PCA's were combined. Due to the potential underreporting of issues during antenatal appointments, if variables were indicated in data gathered from PCAs but not in data gathered from antenatal record forms (for e.g., antenatal record forms indicated no prior child protection history, but PCA reports indicated child protection history), they were included in the combined data set. Descriptive analysis of each pregnancy and antenatal appointment attendance was conducted using data from the antenatal record forms and appointment attendance records.

Data from the antenatal record forms and appointment attendance records were used to identify associations between birthing parent's pregnancy characteristics and referrals made by midwives to hospital-based support services. This data represents information that was known to midwives at the time of potential referrals. Data from the combined antenatal/PCA dataset were used to identify associations between birthing parent's characteristics and acceptance and attendance rates for hospital-based support services. Data from the combined dataset were used for this analysis as it is likely to represent more accurate information than either of the datasets (antenatal record forms or PCAs) alone. Data from antenatal record forms were compared to data from PCAs to assess discrepancies in disclosure and recording at both engagement points.

Results

The 135 PCAs included for analysis pertained to 135 pregnancies, 136 children (1 set of twins), and 116 women (mothers). 17 women had 2 pregnancies/births during this period, and 1 woman had 3 pregnancies/births during this period. The remaining 99 had one pregnancy/birth.

Mothers

Of the 116 women included in the study, 76% (n = 88) were noted as Caucasian and 24% (n = 28) were noted as Aboriginal and Torres Strait Islander. The antenatal record forms used at the hospital only record pregnant people's ethnicity as Caucasian or Aboriginal and Torres Strait Islander, which likely does not allow for an accurate representation of pregnant people's ethnicity. Only 7 women of the total sample of 114 were not recorded as being victim/survivors of interpersonal violence and abuse at some point throughout their lives. Of those 7, 2 women did not engage with the PCA process at all, thereby limiting the amount of historical and current information available, and 3 had intellectual disability (see Table 1.1).

Table 2.1

Characteristics of Mothers from Combined Dataset

Characteristics of mothers	*n*	%
Victim/survivor of interpersonal abuse during adulthood		
Domestic violence	87	75
Sexual assault	6	5
All	91	78
Victim/survivor of childhood abuse		
Physical abuse	45	39
Sexual abuse	70	60
Emotional abuse only	16	14
All	96	83
Victim/survivor abuse across lifetime (child and/or adult)		
Sexual or physical violence	104	90
All abuse types	109	94
Child protection history		
Investigations during childhood	60	52
Care placements during childhood	36	31
Long-term (GOM18 orders) during childhood	15	13
Intellectual disability		
Yes	12	10
No	104	90

Pregnancies

Of the 135 pregnancies included in the study, mothers were on average 25 years of age at the time of birth, with the youngest being 13, and the oldest being 44. With regards to psychosocial risk, for each pregnancy, women scored an average of 9.13 on the Edinburgh Perinatal Depression Scale, and 29.42 on the Antenatal Risk Questionnaire. Cut offs indicative of perinatal depression

and significant psychosocial risk are 13 and 23, respectively (see Table 2.2). Antenatal records suggest that in 51% (n = 69) of pregnancies, the mother had experienced previous child protection intervention for another child, however data extracted from parenting capacity assessments suggest this number to be 59% (n = 79; see Table 2.3).

Table 2.2

Characteristics of Pregnancies from Antenatal Record Dataset

Characteristics of pregnancies	*n*	%
Edinburgh Perinatal Depression (EPDS) score		
Above cut-off indicative of perinatal depression	34	25
Below cut-off indicative of perinatal depression	101	75
Antenatal Risk Questionnaire (ANRQ) score		
Above cut-off indicative of significant psychosocial risk	85	63
Below cut-off indicative of significant psychosocial risk	50	37
Birth alert		
Low risk	5	4
Medium risk	11	8
High risk	107	80
All	123	91
Plans to notify DCP at 34-weeks gestation and at birth		
Yes	12	10
No	104	90
Removal at birth		
Yes	53	39
No	82	61

Comparison of Antenatal and PCA data

Data extracted from the antenatal screening form (history of child protection intervention, history of child sexual abuse, history of child abuse, history of domestic violence, stable housing,

intellectual disability) were compared to data extracted from PCAs to examine any discrepancies arising within information gathered and reported at both intervention points. All data were underreported during antenatal appointments when compared to parenting capacity assessments (see Table 2.3).

Table 1.3

Comparison of Women's Characteristics as Reported During Antenatal Appointments and Parenting Capacity Assessments

Recorded characteristics	Antenatal Appointments		Parenting Capacity Assessments	
	n	%	*n*	%
History of Childhood Sexual Abuse	44	31	74	53
History of Childhood Abuse	51	36	70	50
History of Domestic Violence	53	38	91	65
Intellectual Disability	10	7	13	9
History of Child Protection Intervention	69	51	79	59

Referrals Offered and Appointments Attended

Antenatal record forms suggest that in 63% of pregnancies (n = 85), women were offered referrals to at least one of either hospital-based social work, perinatal mental health, and/or drug and alcohol services. Hospital attendance records suggest during 17% of pregnancies (n = 23), women attended at least one appointment to either hospital-based social work, perinatal mental health, or drug and alcohol services. The number of women who attended at least one appointment with hospital-based services accounts for 27% of those that were offered referrals (see Table 2.4).

Table 2.4

Referrals Offered to Hospital-based Support Services, and Appointments Attended.

Services	Referrals offered		At least 1 appointment attended		At least 1 appointment attended of referrals offered	
	n	%	*n*	%	*n*	%
Social work	64	47	9	7	9	14
Perinatal mental health	53	39	9	7	9	17
Drug and Alcohol (DASSA)	35	26	13	10	13	37
All	85	63	23	17	23	27

The 17% of pregnancies where women did attend at least one appointment accounted for an overall total of 60 appointments attended over the antenatal period, with most women who did attend at least one appointment, attending more than one appointment throughout the course of their pregnancies (56%, n=13). 30% of women (n=7) who attended at least one appointment, attended appointments with more than one service. Appointment attendance at the three different services were significantly correlated (see Table 2.5), suggesting that appointment attendance at one service predicted appointment attendance at another. The most frequent number of appointments attended at all 3 services was 1. The maximum number of appointments attended was 3 for social work, 4 for perinatal mental health, and 6 for DASSA.

Table 2.5

Correlations for Appointments Attended.

Variable	1	2
1. Social work appointments attended	–	
2. Perinatal mental health appointments attended	.263**	–
3. DASSA appointments attended	.252**	.251**

** Correlation is significant at the 0.01 level

Pearson's Chi-square analysis was used to identify associations between client characteristics as taken in the antenatal record form (thus, those that were recorded by, and known to, midwives), and referrals offered. There was no statistically significant association between women's ethnicity, history of childhood sexual abuse, history of domestic violence, physical disability, intellectual disability, birth alert status, and removal at birth and referral to any services.

Chi-square tests indicated that midwives were significantly more likely to refer to social work services in pregnancies where women had a history of childhood abuse $p = .02$, *phi* = .24; had unstable housing $p < .01$, *phi* = .27; and scored above the cut-off indicative of significant psychosocial risk on the ANRQ $p = .03$, *phi* = .20; and were significantly less likely to refer to social work services when there was a plan to re-notify the DCP at 34-weeks gestation and at birth $p = .02$, *phi* = .24 (see Table 2.6).

Table 2.6

Frequencies and Chi-Square Results for Pregnancy Characteristics and Referrals Made to Hospital-Based Social Work Services.

	Social work referral offered		Social work referral not offered		X^2 (1)
	n	%	*n*	%	
History of childhood abuse	32	62.7%	19	37.3%	7.89*
No history of childhood abuse	26	37.1%	44	62.9%	
Unstable housing	15	78.9%	4	21.2%	9.48**
Stable housing	46	43.4%	60	56.6%	
Scored above cut-off on ANRQ	46	54.1%	39	45.9%	4.87*
Scored below cut-off on ANRQ	14	33.3%	28	66.7%	
Plan to re-notify DCP at 34-weeks gestation and at birth	37	48.7%	39	51.3%	7.69*

No plan to re-notify DCP at 34-weeks gestation and at birth	24	57.1%	18	42.9%	

* $p < .05$
** $p < .01$

Chi-square tests indicated that midwives were significantly more likely to refer to perinatal mental health services in pregnancies where women had a history of childhood abuse $p = .04$, *phi* = .22; scored above the cut-off score indicative of perinatal depression on the EPDS $p < .01$, *phi* = .27; and scored above the cut-off score indicative of significant psychosocial risk on the ANRQ $p < .01$, *phi* = .40; and were significantly less likely to refer to perinatal mental health services when there was a plan to re-notify the DCP at 34-weeks gestation and at birth $p = .04$, *phi* = .22 (see Table 2.7).

Table 2.7

Frequencies and Chi-Square Results for Pregnancy Characteristics and Referrals Made to Hospital-Based Perinatal Mental Health Services.

	Perinatal mental health referral offered		Perinatal mental health referral not offered		X^2 (1)
	n	%	*n*	%	
History of childhood abuse	27	52.9%	24	47.1%	6.47*
No history of childhood abuse	22	31.4%	48	68.6%	
Scored above cut-off on EPDS	21	61.8%	13	38.2%	9.29**
Scored below cut-off on EPDS	30	31.9%	64	68.1%	
Scored above cut-off on ANRQ	45	52.9%	40	47.1%	19.83**
Scored below cut-off on ANRQ	5	11.9%	37	88.1%	
Plan to re-notify DCP at 34-weeks gestation and at birth	32	42.1%	44	57.9%	6.28*
No plan to re-notify DCP at 34-weeks gestation and at birth	19	45.2%	23	54.8%	

* $p < .05$
** $p < .01$

Chi-square tests indicated that midwives were significantly more likely to refer to drug and alcohol services in pregnancies where women had a history of child protection involvement with their other children $p = .01$, *phi* = .22; scored above the cut-off score indicative of significant psychosocial risk on the ANRQ $p < .01$, *phi* = .40, and when there was a plan to re-notify the DCP at 34-weeks gestation and at birth $p = .02$, *phi* = .24 (see Table 2.8).

Table 2.8

Frequencies and Chi-Square Results for Pregnancy Characteristics and Referrals Made to Hospital-Based Drug and Alcohol Services.

	Drug and alcohol referral offered		Drug and alcohol referral not offered		X^2 (1)
	n	%	*n*	%	
History of child protection involvement	24	34.8%	31	44.9%	12.44**
No history of child protection involvement	7	11.9%	39	66.1%	
Scored above cut-off on ANRQ	30	35.3%	39	45.9%	9.52**
Scored below cut-off on ANRQ	4	9.5%	29	69.0%	
Plan to re-notify DCP at 34-weeks gestation and at birth	25	71.4%	51	51.0%	7.97*
No plan to re-notify DCP at 34-weeks gestation and at birth	10	28.6%	32	32.0%	

* $p < .05$
** $p < .01$

Pearson's Chi-square analysis was used to identify associations between client characteristics as taken in both the antenatal record form (for mothers' age, ethnicity, and EPDS and ANRQ cut-off scores) and PCAs, and referrals resulting in at least one appointment attended at either hospital-based social work, perinatal mental health or drug and alcohol services. There was

no statistically significant association between women's age, intellectual disability, presence of domestic violence, history of child protection involvement as a child (including alternative care placements and GOM18 orders), history of child protection involvement with other children, history of childhood physical abuse, history of childhood emotional abuse, birth alert status, plans to notify the DCP, and child protection concerns pertaining to domestic violence and drug and alcohol use, and attendance to at least one appointment with hospital-based social work, perinatal mental health, and drug and alcohol services.

Chi-square tests indicated that women were more likely to attend at least one appointment with hospital-based social work services when they were Aboriginal and Torres Strait Islander p = .01, *phi* = .26; when mental health issues were reported as a child protection concern p = .04, Φ = .18; and when homelessness was reported as a child protection concern p = .02, Φ = .21 (see Table 2.9).

Table 2.9

Frequencies and Significant Chi-Square Results for Women's Characteristics and Appointments Attended (of referrals offered) at Hospital-Based Social Work Services.

	Social work appointment attended		Social work appointment not attended		X^2 (1)
	n	%	*n*	%	
Aboriginal and/or Torres Strait Islander	6	18.2	27	81.8	9.21**
Not Aboriginal or Torres Strait Islander	3	2.9	100	97.1	
Mental health reported as child protection concern	7	12.1	51	87.9	4.21*
Mental health not reported as child protection concern	2	2.8	69	97.2	
Homelessness reported as child protection concern	4	19	17	81	5.63*

Homelessness not reported as child protection concern	5	4.6	104	95.4	

* $p < .05$
** $p < .01$

Chi-square tests indicated that women were more likely to attend at least one appointment with hospital-based perinatal mental health services when they scored above the cut-off indicative of perinatal depression p = .01, Φ = .25; and when they scored above the cut-off indicative of significant psychosocial risk p =.03, Φ = .19 (see Table 2.10).

Table 2.10

Frequencies and Significant Chi-Square Results for Women's Characteristics and Appointments Attended (of referrals offered) at Hospital-Based Perinatal Mental Health Services.

	Perinatal mental health appointment attended		Perinatal mental health appointment not attended		X^2 (1)
	n	%	*n*	%	
Scored above cut-off on EPDS	6	17.5	28	82.5	7.98**
Scored below cut-off on EPDS	3	3.2	91	96.8	
Scored above cut-off on ANRQ	9	10.6	76	89.4	4.79*
Scored below cut-off on ANRQ	1	2.0%	49	98%	

* $p < .05$
** $p < .01$

Chi-square tests indicated that women were more likely to attend at least one appointment with hospital-based drug and alcohol services when they scored above the cut-off indicative of significant psychosocial risk p =.03, Φ = .19; and when they were reported to have experienced childhood sexual abuse p = .04, Φ = .18 (see Table 2.11).

Table 2.11

Frequencies and Significant Chi-Square Results for Women's Characteristics and Appointments Attended (of referrals offered) at Hospital-Based Drug and Alcohol Services.

	Perinatal mental health appointment attended		Perinatal mental health appointment not attended		X^2 (1)
	n	%	*n*	%	
Scored above cut-off on ANRQ	11	12.9	74	87.1	3.67*
Scored below cut-off on ANRQ	1	2.4	41	87.6	
Victim/survivor of childhood sexual abuse	11	14.9	63	85.1	4.26*
Not a victim/survivor of childhood sexual abuse	2	3.7	52	96.3	

* $p < .05$
** $p < .01$

Repeat pregnancies in the 5-year study period

Of the 18 mothers with repeat pregnancies/births at the hospital during the 5-year study window, 14 did not have any appointments with hospital-based support services, leaving only 4 that did. Due to the small sample of women (4) who attended any appointments with hospital-based services during either their first or second pregnancy in the five-year study period, it is not possible to provide an analysis of within-person trends in appointment attendance between first and second pregnancies, beyond qualitative reporting.

Of the four women that did attend hospital-based support services, 2 women were amongst the highest engagers during their first pregnancies, attending 3 and 6 appointments, respectively. Both women did not attend any appointments during their second pregnancies, despite being offered referrals, and despite these pregnancies resulting in the removal of their children after birth. The remaining 2 women did not attend any appointments during their first pregnancies, and both attended 1 appointment during their second pregnancies.

Of the 18 mothers with more than one pregnancy/birth at the hospital during the study period, 4 attended separate PCAs for each child, and 14 attended the same PCA for more than one child. For the 14 mothers that attended the same PCA for more than one child, it was the case that statutory child protection intervention occurred at one time point for all children, and that the one PCA therefore captured the same time point and child protection concerns. For the 4 mothers that attended separate PCAs for each child, it was the case that the first PCA occurred after the birth of their first child and before the birth of their second child, and that their second child was subsequently removed at birth, at which point a new PCA was mandated.

Of the 4 mothers who attended two separate PCAs – whose child/ren had been removed from their care in the 5-year study period between their first and second births – only 2 were offered referrals to hospital-based services during their second pregnancies. This is despite the two women having an ANRQ score above the recommended cut off for significant psychosocial risk (cut off: 23, women scoring 36 and 40), both having High Risk Birth Alerts, and both having their second child removed at birth. The 2 women that were offered referrals to hospital-based support services during their second pregnancies declined all referrals.

Discussion

The aim of this retrospective case file audit was to explore the engagement of pregnant people during routine antenatal appointments at one South Australian public hospital prior to the removal of their child(ren) by statutory child protection services. Hospital case file data was linked with data from Parenting Capacity Assessment (PCA) reports to describe the characteristics of pregnant women and their pregnancies, their disclosures and surveillance during antenatal appointments, and rates and patterns of the provision and uptake of referrals to hospital-based support services. The results of this study illustrate a cohort of women with significant histories as victim/survivors of violence and abuse and with child protection services, whose pregnancies are well surveilled, but who are too often not being offered, and overwhelmingly not accepting, hospital-based support services during their pregnancies.

The vast majority – indeed, close to the full sample – of pregnant women included in this study were victim/survivors of abuse and violence both in childhood and adulthood. While these results are consistent with findings of the experiences of mothers involved in child protection services in the United States (Perepletchikova et al., 2012), England (Broadhurst et al., 2017), and Australia (Taplin & Mattick, 2014), the rates of these experiences are higher again in the present study. This may be due to the extensive nature of the information gathered during PCA's, whereby a woman's child and adult history is scoured from several government databases (for e.g., child protection, health, police). Consistent with their histories of childhood abuse, most women were also subject to child protection investigations as children, and most had previous experiences with statutory child protection services with their other children. Overwhelmingly, these findings highlight a sample of women for whom violence, abuse, and statutory child protection contact is commonplace. Such experiences may create a barrier to engagement with services, particularly when the content of this engagement may trigger memories of traumatic experiences and/or be experienced as stigmatising or shame inducing (Curran, 2022; Oni et al., 2022).

The findings suggest that women are, to an extent, withholding their engagement and disclosures during antenatal appointments, or that midwives are not asking or recording all questions of pregnant women. Data recorded during antenatal appointments were underreported for all variables in the antenatal questionnaire (intellectual disability and history of childhood sexual abuse, childhood abuse, domestic violence, and child protection involvement) when compared to those same variables recorded within PCAs. While antenatal appointment records rely on the questions of midwives and disclosures of pregnant women, PCAs include information sourced from multiple agencies in addition to personal disclosure, which may explain the discrepancy in reporting. Scores on the Antenatal Risk Questionnaire – a self-report measure – were also relatively low within a sample that experienced the removal of their children within 2 years of birth.

There are several reasons as to why women may withhold disclosure of these issues or experiences, including the need to develop safety and trust with practitioners in the case of

childhood abuse disclosures (Tener & Murphy, 2014), fear of negative consequences such as judgement and stigma from practitioners and repercussions from partners in the case of domestic violence (Heron & Eisma, 2021), and the fear of detection by, and intervention of, statutory child protection services (Chan & Moriarty, 2010; Oni et al., 2022). Research on the screening practices of midwives suggests that issues such as a lack of training, education, and confidence, high workloads, and the presence of partners in appointments (De Backer et al., 2024; Johnsen et al., 2024; Abrahams et al., 2023) act as barriers to midwives asking all screening questions during antenatal appointments. In any case, reduced engagement between women and midwives – be that midwives' hesitation to ask all questions, women withholding disclosures, or a combination of the two – impacts the capacity for midwives and women to develop a shared understanding regarding a pregnant woman's needs, which is a key aspect of a successful referral process.

Despite underreporting during antenatal appointments, the vast majority of pregnancies were given high-risk birth alerts, reported to the Department of Child Protection (DCP), and subject to ongoing surveillance during pregnancy. This surveillance included the monitoring of antenatal appointments, and reporting to the DCP at 34-weeks gestation and at birth, with over a third of all pregnancies then involving the removal of a child at birth. In these instances, social notes recorded on the SA Health database did not make it clear whether the mother was made aware of plans of the removal of the child at birth. While the SA Health guidelines for managing high-risk infants stipulates that the DCP should inform parents of the intention to proceed with formal care and protection action (the orders that precede a removal at birth), they stipulate that this should be done only when safety concerns do not exist (SA Health, 2019). While what constitutes a safety concern is ambiguous within the guidelines, women being cited as a 'flight-risk' – that is, that they would not attend hospital and seek to birth their child elsewhere – is often cited as a safety concern, and is often cited as a reason to conceal plans to remove a baby at birth (Marsh et al., 2019; Davis, 2019; Wise & Corrales, 2021; Lawrie, 2024).

Referrals made by midwives to hospital-based support services (social work, perinatal mental health and drug and alcohol services) are low for this cohort. It is stipulated within SA Health policy (SA Health, 2019) that in all pregnancies with birth alerts, women should be referred to support services. However, in a cohort where 91% of pregnancies were given birth alerts, it was in only 63% of pregnancies that women were offered referrals to support. The relatively low rates of referrals in this cohort are in contrast with state and national child protection frameworks (Department of Child Protection, 2020; Commonwealth of Australia, 2021) that stipulate that targeted support should be offered to families prior to intervention by statutory child protection agencies.

It is concerning that in pregnancies where there was a plan to re-notify the DCP at 34-weeks gestation and at birth, women were less likely to be referred to social work and perinatal mental health services. While it's possible that women were arriving to antenatal care late in their pregnancies – which may increase their monitoring by the DCP but leave less time for the provision of referrals – this is less likely to be the case when considering that in pregnancies where there were plans to re-notify the DCP, midwives were more likely to refer women to drug and alcohol services. It may therefore be more likely that where there is a plan for ongoing monitoring by the DCP, midwives feel less responsibility to follow-up with women themselves, or feel that the risk to the baby is being managed via potential plans for removal at birth. As prenatal drug use poses a risk to an unborn baby regardless of plans post-birth, this would explain the higher likelihood of drug and alcohol referrals despite lower likelihood of social work and perinatal mental health referrals. This would suggest that referrals are being made to mitigate the risk of harm to the unborn baby (i.e., prenatal drug use), but referrals are not being made to support pregnant women to reduce the risk of harm to a child post-birth, and to reduce those factors that are likely to lead to the removal of a child at birth (for e.g., domestic violence, ill-mental health, homelessness).

Referrals appear, with the exception of those pregnancies subject to higher reporting and surveillance (i.e., those marked for reporting at 34-weeks gestation and at birth), to be made

according to need. Women who scored above the cut-off scores in both screening tools – the EDPS and ANRQ – were more likely to receive referrals to the appropriate hospital-based support services, with these being perinatal mental health and social work services, respectively. The findings suggest that hospital based social work services are most favoured for referrals by midwives, despite these services being the least attended by pregnant women. Social work services are likely to be preferred as somewhat of a 'catch-all' service that can provide further assessment and referrals, which may alleviate this work, and these decisions, from midwives.

Overall attendance rates by pregnant women at hospital-based support services are low. Just under one third of the sample of women who were offered a referral attended at least one appointment with hospital-based perinatal mental health, drug and alcohol, or social work services. Given the low referral rates, this equated to just over a quarter of the total sample of women attending any appointments with support services. These numbers highlight not only the issue of pregnant women's attendance, but the issue of low referral rates, which of course are a precursor to attendance. The impact of low referral rates is often missing in considerations of pregnant women's engagement with support services, which in many cases is an issue attributed solely to women themselves (as a 'hard to reach' or 'hard to engage' cohort; Boag-Munroe & Evangelou, 2010). Patterns of attendance rates again appear to be according to need, where attendance at appointments for relevant services were more likely for women who met cut-off scores on the EPDS and ANRQ, and for whom homelessness and mental health were cited as child protection concerns. Consistent with attendance according to needs, it's likely that the association between childhood sexual abuse and attendance at drug and alcohol appointments is due to the higher rates of drug use amongst women with sexual abuse histories (Fletcher, K. 2020). The finding that Aboriginal and Torres Strait Islander women were more likely to attend social work appointments – indeed making up two thirds of all social work appointments attended – is inconsistent with a common view of Aboriginal women as a 'hard-to-reach' population group.

Social work, despite being the service most referred to, was the service least attended by pregnant women. Conversely, drug and alcohol services, being the service least referred to, was most attended by pregnant women. This was true both of initial appointment attendance, and of ongoing appointment attendance. It may be the case that referrals to drug and alcohol services occur after open engagement between pregnant women and midwives, such that a need for the referral is identified, and women have a clear understanding of why the referral is being made. Conversely, the reason for social work referrals may be less clear to women, as these may occur when midwives would like further assessment or follow-up of women, but where a less tangible need has been identified with them. It may also be the case that social work, as a profession, is associated with child protection intervention, and may therefore be a profession that invokes more fear and avoidance in pregnant women at risk of child removal. These findings suggest that it may be more beneficial for midwives to refer directly to relevant services rather than to hospital-based social work services. This may, however, require a more thorough assessment process and deeper engagement with women by midwives at antenatal appointments.

The findings from this case file review describe the rates and patterns of referrals made to hospital-based support services during routine antenatal appointments for pregnant women who experienced the removal of their child(ren) by statutory child protection services within two years of birth. While these findings provide some suggestions about the engagement between pregnant women and midwives during antenatal screening, the ways in which midwives engage with pregnant women and speak with them about their needs and any child protection concerns cannot be explored via the available quantitative data. Likewise, while the findings from this study illustrate the rates of referrals and attendance at hospital-based support services, the reasons why women may not follow through with referrals, and the nature of women's engagement with external services, is unexplored.

While the antenatal period is one of two intervention points between Child Protection Services and pregnant people/parents, there is no known direct contact or interaction between these

two parties during the antenatal period. The work of CPS during pregnancy relies on the screening of midwives, and referral to the service via the creation of a high-risk birth alert. CPS then monitors the pregnancies and antenatal engagement of parents during this time, whilst liaising with midwives, other hospital and SA Health staff, and staff from the DCP. While the findings from this study therefore illustrate the work of midwives in screening and referral, as well as the engagement of pregnant women, little is known about the direct work of CPS, and how CPS may engage and work with parents who are in contact with the statutory child protection system.

Study 2.2

To gain an understanding of the direct engagement between CPS and mothers, and to gain an understanding of women's engagement following the birth of their child and following their child's removal by statutory child protection services, I conducted a qualitative analysis of data within Parenting Capacity Assessments (PCAs). Specifically, the subsections of PCAs that report on the engagement between CPS clinicians and mothers (mothers' engagement with the assessment), and that report on mothers' engagement with support services (including their comments regarding their engagement or non-engagement), were extracted for analysis. In addition to developing a picture of the engagement between CPS and mothers, this study may address some of the limitations of study 1, namely, how health staff and women engage in conversations about child protection concerns and perceived needs for support, and the views of mothers, as reported to clinicians, regarding their engagement with support services.

The objective of study 2.2 was to examine the engagement between child protection clinicians and mothers during parenting capacity assessments conducted at Child Protection Services as an outpatient clinic of a public hospital in metropolitan Adelaide. Specifically, the study had the following aims:

1) To examine the engagement between mothers and CPS clinicians during PCAs conducted following the removal of her child(ren) by statutory child protection services.

2) To examine reports by mothers of their views regarding their engagement with services, as made to clinicians during PCAs conducted following the removal of her child(ren) by statutory child protection services.

Method

Qualitative data were extracted from the same sample of 135 PCA reports. PCA reports follow a set structure whereby parents' engagement with the assessment process (under the subheading 'Presentation') and their engagement with services (under the subheading 'Engagement with Previous and Current Supports') are noted under specific subheadings within the report. Qualitative data under each of these subheadings were extracted for analysis as they report on women's engagement with the assessment process and with support services, as assessed by clinicians at CPS. Data were deidentified and entered into NVivo (Version 12.6) for analysis.

Thematic analysis of the qualitative data was conducted following the 6-phase process of reflexive thematic analysis outlined by Braun and Clarke (2022). Following familiarisation with the data, I coded and grouped the data to create preliminary themes. I then reviewed and refined the themes to ensure they accurately reflected the data and named and defined them to support the reporting of results.

Results

My thematic analysis of mothers' engagement with the parenting capacity assessment process and comments on their engagement with support services included 3 themes and 6 subthemes. These themes were; (1) Disengagement with PCAs; (i) Engagement as distressing, (ii) Disengagement to manage distress, (iii) Reduced capacity to engage; (2) Open engagement with PCAs; (3) Engagement with Services; (i) Barriers to service engagement, (ii) Compliance with service engagement, and (iii) Positive engagement with services.

Theme 1: Disengagement with PCAs

Most PCA reports noted issues with engagement between clinicians and mothers, or noted a breakdown in engagement over time. It appeared that the process of the assessment was particularly distressing for mothers, and that mothers often modulated their engagement to reduce their distress. In addition to mothers' reduced psychological capacity to engage in the assessments was, for a smaller subset of mothers, the issue of reduced cognitive capacity to engage in the assessments due to cognitive disability.

i. Engagement with PCAs as distressing. Most PCA reports noted significant displays of distress by mothers throughout their engagement in the assessment process. The reports noted that mothers were anxious, teary, sad, emotionally labile, agitated, frustrated, and angry. Regarding anxiety, the reports provided descriptions of mothers trembling, picking their nails, sitting on the edge of their seats, and avoiding eye contact. Some reports noted that mothers' distress was the result of feelings of shame and guilt:

> *She presented in all assessment sessions as teary and at times distressed. When querying this with her, she reported that her teariness was due to 'everything' and more specifically feeling 'guilty' about her baby's current withdrawal.*

In some reports, it was noted that mothers' distress during the parenting capacity assessment process was exacerbated by the loss and grief they were experiencing due to the recent removal of their child(ren).

> *She later conveyed that she needed significant support from mental health services to manage the demands of Families SA[1] involvement and the current assessment, including the need to take Valium after attending appointments due to how overwhelming and distressing she found them.*

Additionally, distress during parenting capacity assessments appeared to result from assessment topics that were difficult in nature. These topics often related to mothers' own experiences of interpersonal and childhood trauma, or about their responsibility for the harm or risk

[1] The Department for Child Protection (DCP) was formally named Families SA.

posed to their children (i.e., the child protection concerns). Another cause of distress for mothers appeared to be their awareness of the process of being assessed:

> *She appeared to find the process difficult and tended to provide brief responses and sparce fragments of information she could not elaborate on. She presented as fearful, struggled to regulate her emotions, and frequently sought reassurance about her 'performance' throughout the interview.*

ii. Disengagement strategies to manage distress. Mothers' distress appeared to impact their engagement with PCAs, whereby it was noted in the reports that mothers often steered the conversation to avoid sensitive topics, provided superficial responses, or ended the assessment process early. Mothers were often noted to steer conversations away from topics relating to their own experiences of abuse and trauma:

> *She appeared to use avoidance as a strategy to cope with topics of conversation that were difficult or distressing, such as her childhood experiences. The clinician noted that her rapid speech appeared to be a technique to avoid certain topics as she would talk rapidly and for long periods making it more difficult to pose questions to her.*

The reports noted that mothers engaged in a way that was 'superficial', or that provided dishonest responses to questions. It appeared that this was often done in response to distress, distrust, and concern about being assessed:

> *Her high level of distrust of Families SA and CPS became evident as she struggled to volunteer information about herself and her family unless she was aware that the CPS already had this information. She later stated, "I don't want to say something and then regret it".*

It appeared throughout the reports that for some mothers, the assessment process was so distressing that the engagement between them and the clinicians broke down and they ceased to attend and engage with the assessment process altogether. Throughout many reports, it appeared that there was a marked deterioration in engagement as the assessments progressed:

When the assessment session commenced, she was initially responsive to the clinicians as she began making direct eye contact and answering questions asked of her. However, as the assessment interview continued, she became increasingly distressed and was observed to quietly cry, with tears streaming down her face. It was further noted that she became increasingly unresponsive to the clinicians' questions which led to the interview ending early.

iii. Reduced capacity to engage. In addition to the experience of distress that often impacted mothers' emotional capacity to engage in the assessment process, was the effect of some mothers' cognitive capacity. It was noted in reports that mothers with cognitive difficulties or intellectual disabilities struggled with the demands of the assessment process:

From the onset of this assessment, it appeared that she was greatly impacted by her intellectual disability and while she attended all scheduled appointments for this assessment and was on time, she struggled to manage to stay for the duration of the interviews. During the interviews the clinicians noticed that her concentration wavered between twenty and forty minutes into the interviews, and as a result the sessions were shorter in duration, with the last interview only lasting twenty minutes before she was unable to remain focussed.

It was unclear if accommodations were made beyond the shortening of sessions, and it was noted within just one report that a mother with an intellectual disability had a support person with them for the assessment process.

Theme 2: Open Engagement with PCAs

While the reports noted significant challenges to mothers' engagement in the assessments, some reported positive engagement in the process. For mothers who were noted to have been well engaged, they were commonly noted as being open, cooperative, polite, and as having managed the demands of the assessment.

She presented as polite, demonstrated an overall willingness to cooperate, and appeared to sufficiently manage the demands of Families SA involvement and of the CPS assessment.

In few cases, it was noted within the reports that women's engagement increased overtime:

> *Initially, she presented as very anxious and stated to the CPS clinicians that she felt extremely anxious about the process. During subsequent sessions her anxiety appeared to reduce somewhat and this allowed her to become more involved in and contributory to the assessment process.*

Theme 3: Engagement with Services.

It appeared throughout the reports that the way that mothers discussed their engagement with services was, to an extent, dependent on their engagement with the PCAs. Some mothers spoke more freely about their experiences with services, including both the positive aspects of their engagement and the barriers they experience to engaging with services. Oftentimes, for mothers who were reported to have a strained engagement during the PCAs, it appeared that they stated their willingness to comply with requests to engage with external services, but did not disclose much of their feelings or perspectives regarding the request by CPS clinicians to engage with services.

i. Barriers to engaging with services. It was noted throughout the reports that mothers cited several barriers to their engagement with support and statutory services during the assessments. These included experiences of shame, of negative repercussions from partners, fear of speaking to new people, distrust of services, previous negative experiences with services, and a belief that services are not needed. Distrust and previous negative experiences with services appeared to be a core issue for mothers. Reports noted that mothers were particularly concerned with services making notifications to the Department of Child Protection, or were apprehensive to reengage with services who had made notifications in the past:

> *She had disclosed her drug use to her antenatal care providers who had then made a CARL report, and while she was in the preliminary stages of change with regards to her drug use, she expressed significant hesitancy about service engagement.*

They were apprehensive about taking their child to kindergarten due to concerns that his behaviour might alert Families SA, with both parents being wary of Families SA due to their own histories with this service.

The reports noted that mothers experienced significant challenges in their engagement with statutory child protection services – previously Families SA and currently the Department for Child Protection. It was noted that mothers expressed feeling that they had been unfairly treated, and this appeared to be a significant barrier to developing trust and rapport with statutory and other support services. This was sometimes exacerbated by experiences with statutory services during childhood, or with other children. It was not that for some mothers, the grief and trauma of their child's removal created a significant barrier to their further engagement with statutory services:

She reported that she "went off" at Families SA when they arrived to take her baby from the hospital. In recalling this incident, she reported that the doctors had just removed "blood clots" from "inside" of her when Families SA arrived to remove her baby. She acknowledged that she "lost it" at the workers referring to them as "scumbags and evil". She went on to question how Families SA could remove a newborn in this manner, clearly conveying how this experience had been traumatic for her.

Some mothers with histories of trauma were also noted as being apprehensive to engage in services that they believed would worsen their mental health symptoms:

Of significance, she articulated a history of involvement with mental health services, however expressed her strong belief that their intervention was a "load of crap", noting they wanted her to "re-hash" her past which further intensified her symptomology, resulting in her experiencing escalating thoughts of self-harm. As such, she reported having advised mental health services that if they wanted her to continue to engage with such a service she would require "sedation" following sessions.

ii. Compliance with service engagement. Many mothers throughout the reports were noted as being willing to engage with services if this was required to regain custody of their children. In these

cases, it was often noted that mothers were not fully convinced of their need for service support, or were hoping to appease statutory services in absence of a shared understanding about their circumstances and needs:

> *She would disagree that help was warranted, suggesting that her expression of motivation to engage were superficial engagement or disguised compliance to appease Families SA rather than a genuine desire to improve her capacity to meet her baby's needs.*

While in some reports, compliance was noted in negative terms, in others, it was noted as a requirement of mothers. In some cases, it was noted that mothers experienced significant challenges complying with the demands of statutory services:

> *It appeared that she seemed to be in an internal battle wherein she knew that she needed to comply with DCP, but that this required an inordinate amount of energy and strength given her significant distrust of DCP.*

iii. Positive engagement with services. It was noted throughout some reports that mothers had previous positive experiences with services, were currently engaged with support services, or were motivated to engage with services. It appeared that having a previous positive experience motivated mothers to engage in further service support, as did perceiving a need for support services. In these instances, it appeared that mothers had a clear understanding of what they may gain from their engagement with services, and what kind of support they would like to receive:

> *She acknowledged that she had not been able to resolve her previous experiences of trauma and she that she believed that she was beginning this process at the time of the current assessment. She reported that she had begun exploring her history with her current mental health service and was planning to engage in domestic violence counselling as well as engaging with Dialectical Behaviour Therapy.*

Discussion

The aim of this retrospective case file audit was to explore the engagement between CPS clinicians and mothers during Parenting Capacity Assessments (PCAs), and to explore the ways that

mothers discussed their engagement with services during PCAs. It appeared that engagement with the PCA process was overwhelmingly a distressing experience for mothers, and that this distress limited the capacity for open engagement between mothers and CPS clinicians. The distress that mothers expressed during the PCA process appeared to result from four main sources; the grief surrounding the removal of their child(ren); the shame arising from discussions about the reasons for their child(ren)'s removal; fear of being assessed and the outcomes of their assessment; and conversations about mothers' own experiences of trauma and abuse. Under these circumstances, it appeared that mothers often stated that they would comply with the services deemed necessary to regain custody of their child(ren), but that this was oftentimes in absence of the development of a shared understanding with CPS clinicians about why these services were needed, and what mothers could gain from their engagement with them. Mothers also expressed commonly reported barriers to their engagement with services, most of which were related to previous negative experiences with services, and their fear of the negative consequences of their future engagement with services. It appeared that a key issue for mothers was their experiences of services making reports to the DCP. Indeed, for a cohort of mothers who had all experienced the removal of their children by statutory services, this was a pertinent issue that appeared to have increased their experiences of grief, shame, and distrust of service providers.

The experience of grief following the removal of a child by statutory child protection services has been likened, by practitioners and by parents, as similar to the grief experienced by parents following the death of a child (Marsh et al., 2020; Broadhurst & Mason, 2020). Mothers who have had their children removed by statutory child protection services experience an immediate psychosocial crisis and exacerbation of the issues – such as drug use, poor mental health, and homelessness – that were cited as cause for their child's removal (Broadhurst & Mason, 2020). The extent of these crises is apparent in the heightened rates and risk of mothers attempting and completing suicide (Wall-Wieler et al., 2018) and succumbing to unintentional fatal drug overdoses (Thumath et al., 2021) following the removal of their children by statutory services. The extent of

the grief, loss, crisis, and distress that is experienced by mothers following the removal of a child perhaps explains the distress noted within PCA reports, and the resultant challenges in engagement during PCAs. The extent of mothers' distress explains the findings of some mothers ending the assessment process early, self-medicating following the assessments, and the high levels of anxiety noted within the reports regarding mothers' concerns with their performance during the assessment and with the outcome of the assessment process.

In addition to experiences of grief for women who have experienced the removal of their child(ren), is the experience of stigma and shame. In a qualitative, observational case study of child protection practices in the United Kingdom, Gibson (2020) found the experience of shame to be omnipresent in parents subject to child protection intervention due to the negative assessment and judgement of one's parenting practices inherent in this context. Additionally, were specific, individual circumstances of parents (for example, their own experiences of childhood sexual abuse), and practices by clinicians (for example, clinicians attempting to induce shame to gain responsibility taking by parents) that further exacerbated the experiences of stigma and shame. These experiences, coupled with mothers' own histories of complex trauma, create a significant challenge to engagement, particularly during topics of conversation that are either particularly shame inducing (such as those centred around the child protection concerns), or that centre around previous traumatic experiences (Mason et al., 2020). Such challenges again explain the distress experienced by mothers noted in the PCA reports, and the attempts made by mothers to disengage during the PCA process.

A precursor for mothers to be motivated to engage with services and to work towards change, is the shared understanding between mothers and clinicians about the circumstances that necessitate their referrals to supports. To come to this shared understanding, open, honest, and respectful engagement between parents and clinicians is necessary (Lehtme & Toros, 2020). However, findings from the current study suggest that conversations regarding mothers' engagement with support services were often conducted within a context that was highly distressing

for mothers, and where this distress had led to a significant breakdown in engagement. In this context, it was reported that many mothers expressed their willingness to comply with services, but that this compliance was void of a sense of internal, personal motivation to engage with them in a meaningful manner.

Mothers' previous and current experiences with services appeared to weigh heavily on their perspectives, as noted in the PCAs, regarding their engagement with future support. Mothers who were already engaged in support, and for whom those experiences were positive, were noted to have expressed a willingness to engage in further supports suggested by CPS clinicians. However, for those mothers who reported negative experiences with services, including the statutory services that were the source of significant distress for mothers, it appeared that the fear of further negative consequences of engagement acted as a significant barrier to engagement. This demonstrates the significant challenge present in attempts to engage mothers with support services following the removal of their child(ren) by statutory child protection services.

General Discussion

The main aim of this explorative, retrospective case file analysis was to examine the engagement between SA Health clinicians and parents during antenatal appointments and PCAs, to gain a deeper understanding of the nature of engagement between these two parties, and to identify factors that influence this engagement. Overall, the findings suggest that low referral rates to support made my midwives during the antenatal period, as well as low acceptance rates by pregnant women, significantly impact upon the engagement of pregnant women with hospital-based support services prior to the removal of their children by statutory services. It appears that while early intervention programs like Early Links are effective at identifying infants deemed at-risk and reporting these cases to statutory services, they are less affective at engaging women with support services to ameliorate the risk of child harm and removal following birth. The findings suggest that efforts to engage women during PCAs, and following the removal of their children by statutory child protection services, are significantly impacted by the grief, shame, and distrust that women

feel as a result of their children being removed from their care. The challenges to engagement that these issues pose during PCAs may be a barrier to reunification efforts, to the extent that women and clinicians are not able to come to a shared understanding of women's needs for further support, and to the extent that this process, and the experience of their child(ren)'s removal, influences women's attitudes towards engagement with support services.

While CPS has two intervention points in their work with parents, the first contact point, during antenatal appointments, remains largely behind the scenes. CPS clinicians – social workers and psychologists – do not have a direct contact role with parents of infants deemed at-risk during the antenatal period and instead arrange case planning between hospital staff and statutory services. The work of referring parents to support, as well as discussing any child protection concerns that form the basis of these referrals, falls onto midwives during antenatal appointments. Two recent systematic reviews conducted on the interactions between pregnant women and hospital-based healthcare workers (De Backer et al., 2024; Johnsen et al., 2024) found that healthcare workers often felt underprepared, undertrained, and under-resourced in this work with women during antenatal appointments. Indeed, the last evaluation of Early Links (Powers et al., 2007) identified lack of resourcing and training for midwives was an issue, and recommended improvements in these areas. While it remains unclear if, and to what extent, this is currently an issue for midwives in their engagement with parents, as psychologists and social workers, CPS clinicians are well trained to engage with parents about issues of psychosocial risk. Therefore, it will likely be of benefit to have CPS clinicians take on a direct role of engaging with parents of infants deemed at-risk of harm during the antenatal period.

The South Australian Commissioner for Aboriginal Children and Young People (CACYP) released a commissioned report in 2024 (Lawrie, 2024) on the application of the Aboriginal Child Placement Principle in the removal and placement of Aboriginal children. The report synthesised expert evidence, literature, case file reviews, and data from stakeholder forums, and found that most parents of Aboriginal children are not being provided preventative support during pregnancy, to

reduce rates of child removals at birth. These findings are consistent with that of the current two studies, where overall referral rates to support services for both Aboriginal and non-Aboriginal women were low. This is despite Aboriginal women being more likely to attend appointments when they were offered referrals. The report by the CACYP (Lawrie, 2024) also found that Aboriginal pregnant women were not told of plans to remove their child at birth, and that this left women with profound loss and trauma following the removal of their children. While the report focused solely on the experiences of Aboriginal women, if this finding is generalisable to non-Aboriginal women, it provides context to the findings of the current studies. Indeed, it is consistent with the level of distress reported of women during PCAs in the findings of study 2.2.

If parents are not being told of the child protection concerns during pregnancy, or of plans to remove their children at birth, this may be a significant factor in their uptake of referrals and attendance with support services during the antenatal period. If women are not aware that their pregnancies are being monitored, that there is a likelihood of removal at birth, and that engaging with services is a way to reduce this likelihood, it is possible that women are foregoing attendance with supports to avoid detection by statutory services. This provides explanation for the very low rates of pregnant women's referral uptake to support services during the antenatal period. Such an explanation raises significant concerns about the actualisation of early intervention during pregnancy – in this case, that the dual arms of early detection and support are not balanced, and are rather skewed towards surveillance and removal.

Women who have experienced the removal of a child by statutory child protection services have reported that prior knowledge of the plans for removal would have facilitated their engagement with support, particularly in cases where they have wanted this support but that fear of detection by statutory services had been a barrier to their engagement (Krakouer et al., 2024; Lefebvre et al., 2010). This is consistent with the findings from Study 2.1, whereby it appeared that the uptake of referrals was, to an extent, predicted by women's needs. It is commonly reported that women with more complex or cooccurring issues are harder to engage with support services. While

this was not the case in Study 2.1, it was the case that women deemed to be at higher risk were less likely to be referred to some services. As such, it is important that research on the predictors of attendance or engagement of pregnant women must also consider the influence of referral rates and the context within which referrals are being made (for e.g., the guiding policies and practices of referrers). To do otherwise would risk misattributing the level of responsibility for non-engagement to pregnant women and people.

The level of distress experienced by women during PCAs suggests that efforts to engage with women about their needs for support that may reduce the risks of harm to their children and may support reunification are significantly impacted by their recent experience of child removal. Compromised engagement during PCAs – demonstrated by women withholding open engagement or disengaging from the assessment process due to heightened distress – may impact the capacity for clinicians and women to set collaborative goals for future support service engagement that may facilitate reunification efforts. Additionally, it appears that women's trust of services is significantly impacted by the experience of having their child(ren) removed from their care, and that this acts as a significant barrier to women's engagement with CPS clinicians during PCAs, and to women's desire to engage with external support services. Research suggests that following the removal of a child by statutory services, mothers experience a worsening of their mental ill-health and drug and alcohol use, and that these experiences pose significant challenges to reunification that is often dependant on positive changes (i.e., a reduction in symptoms or use) in these areas (Broadhurst & Mason, 2020). The findings from Study 2.2 are consistent with these findings and provide an additional consideration, which is the extent to which the experience of child removal holds negative implications for women's engagement with support and statutory services. As the engagement and collaboration between parents and clinicians is understood as a key factor promoting reunification (Jedwab et al., 2018), a breakdown in trust and a reduced willingness of parents to engage with statutory and other services following the removal of their child(ren) poses a significant barrier to reunification efforts. Overall, these findings suggest that preventative efforts

(those that aim to provide support prior to the removal of a child) are of key importance, due to the significant challenges to women's wellbeing and their engagement following child removal. Indeed, such challenges may explain why most children who are removed from the care of their parents on temporary orders are not successfully reunified (AIHW, 2023).

While the current two studies provide insight into the rates and trends of referral provision and uptake, a key limitation of the current research is that it does not provide insight into the nature of the engagement between midwives and pregnant women. The extent to which midwives speak with women about the child protection concerns, their needs, and the nature of support on offer, remains unclear. An important avenue for future research is therefore with midwives, of their experiences of antenatal screening and referrals, as well as pregnant people, of their experiences during antenatal appointments. The data from the current research was extracted from hospital databases and PCA reports that are recorded by clinicians. It is important to consider that the nature of child protection concerns are often contested, and that this presents a limitation to the current research. An analysis of PCA reports alongside accounts from the parents that are subject to them would provide a more balanced analysis and is an avenue for further research. With regards to the PCA reports, Study 2.2 extracted data relating to women's engagement with the assessment, as well as their stated views regarding their engagement with services. However, engagement is dependent upon both parties, and the willingness of parents to engage with further supports is influenced, to an extent, by the ways in which clinicians speak with parents about the child protection concerns and their need for further support. As such, future research should consider in more detail, the role of clinicians with the PCA process. An exploration of the approaches to engagement of clinicians, their perceptions of clients' presentations, and the way that they engage with clients about their concerns and recommendations, would provide a more nuanced, dyadic exploration of the engagement between clinicians and parents during PCAs.

In conclusion, the current research suggests that efforts to engage parents of infants deemed at-risk during pregnancy is falling short of the preventative goals stated within South Australian and

Australian national child protection policy frameworks (Commonwealth of Australia, 2021; Department of Child Protection, 2020). Rather, it appears that early intervention – with dual aims of early detection and prevention – is, in this service context, fulfilling its goal of detection, but not prevention. Many parents of children who were removed within two years of birth were either not offered, or did not engage with, preventative support services. After a child is removed, it appears that the damage to a mother's mental health (as evidenced by high levels of distress), and the damage done to her perception and trust of services, provides a significant challenge during assessments for family reunification. As such, and consistent with state and federal child protection frameworks, more must be done to support parents and to prevent child harm and removal during pregnancy and shortly after birth.

CHAPTER 3. Barriers to and Facilitators of Engagement with Early Intervention Services by Pregnant Women at Risk of Child Removal: A Mixed Methods Systematic Review

Chapter 3 is published as:

Hermes, I., Cibich, M., Hines, S., & Woodyatt, L. (in press). Barriers to and facilitators of engagement with support services by pregnant women at risk of child removal: a mixed methods systematic review. *JBI Evidence Synthesis*

Abstract

Objective: The objective of this review was to synthesize existing qualitative, quantitative, and mixed-methods evidence to identify and examine the barriers to and facilitators of engagement with preventative support services by pregnant people at risk of child removal.

Introduction: Despite a stated shift towards early intervention, prevention, and support, the rate in which children are entering statutory child protection systems remains troublingly high. Of concern is the number of infants being removed at or close to birth. Engaging pregnant people with support during the prenatal period is an important component in reducing rates of child harm and removal, however, many pregnant people either do not receive this support or struggle to engage with it. The barriers and facilitators of pregnant people engaging with support must be identified and addressed for prevention and support efforts to be successful in reducing child harm and removal.

Inclusion criteria: This mixed methods systematic review included qualitative, quantitative, and mixed methods studies of pregnant people at risk of child removal. Studies were included if they reported on barriers to or facilitators of engagement with support services that address risk factors for child removal.

Methods: The systematic review was conducted in accordance with JBI methodology for mixed methods systematic reviews. A range of databases were searched, including MEDLINE (Ovid), ProQuest Central and Social Sciences Premium, PsycINFO (Ovid), and Scopus (Elsevier).

Critical appraisal and data extraction for studies meeting the inclusion criteria were performed by two reviewers using standardized JBI tools. Data synthesis followed the convergent integrated approach to mixed methods systematic reviews.

Results: A total of 10,060 studies were screened for inclusion, of which 23 were included for review. The included studies represented 8248 participants. Most participants were pregnant women, while some were clinicians and prenatal healthcare staff. The included studies were observational, quasi-experimental, randomized control trials, and qualitative studies. Mixed-methods studies contributed quantitative and qualitative components to the review. Methodological quality of the studies was varied. Barriers were reported at the individual and service level, and most related to perceived consequences of engaging with services or the lack of availability and accessibility of services. In addition to more commonly reported issues in help-seeking research, such as stigma and judgement, were those specific to pregnant women at risk of child removal, such as fear of child removal and fear of criminal prosecution. Services were often inaccessible due to unavailability and cost, and inaccessibility was exacerbated by social disadvantage. Trust, safety, encouragement, an absence of stigma and discrimination, and support tailored towards the specific needs of disadvantaged pregnant women were facilitators to engagement at the service level, and an internal sense of need and social support were facilitators to engagement at the individual level.

Conclusions: Significant barriers to engagement with support services exist for pregnant women who are at risk of child removal. Efforts to increase the engagement of pregnant people with support services should be done alongside reconsideration of the policies and practices that dissuade them from engaging with support. More needs to be done to increase the accessibility of support services and to reduce social disadvantage amongst pregnant people who are at risk of child removal.

Review registration: PROSPERO CRD42021254794

Introduction

Child protection systems in Anglophone countries, that are oriented towards a more forensic, investigative, and risk driven approach to child welfare (Kojan, 2012), have been grappling with extensive demand over the last few decades. As a striking example, in the United States, roughly one third of all children will be involved in a child protection investigation before they turn 18 (Human Rights Watch, 2022). The rates of child removal by statutory child protection services across countries such as Canada, the United States, England, Australia, and New Zealand, have likewise increased exponentially over the last few decades (Parton, 2017).

Contemporary child protection services and mandatory reporting legislation throughout Anglophone countries were developed in response to the growing awareness and concern of child abuse in the United States in the 1960s (Kempe et al., 1962). The concern at that time was the intentional physical abuse of children. Hence, the forensic and investigate approaches of child protection systems were adopted to address what was understood as a relatively small cohort of parents responsible for the physical abuse of children (Raz, 2020).

However, the vast majority of all child protection investigations and removals throughout Anglophone countries are now due to issues of neglect or emotional abuse (AIHW, 2024; Department for Education, 2023; U.S. Department of Health and Human Services, 2024). Common under these categories are issues such as poverty, homelessness, parental drug use, gendered violence, and parental mental ill health. Marginalized and racialized families comprise most of those within child protection systems, in part due to their experience of social and financial disadvantage (Raz, 2020). As such, there is now growing concern that, as the definition of child harm has expanded to encapsulate issues that often arise from broader social inequalities and disadvantage, that child protection systems oriented towards investigation and removal are no longer fit for purpose. Instead, it is argued that child protection systems must adopt more social welfare-oriented responses that prioritize care and support to families over the investigation and the removal of children.

Anglophone countries have more recently stated the need to move towards a public health model of child welfare and protection, with increased resourcing of universal health initiatives and targeted prevention services, and involvement of statutory child protection systems as a last resort (Child Welfare Information Gateway, 2019; Council of Australian Governments, 2009; Education Department, 2006; Ministry of Children, Community and Social Services; 2021). Underpinning this approach is the understanding that it is best for children to stay with their families where possible, due to the negative and long-lasting effects of removal on children and families. However, despite this stated shift in alignment of child protection systems, it is still the case that most funding is allocated towards statutory services (Human Rights Watch, 2022). It follows that, for many families, their first point of contact is with statutory services, rather than prevention services, and that rates of child removal remain high (Higgins et al., 2019).

Alongside the stated shift towards a public health model of child protection has been an increased focus on early intervention. While in some instances this can mean providing earlier support to parents, this focus is also responsible for the introduction of prenatal reporting. As such, the increased focus on early intervention has seen a rise in the removal of babies and infants across all Anglophone countries (Lonne, 2009). In the United States and Australia, most removals by statutory services are of babies and infants, and children removed at this age are least likely to be reunified with their families (AIHW, 2024; U.S. Department of Health and Human Services, 2022).

The removal of infants at birth is a deeply distressing experience for parents and healthcare professionals (De Backer et al., 2024; Marsh et al., 2020). For mothers and birthing people, the trauma of this experience often increases the issues and behaviors which were cause for removal, such as mental ill health and substance use, therefore making family reunification more challenging (Broadhurst & Mason, 2019). As removals at birth are made predominantly due to risk of harm – due to issues such as prenatal substance use, parental mental ill health, domestic and family

violence, and homelessness – much can and should be done during pregnancy to support parents to ameliorate these risks and to maintain custody of their children in a safe and secure environment. Most of the support during pregnancy for parents at-risk of child removal is provided by the non-government sector on a voluntary basis, and with variable outcomes with regards to the engagement of pregnant people with this support (Cortis, 2011). Given the benefits of providing earlier support to pregnant people when they are at risk of child removal, the effectiveness of efforts made to provide and to engage pregnant people with support is of key importance.

Parental non-engagement with support services has been reported as a commonly cited concern of child protection clinicians, and as a key factor in decisions of statutory child protection agencies to intervene to remove a child from the care of their family (Broadhurst et al., 2017). This is in part due to concerns that the risk posed to a child has not been reduced or is not being managed via the provision of services. Also contributing to the concern of clinicians, is a common but disputed assessment by clinicians of parental non-engagement demonstrating a parent's lack of insight into their situation, or of their resistance to change (Hermes & Woodyatt, 2023; Mason et al., 2020). An exploration of the factors that influence pregnant people's engagement with support is therefore warranted, given the variability in understandings as to the factors influencing pregnant people's engagement, and given the consequences of these understandings on the decision making of statutory services.

There are varied approaches to the issue of parental engagement in child protection contexts. In some cases, the focus is on the parent factors (e.g., demographics, risk factors, attitudes) that are believed to contribute to parents at risk of child removal being a particularly 'hard to reach' or 'hard to engage' cohort (Tuck, 2012). In other cases, the focus is the identification of service factors (e.g., policies, clinician characteristics) that make support services hard to engage with for families and parents (Leigh et al., 2020). Overarching these lenses, is the question of whether adequate support services exist for parents and pregnant people when they are at risk of child removal, and whether

child protection systems have been successful in implementing their purported changes towards prevention and support.

The aim of this systematic review was to synthesize the barriers and facilitators to engagement with support services by pregnant people who are at risk of child removal. Synthesizing the factors that affect pregnant people's engagement with support services is important within contexts where child protection policies are highlighting the need for more supportive, preventative approaches to child welfare, but where many families are still not receiving support before encountering statutory child protection services.

A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews, and JBI Evidence Synthesis was conducted and no current or in-progress systematic reviews on this specific topic were identified. A recent review published by Barnett and colleagues (Barnett et al., 2021) examined the barriers to and facilitators of treatment amongst mothers with substance-use disorders, however, this review was confined to studies in the United States, considered both pregnant and parenting people, and did not consider the range of preventative support services relevant to child-protection concerns (e.g., mental health treatments or services for intimate partner violence). This review aimed to broaden the scope of analysis beyond the United States, focus solely on pregnant people, and expand the scope of treatment services to identify and synthesize barriers and facilitators across a range of support services.

The objective of this review was to synthesize existing qualitative, quantitative, and mixed methods evidence to identify and examine the barriers to and facilitators of engagement of pregnant people at risk of child removal in preventative support services.

Review Question

What are the barriers to and facilitators of engagement with support services by pregnant people at risk of child removal?

Inclusion Criteria

Participants

This review considered quantitative, qualitative, and mixed methods studies that included pregnant people with risk factors for child removal by statutory child-protection agencies. This included pregnant people of all ages, with current alcohol and other drug, family violence, or mental health concerns, as these are the most-cited risk factors involved in child-protection investigations and removals (Australian Centre for Child Protection). The review also considered quantitative, qualitative, and mixed methods studies that included healthcare workers that are employed to work with pregnant people with risk factors for child removal. This included doctors, nurses, midwives, mental health practitioners, and social workers. The inclusion of healthcare workers deviated from the protocol that listed only pregnant people as participants. While pregnant people at risk of child removal remain the population of interest, the inclusion of healthcare workers as participants allowed for a more thorough synthesis of the phenomena of interest, and sought to include those who design and deliver services to pregnant people (Hermes et al., 2022). Studies involving postnatal participants were excluded if they related to experiences during the postnatal period, but were included if they involved postnatal people reporting on their experiences during pregnancy. This deviated from the protocol that listed only pregnant people as participants. Again, this deviation allowed for a more thorough synthesis of the phenomena of interest, whilst maintaining consistency with the protocol regarding the population of interest being pregnant people at risk of child removal.

Phenomena of Interest

We considered studies that investigated the barriers to and/or facilitators of engagement with preventative support services. Barriers and facilitators (or enablers) are individual, psychological, social, or structural factors or characteristics that either impede or support engagement with support services. Engagement is classified as initial attendance and/or continued attendance at support services, or attendance at and/or completion of treatment programs.

Context

This review considered studies that included preventative support services that address risk factors for child removal. Services are considered preventative services when they provide support and treatment for the issues that constitute risk factors for child removal. In the context of this review, these are services that are provided and utilized during pregnancy. These include alcohol and other drug treatment services, services addressing intimate partner and family violence, mental health treatment services, parenting programs (aimed at capacity building for pregnant people), intensive case-management, and housing and social work services.

Types of Studies

Quantitative, qualitative, and mixed methods studies were considered for inclusion. Quantitative studies or components that included analytical or descriptive case study and observational designs were considered for inclusion, as were qualitative studies or components such as phenomenology, grounded theory, ethnography, qualitative description, and action research. Experimental studies were considered if they tested the effects of an intervention that acts as a facilitator to engagement with services. Only studies in English were included due to resourcing constraints, however, studies from all languages were included in the search strategy in order to report on exclusions based on language criteria.

Method

This review was conducted in accordance with the JBI methodology for mixed methods systematic reviews (Lizarondo et al., 2020). This review was registered with PROSPERO (CRD42021254794) and was conducted in accordance with an a priori protocol (Hermes et al., 2022).

Search strategy

The search strategy aimed to locate both published and unpublished studies. A three-step search strategy was utilized in this review. First, an initial limited search of PsycINFO (Ovid) was undertaken followed by analysis of the text words contained in the title and abstract and the index

terms used to describe the articles. The search strategy, including all identified keywords and index terms, was adapted for each included information source and a second search was undertaken in October 2022 and updated in September 2023. The full search strategies are provided in Appendix A. Finally, the reference list of all studies selected for critical appraisal were screened for additional studies.

Studies published in any language were included in the search, however, as per the protocol (Hermes et al., 2022), only studies published in English were included for extraction due to resourcing constraints. One study was excluded at the stage of full text review as it was not written in English (see Appendix B). Studies published from the year 2000 onwards were included in the search, as it was after this time that child protection frameworks began to highlight the need for more preventative support during pregnancy, and child protection systems adopted an early intervention approach that saw the introduction of prenatal reporting and the increased practice of removal of children at birth (Lonne, 2009).

The databases searched included MEDLINE (Ovid), ProQuest Central and Social Sciences Premium, PsycINFO (Ovid), and Scopus (Elsevier). ProQuest Dissertations and Theses was searched for unpublished studies and gray literature. This search strategy deviated from the protocol (Hermes et al., 2022) that also listed Informit, EBSCO Open Dissertations and Open Access Theses and Dissertations as databases for inclusion in the search. These databases were not included in the database search as Informit and EBSCO Open Dissertations did not allow for bulk download of citations, and Open Access Theses and Dissertations did not allow for advanced searching (as per message on their website dated October 3, 2022).

The first author conducted a search in Informit and EBSCO Open Dissertations in December 2023 using adapted search terms from the search strategy (see Appendix A), and screened articles manually for any additional studies. This was done concurrent to the screening of additional studies from the reference list of all studies included for critical appraisal, which was conducted in Google Scholar in December 2023.

Study selection

Following the search, all identified citations were collated and uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and duplicates removed. Two independent reviewers conducted a pilot test, whereby the first 100 study titles and abstracts were independently screened against the inclusion criteria to ensure congruency in judgement. Following the pilot test, the remaining titles and abstracts were screened by the same 2 independent reviewers for assessment against the inclusion criteria for the review. Potentially relevant studies were retrieved in full, and their citation details imported into the JBI System for the Unified Management, Assessment and Review of Information (JBI SUMARI; JBI, Adelaide, Australia; Munn et al., 2019). Full-text studies that did not meet the inclusion criteria were excluded and reasons for their exclusion are provided in Appendix B. Any disagreements that arose between the reviewers were resolved through discussion.

Assessment of methodological quality

Eligible studies were assessed by 2 independent reviewers for methodological validity prior to inclusion in the review. Quantitative studies (and quantitative components of mixed methods studies) were assessed using standardized critical appraisal instruments from JBI SUMARI for randomized controlled trials, quasi-experimental, and analytical cross-sectional studies (Tufanaru et al., 2020). Qualitative studies (and the qualitative components of mixed methods studies) were assessed using standardized critical appraisal instruments from JBI SUMARI for qualitative studies (Lockwood & Porritt, 2015). For mixed-methods studies, the quantitative and qualitative components were assessed separately using the relevant critical appraisal instrument from JBI SUMARI.

One author was contacted to request missing or additional data for clarification; however, no response was received. Any disagreements that arose between the reviewers was resolved through discussion. As per the protocol (Hermes et al., 2022), data from all studies, regardless of the results of their methodological quality, were extracted and synthesized. The impact of methodological

quality was considered when developing and reporting synthesized findings, conclusions, and recommendations, and is reported in narrative form throughout these sections of the review.

Data extraction

Quantitative and qualitative data were extracted from studies included in the review by 2 independent reviewers using the standardized JBI data extraction tool in JBI SUMARI (Lockwood & Porritt, 2015). The data extracted included specific details about the populations, study methods, phenomena of interest, context, and outcomes of relevance to the review question. Specifically, quantitative data were composed of data-based outcomes of descriptive and/or inferential statistical tests. In addition, qualitative data were composed of verbatim themes or subthemes with corresponding illustrations and were rated according to JBI levels of credibility (Lockwood & Porritt, 2015). These levels were: unequivocal, credible, and not supported.

Any disagreements that arose between the reviewers was resolved through discussion, and as there was agreement on data extracted, the third reviewer was not required. Authors of one paper were contacted to request additional information; however, a response was not received.

Data transformation

The quantitative data were then converted into "qualitized" data by 2 independent reviewers. This involved transformation into textual descriptions and narrative interpretation of the quantitative results in a way that answers the review question. For Analytical Cross-Sectional studies, this involved formulating textual descriptions of items listed within quantitative surveys and the extent to which these were endorsed by participants. For Analytical Cross-Sectional studies, this also involved formulating textual descriptions that summarized the quantitative findings in a way that was consistent with how key findings were qualitatively reported and concluded on within each study. For Randomized Controlled Trials and Quasi-Experimental studies, this involved formulating textual descriptions of the overall effectiveness of the tested intervention. This, again, was formulated consistent with the way that key findings were qualitatively reported and concluded on within each study.

Data synthesis and integration

This review follows a convergent integrated approach according to the JBI methodology for mixed methods systematic reviews using JBI SUMARI (Lizarondo et al., 2020). This involved assembling the qualitized data with the qualitative data. Assembled data were categorized and pooled together into syntheses based on similarity in meaning to produce a set of integrated findings.

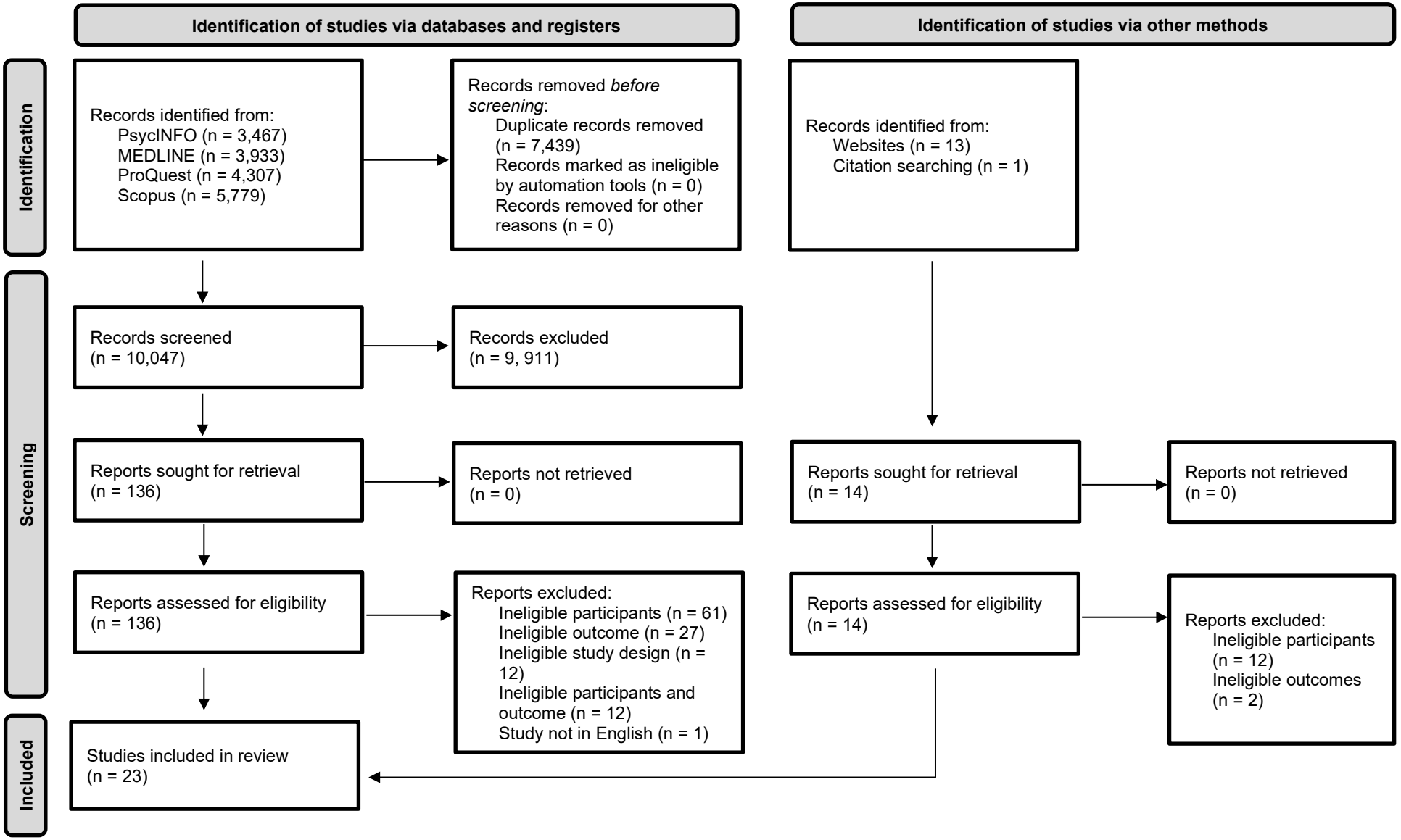
Results

Study inclusion

There were 10,061 records identified by the search strategy (10,047 identified from databases, 13 from a manual search of EBSCO Open Dissertations, and 1 from reference lists) after removing duplicate records. After a review of the titles and abstracts, 9,925 were deemed not relevant and were excluded based on the exclusion criteria set out in the review protocol (Hermes et al., 2022). Full text publications were retrieved for the remaining 163 reports. These reports were reviewed against the eligibility criteria, and a further 113 were excluded, with reasons for exclusion detailed in Appendix B. The majority of reports excluded at full text review were studies of perinatal rather than pregnant participants, and studies that reported predictors of engagement, rather than barriers and facilitators. This left 23 reports for inclusion in the review (Figure 1), of which; 10 were quantitative studies (observational, quasi-experimental and experimental), 11 were qualitative studies, and 2 were mixed-methods studies. The 2 mixed-methods studies contributed both qualitative and quantitative data to the review. An overview of the included reports and studies is shown in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Page et al., 2021; Figure 1).

Figure 3.1

PRISMA Flow Diagram Displaying Search Results, Study Selection, and Inclusion Process.



Methodological Quality

Randomized Controlled Trials

Of the three randomized controlled trials in this review, participants, facilitators, and assessors were not blind to treatment assignment as the treatment group received voucher incentives for all appointments attended. The methods for randomization were not clear in the studies by Jones et al. (2000) and Svikis et al. (2007). The studies by Jones et al. (2000) and Sacks et al. (2015) did not include a follow-up measure, however, sustained engagement beyond the provision of vouchers during the service provision period was not an outcome of interest in these studies. Most other appraisal criteria were met by the studies.

Table 3.1

Critical Appraisal Results for Randomized Controlled Trials

Citation	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7	Q 8	Q 9	Q 10	Q 11	Q 12	Q 13
Jones et al. (2000)	U	U	Y	N	N	N	Y	N	Y	Y	Y	Y	Y
Sacks et al. (2015)	Y	N	Y	N	N	N	N	N	U	Y	Y	Y	Y
Svikis et al (2007)	U	N	Y	N	N	N	U	Y	Y	Y	Y	Y	Y
%	33	0	100	0	0	0	33.3	33.3	66.6	100	100	100	100

Y, yes; N, no; NA, not applicable, U, unclear
JBI critical appraisal checklist for Randomized Controlled Trials
Q1. Was true randomization used for assignment of participants to treatment groups?
Q2. Was allocation to treatment groups concealed?
Q3. Were treatment groups similar at the baseline?
Q4. Were participants blind to treatment assignment?
Q5. Were those delivering treatment blind to treatment assignment?
Q6. Were outcomes assessors blind to treatment assignment?
Q7. Were treatments groups treated identically other than the intervention of interest?
Q8. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?
Q9. Were participants analysed in the groups to which they were randomized?
Q10. Were outcomes measured in the same way for treatment groups?
Q11. Were outcomes measured in a reliable way?
Q12. Was appropriate statistical analysis used?
Q13. Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?

Quazi-Experimental Studies

The one quasi-experimental study in this review did not use a control group, did not include any pre-intervention measures, and did not report on the measures used at follow-up. The authors of this study were contacted to provide further clarity, but a response was not received.

Table 3.2

Critical Appraisal Results for Quasi-experimental Studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Shenai et al. (2019)	Y	Y	Y	N	N	N	Y	N	Y
%	100	100	100	0	0	0	100	0	100

Y, yes; N, no; NA, not applicable, U, unclear
JBI critical appraisal checklist for quasi-experimental studies
Q1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e., there is no confusion about which variable comes first)?
Q2. Were the participants included in any comparisons similar?
Q3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?
Q4. Was there a control group?
Q5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?
Q6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?
Q7. Were the outcomes of participants included in any comparisons measured in the same way?
Q8. Were outcomes measured in a reliable way?
Q9. Was appropriate statistical analysis used?

Analytical Cross-Sectional Studies

Most of the nine analytical cross-sectional studies included in the final synthesis met all applicable appraisal criteria. Questions 5 and 6 that relate to confounding factors are not relevant to cross-sectional studies using survey designs to measure perceived barriers and/or facilitators. For the two studies by Salameh et al. (2019; 2021), the authors categorized responses to their measure in a way that obscured results. For example, ‘confidentiality concerns’ were categorized under stigma, and ‘fear of being medicated/committed’ was categorized under opposition to treatment. For the study by Shenai et al. (2019), no information was provided about the measures or statistical

analysis used. The authors were emailed and asked to provide further clarity, but no response was received.

Table 3.3

Critical Appraisal Scores for Analytical Cross-sectional Studies

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Ayres et al. (2019)	Y	Y	Y	Y	N/A	N/A	Y	Y
Bedrick et al. (2020)	Y	Y	Y	Y	N/A	N/A	Y	Y
Kelley et al. (2022)	Y	Y	Y	Y	N/A	N/A	Y	Y
Kopelman et al. (2008)	Y	Y	Y	Y	N/A	N/A	Y	Y
Logan et al. (2003)	Y	Y	Y	Y	N/A	N/A	Y	Y
Morain et al. (2022)	Y	Y	Y	Y	N/A	N/A	Y	Y
Salameh et al. (2019)	Y	Y	Y	Y	N/A	N/A	N	Y
Salameh et al. (2021)	Y	Y	Y	Y	N/A	N/A	N	Y
Shenai et al. (2019)	Y	Y	U	U	N/A	N/A	U	U
%	100	100	87.5	87.5	0	0	62.5	100

Y, yes; N, no; NA, not applicable, U, unclear
JBI critical appraisal checklist for analytical cross-sectional studies
Q1. Were the criteria for inclusion in the sample clearly defined?
Q2. Were the study subjects and the setting described in detail?
Q3. Was the exposure measured in a valid and reliable way?
Q4. Were objective, standard criteria used for measurement of the condition?
Q5. Were confounding factors identified?
Q6. Were strategies to deal with confounding factors stated?
Q7. Were the outcomes measured in a valid and reliable way?
Q8. Was appropriate statistical analysis used

Qualitative Studies

None of the nine qualitative studies included in the final synthesis met all appraisal criteria. Most of the included qualitative studies did not include a stated philosophical perspective, which made any congruence between philosophical perspectives and research methodologies unclear. Very few studies included statements that located the researchers theoretically, and likewise, that

addressed the impact of the researcher on the research and vice versa. The study by Jackson & Shannon (2012) scored particularly low and notably provided no participant quotes or data to illustrate their findings.

Table 3.4

Critical Appraisal Results for Qualitative Research

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Abrahams et al. (2023)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Chan & Moriarty (2010)	Y	Y	Y	U	U	N	N	Y	Y	Y
Curran, (2022)	U	Y	Y	Y	Y	N	U	Y	Y	Y
Hasselle et al. (2020)	Y	Y	Y	Y	Y	N	N	Y	U	Y
Jackson & Shannon (2012)	U	U	U	U	U	N	N	N	Y	Y
Jessup et al. (2003)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kemet et al. (2022)	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Kopelman et al. (2008)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Kruk & Banga (2011)	Y	Y	Y	Y	Y	Y	U	Y	U	Y
Lefebvre et al. (2010)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Oni et al. (2022)	U	Y	Y	Y	Y	N	U	Y	Y	Y
Sacks et al. (2015)	U	Y	Y	Y	Y	N	N	Y	Y	Y
Williams et al. (2023)	U	Y	Y	Y	Y	N	N	Y	Y	Y
%	30.8	92.3	92.3	84.6	84.6	15.4	0	92.3	84.6	100

Y, yes; N, no; NA, not applicable, U, unclear
JBI critical appraisal checklist for qualitative research
Q1. Is there congruity between the stated philosophical perspective and the research methodology?
Q2. Is there congruity between the research methodology and the research question or objectives?
Q3. Is there congruity between the research methodology and the methods used to collect data?
Q4. Is there congruity between the research methodology and the representation and analysis of data?
Q5. Is there congruity between the research methodology and the interpretation of results?
Q6. Is there a statement locating the researcher culturally or theoretically?
Q7. Is the influence of the researcher on the research, and vice-versa, addressed?
Q8. Are participants, and their voices, adequately represented?

Q9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
Q10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Characteristics of Included Studies

The 23 included studies in this systematic review included 10 quantitative (Ayres et al., 2019; Bedrick et al., 2020; Jones et al., 2000; Kelley et al., 2022; Logan et al., 2003; Morain et al., 2023; Salameh et al., 2019; Salameh et al., 2021; Shenai et al., 2019; Svikis et al., 2007), 11 qualitative (Abrahams et al., 2023; Chan & Moriarty, 2010; Curran, 2022; Hasselle et al., 2020; Jackson & Shannon, 2012; Jessup et al., 2003; Kemet et al., 2022; Kruk & Banga, 2011; Lefebvre et al., 2010; Oni et al., 2022; Williams et al., 2023), and 2 mixed-methods studies (Kopelman et al., 2008; Sacks et al., 2015). The 2 mixed-methods studies both contributed quantitative and qualitative data to the review. The quantitative studies included Randomized Controlled Trials (RCTs; $n = 3$; Jones et al., 2000; Sacks et al., 2015; Svikis et al., 2007), quasi-experimental studies ($n = 1$; Shenai et al., 2019),[37] and analytical cross-sectional studies ($n = 8$; Salameh et al., 2019, 2021; Ayres et al., 2019; Bedrick et al., 2020; Kelley et al., 2022; Logan et al., 2003; Morain et al., 2023; Shenai et al., 2019). No quantitative studies that utilized a descriptive design met criteria for inclusion for the review. The qualitative studies included in the review did not state their study type beyond that of a qualitative design.

A total of 48 clinicians and 336 pregnant or parenting women were included in the qualitative studies. The number of participants, all pregnant women, in the RCTs and quasi-experimental studies ranged from between 10 and 93. The analytical cross-sectional studies surveyed pregnant women and clinicians, and the number of participants surveyed ranged from 138-5520. A total of 138 clinicians and 7726 pregnant women were included in the quantitative studies. The total participants across all studies were 186 clinicians and 8062 pregnant and parenting women, for a combined total of 8248 participants.

The included studies were conducted on a range of participant groups, including pregnant or parenting women experiencing mental health (10 studies; Hasselle et al., 2020; Kopelman et al.,

2008; Lefebvre, 2010; Logan et al., 2003; Kelley et al., 2022; Kemet et al., 2022; Sacks et al., 2015; Salameh et al, 2019, 2021; Shenai et al., 2019), alcohol and other drug (15 studies; Abrahams et al., 2023; Ayres et al., 2019; Bedrick et al., 2020; Chan & Moriarty, 2012; Curran, 2022; Jackson & Shannon, 2012; Jessup et al., 2003; Jones et al., 2000; Kruk & Banga, 2011; Morain et al., 2023; Oni et al., 2022; Salameh et al, 2019, 2021; Shenai et al., 2019; Svikis et al., 2007), domestic and family violence issues (2 studies; Hasselle et al., 2020; Williams et al., 2023), and clinicians working in prenatal health (3 studies; Ayres et a;., 2019; Chan & Moriarty, 2010; Hasselle et al., 2020) and drug and alcohol services (1 study; Chan & Moriarty, 2010).

Sixteen studies were conducted in America (Abrahams et al., 2023; Bedrick et al., 2020; Curran, 2022; Hasselle et al., 2020; Jackson & Shannon, 2012; Jones et al., 2000; Kelley et al., 2022; Kemet et al., 2022; Kopelman et al., 2008; Logan et al., 2003; Morain et al., 2023; Sacks et al., 2015; Salameh et al, 2019, 2021; Shenai et al., 2019; Svikis et al., 2007), 2 in Australia (Ayres et al., 2019; Oni et al., 2022), 2 in Canada (Kruk & Banga, 2011; Jessup et al., 2003), 2 in South Africa (Lefebvre, 2010; Williams et al., 2023), and 1 in New Zealand (Chan & Moriarty, 2012). Studies were conducted in rural and metropolitan locations, in states and countries with different child protection policies, and in states within America with different laws on prenatal drug use. With the exception of South Africa, studies were conducted in countries that adopt a ‘child protection’ orientation to child welfare. Studies were conducted in prenatal health, drug and alcohol, mental health, and community services, as well as within the general community.

The qualitative studies, or qualitative components of mixed-methods studies, conducted focus groups (n = 3; Lefebvre et al., 2010; Kemet et al., 2022; Kopelman et al., 2008) and open-ended or semi-structured interviews (n = 10; Abrahams et al., 2023; Chan & Moriarty, 2010; Curran, 2022; Hasselle et al., 2020; Jackson & Shannon, 2012; Jessup et al., 2003; Kruk & Banga, 2011; Oni et al., 2022; Sacks et al., 2015; Williams et al., 2023) with pregnant or parenting women and clinicians. The RCT studies tested the effect of low-level monetary vouchers on pregnant women’s engagement (Jones et al., 2000; Sacks et al., 2015; Svikis et al., 2007). The quasi-experimental

study tested the effect of an information intervention on pregnant women's intention to seek further support during pregnancy (Shenai et al., 2019). Three analytical cross-sectional studies used a simulated patient paradigm to test the availability and accessibility local mental health and alcohol and other drug services that serviced pregnant people (Bedrick et al., 2020; Kelley et al., 2022; Morain et al., 2023). The remaining 6 analytical cross-sectional studies used questionnaires to survey the beliefs of clinicians (n = 1; Logan, 2003) of the barriers to service engagement experienced by pregnant women, and the experiences of women (n = 5; Ayres et al., 2019; Kopelman et al., 2008; Salameh et al., 2019, 2021; Shenai et al., 2019) of the barriers and facilitators they experienced engaging with support services during their pregnancies.

Review Findings

Qualitative Transformation of Quantitative Findings

Quantitative data from 12 studies (10 quantitative and 2 mixed-methods studies) produced 56 findings which were transformed into qualitative statements that summarized the study findings. Findings from experimental and quasi-experimental studies that tested the effect of facilitators to engagement, and observational designs that used simulated patient paradigms to test the availability of services, were transformed into 1-2 qualitative statements per study that summarized these findings (see Tables 3.5-3.7).

Table 3.5

Qualitative Transformation of Randomized Controlled Trials

Study	Findings	Transformed Statement
Jones et al. (2000)	For Abstinence Treatment (AT) subjects, no significant difference was found in attendance between incentive and control conditions.	Low-level voucher incentive not a facilitator to engagement
Sacks et al. (2015)	No significant differences were observed in the incentive and non-incentive groups on number of mental health visits.	Voucher incentive not a facilitator to engagement

Svikis et al. (2007)	No significant differences were found between voucher incentive and control conditions on residential treatment retention and length of stay.	Voucher incentive not a facilitator to engagement
Svikis et al. (2007)	Among those that did not drop out against medical advice, those in the voucher condition attended on average 1.4 more treatment days that those in the control condition.	Voucher incentive a facilitator to engagement amongst those already engaging

Table 3.6

Qualitative Transformation of Quasi-experimental Studies

Study	Findings	Transformed Statement
Shenai et al. (2019)	All participants reported that the information session helped influence their decision to further pursue treatment or indicated that they were already in treatment (23%).	Information session about PTSD and substance use a facilitator to engagement

Table 3.7

Qualitative Transformation of Analytical Cross-sectional Studies

Study	Findings	Transformed Statement
Bedrick et al. (2000)	42% of buprenorphine providers were unreachable, and a further 60% were not accepting pregnant patients. 14% of opioid treatment programs were unreachable, and a further 20% were not accepting pregnant patients. Only 13% of buprenorphine providers	Access to treatment for opioid use is challenging, and access is limited in rural areas.

	and 5% of opioid treatment programs were in rural areas.	
Kelley et al. (2022)	Of the 34 clinics that were called; 53% were familiar with buprenorphine, 27% had buprenorphine treatment available, 18% offered buprenorphine treatment, and 86% offered a referral to a clinic offering buprenorphine treatment of which 47% offered buprenorphine treatment. Request for referral failed to achieve an appointment more than 60% of the time.	Access to opioid use medication treatment (buprenorphine) for pregnant individuals with opioid use disorder is limited.
Morain et al. (2022)	50% of clinics called were either inaccessible or had access barriers and 44.44% did not accept Medicaid.	Challenges in the accessibility of Perinatal Mood and Anxiety Disorder (PMAD) treatment is a barrier to engagement.

The studies that used questionnaire survey designs (Ayres et al., 2019; Logan et al., 2003; Kopelman, 2008; Salameh et al., 2019, 2021; Shenai et al., 2019) included survey items listing barriers and facilitators that were identified by researchers or identified by researchers with input from prenatal healthcare staff. As such, the findings from these studies do not represent barriers and facilitators that were identified by participants, and the outcome of interest is rather the extent to which participants endorsed the survey items they were presented with. The surveys used in these studies ranged from 11 to 22 item scales, and varied in the reporting of results; one reported mean endorsement on a Likert scale (Logan et al., 2003), four reported the percentage of participants who endorsed each item (Logan et al., 2003; Salameh et al., 2019, 2021, Shenai et al., 2019), and one reported the endorsement of barriers and facilitators between the majority of participants who did and did not attend an appointment with support services during pregnancy, and whether the difference between groups was statistically significant (Ayres, 2019). To synthesize these findings

whilst representing the extent to which participants agreed with them, the level of participant endorsement of the items is included within the meta-synthesis tables (Tables 3.8-3.14).

Meta-Synthesis of all Findings

The meta-synthesis of 23 included studies for this review generated 7 synthesized findings that were developed from 25 categories and 100 findings (56 quantitative and 44 qualitative). Qualitative findings were included in the meta-synthesis if they were rated credible or unequivocal. 4 qualitative findings that were rated as unsupported were not included (Jackson & Shannon, 2012). This section presents the synthesized findings and their included categories (Tables 3.8-3.14), along with a summary of the categories and key illustrations. Details of the qualitative study findings with corresponding illustrations can be found in Appendix C.

Table 3.8

Synthesized Finding 1: Service Delivery Factors Cause Psychological Barriers to Pregnant Women's Engagement.

Findings	Categories
Qualitative	Stigma, judgement, and racism
Stigma and judgement from providers (U)	
Stigma from healthcare providers (U)	
Stigma and judgement from service providers (U)	
Healthcare provider related stigma (U)	
Stigma (U)	
Stigma (U)	
Stigma and discrimination (U)	
Racism and White supremacy (U)	
Social Stigma (C)	

Quantitative '*What other people think*': *M* = 1.52 on 4-point Likert scale, ranked 11th of 11 '*Stigma*': endorsed by 22.5% of White participants, ranked 3rd of 5 '*Stigma*': endorsed by 26.6% of non-White participants, ranked 3rd of 5 '*Social stigma/client embarrassed or shameful to admitting to problem'*: endorsed by 11.6% of participants (healthcare workers), ranked 7th of 11 '*Stigma*': endorsed by 27.3% of participants in 2008-10 and 19.3% in 2011-14, ranked 3rd of 5	
Qualitative Fear of child removal by CPS (U) Fear of child removal (U) Fear of losing child custody (U) Negative impact of CPS involvement (U) Fear of child custody loss and prosecution (U) Fear of helping systems (U) Fear of consequences of disclosure (U) Quantitative *'Legal action/prosecution/fear of social services'*: endorsed by 6.5% of participants (clinicians), ranked 10th of 11	Fear of child protection service involvement, child removal, and criminal prosecution

Qualitative Previous negative experiences with mental health care providers (U) Not feeling heard/understood by providers (U) Inadequate support from service facilities (U) Perceptions of (un)helpfulness of treatment (C) Belief that counselling can't help (U) Quantitative *'Fear of treatment'*: endorsed by 12.9% of participants, ranked 6th of 8 *'Previous bad experience'*: *M* = 1.88 on 4-point Likert scale, ranked 5th of 10 *'Opposition to treatment'*: endorsed by 44% of White participants, ranked 2nd of 5 *'Opposition to treatment'*: endorsed by 39.8% of non-White participants, ranked 1st of 5 *'Opposition to treatment'*: endorsed by 44.8% of participants in 2008-10 and 41.6% in 2011-14, ranked 2nd of 5	Negative beliefs and perceptions about treatment and treatment services
Qualitative Wanting to avoid psychiatric medication (U) Apprehension about methadone being addictive (U) Perceived limited treatment options and their side effects (U)	Medication concerns – not wanting to be medicated, distrust of medication providers

	Lack of trust in providers prescribing medication (U) Financial motivations of providers and prescribers (U) Uncertainty about opioid replacement therapy (C)
Qualitative	Confidentiality concerns and distrust
	Concerns about confidentiality (U) Mistrust of services (C)
Quantitative	
	'*Privacy concerns'*: endorsed by 3.2% of participants, ranked 7th of 8 '*Confidentiality/privacy/fear issue will become public*': endorsed by: 10.9% of participants (clinicians), ranked 8th of 11

U, unequivocal. C, credible.

Synthesized Finding 1: Service Delivery Factors Cause Psychological Barriers to Pregnant Women's Engagement

This synthesized finding includes factors that created hesitancy among pregnant women to engage with services, and that affected their decision and motivation to engage. These factors were often perceptions, worries, or fears regarding their experiences (anticipated or actual) of engaging with services, and occurred independent of women's perceptions of their need for support, and independent to the accessibility and/or availability of services. At the service level, these psychological barriers were primarily concerned with women's poor treatment by services and the potential consequences of their engagement, while including – and sometimes influencing –

negative perceptions and beliefs about services and the intentions of clinicians. This synthesized finding was created from 5 categories and 42 findings (Table 3.8).

Category 1.1: Stigma, Judgment and Racism

Category 1.1 illustrates how stigma, judgement, and racism negatively impact the engagement of pregnant women with support services. While some participants reported the anticipation of being stigmatized or negatively judged caused them to hide or to not disclose their issues or needs to services, most participants reported being stigmatized, judged, and/or subjected to racism during an encounter with services, which in turn led to a breakdown of engagement.

> *"…there where some doctors who stuck their nose up at me… pretty much calling me a bad parent because I was using [using drugs]… I stopped, I stopped seeing them"* (Oni et al., 2022, pg. 179).

Clinicians highlighted the confrontational approach that they took with women when discussing stigmatized issues, such as drug use during pregnancy.

> *"So you have to interrogate the hell out of them. Because normally what they tell you is not what it seems. They will not tell you that they drank last night but you can smell it so I'm like no but you did drink… I do not let up. I'm relentless. Many other people will just like leave it. I'm relentless. I will ask you. If you go into labor now and that water broke and it smells like alcohol do you know your baby can die"* (Williams et al., 2023, pg. 4)*."*

For women of color, racism compounded their experience of stigma and judgement.

> *"My use of opioids and also my color. Because she said that I was careless because using of opioids during pregnancy isn't safe. And yea… I'm a Black person, and these people, some of them was racist. They didn't care about how you are doing; they didn't even want to help"* (Curran, 2022, pg. 109).

In addition to experiencing more overt racism by clinicians within support services, one participant also described the dominance of Whiteness within the field of psychiatry, and how this

impacts the care that Black women receive, regardless of the individual practices and race of clinicians.

> *There are a lot of Black mental health professionals out there. There's a lot more than you think, but they so go into this white supremacy realm that they even stop caring about our Black mental health. I just don't feel like Black, um, mental health is a concern in a white supremacy pyramid"* (Kemet et al., 2022, pg. 783).

The five quantitative findings within this category demonstrate variability in the extent to which stigma operates as a barrier (see Table 8; Kopelman et al., 2008; Logan et al., 2003; Salameh et al., 2019, 2021). Contrary to qualitative findings from pregnant women who reported experiencing stigma from within services, all quantitative items measured social stigma; for example, 'what other people think' (Kopelman et al., 2008) or 'social stigma/client too embarrassed or shameful to admitting to problem' (Logan et al., 2003). In Salameh et al. (2019, 2021) stigma was measured with "four items; fear of neighbors' negative opinion, fear of negative effects on job, confidentiality concerns, and did not want others to find out" (pg. 76, pg. 1009), which appeared to measure not only social stigma, but also concerns about confidentiality and resulting consequences.

Category 1.2: Fear of Child Protection Service Involvement, Child Removal, and Criminal Prosecution

Category 1.1 demonstrates how the threat of child apprehension and punitive intervention acts as a barrier to engagement with support services for pregnant women at-risk of child removal. Participants also highlighted 3 interrelated fears; (1) women reported concern that engaging with services could lead to unwanted intervention from child protection services – the stress of which they reported may impede their progress towards recovery and change (Oni et al., 2022), (2) could lead to their children being removed from their care (Chan & Moriarty, 2010; Curran, 2022; Haselle et al., 2020, Jessup et al., 2003, Oni et al., 2022), and (3) could lead to criminal prosecution and incarceration in American states that criminalize prenatal drug use (Jessup et al., 2003).

Women reported avoiding support services and prenatal care altogether and limiting their engagement and disclosure with services to avoid detection by child protection services and the criminal legal system.

> *"So, I think it's scary because my husband didn't really do anything to my kids it was always to me and that's where of course I didn't want to get involved with things because I was afraid that my children would be took from me because of some of the things that would happen privately. So, that's where I think a lot of fear and that's the reason a lot of women do not participate in things that could be a lot more beneficial to them"* (Hasselle et al., 2020, pg. 296).

In America, state laws that criminalize drug use during pregnancy compound these fears and, along with state-based child protection policies, act as location specific concerns for pregnant women who use substances.

> *"…with a dirty tox screen, it could have been a lot more severe. I could have… been taken to court. I could have been arrested if they wanted to"* (Jessup et al., 2003, pg. 291).
>
> *"If you have another [drug exposed] child within a three-year period, even if you're staying clean and sober, your child will be taken from you, and can automatically be placed for adoption… [it is a] state policy... I wanted to come here [to the treatment program] and there wasn't an opening… I didn't go to my doctor at that time [in pregnancy] because of my name being on that list… I was really scared of that… that's what kept me from going to prenatal care"* (Jessup et al., 2003, pg. 292).

Despite the frequency at which this issue was reported within qualitative research (7 unequivocal findings; see Table 8), only one quantitative finding reported on fear of child removal and prosecution as a barrier for pregnant women (Logan et al., 2003). In that study, that was completed by prenatal healthcare workers, only 6.5% of healthcare workers endorsed this as a barrier for pregnant women. This demonstrates some inconsistency between the beliefs and

experiences of clinicians and pregnant women, and across quantitative and qualitative methodologies, of the extent that this fear operates as a barrier for pregnant women.

Category 1.3: Negative Beliefs and Perceptions About Treatment and Treatment Services

Category 1.3 highlights how negative beliefs about treatment and support services, as well as perceptions about the helpfulness of services, impacts engagement with services by pregnant women. Participants highlighted how previous negative experiences impacted their perceptions of treatment and their current or future motivation to engage with services.

> *"I get really annoyed with it. When I was a teenager I did lots of counselling, and I would see like four different people in the same day, and it just drove me nuts"* (Sacks et al., 2015, pg. 489).

For some participants, treatment services for substance use were "construed as two- or three-day physical detoxification, wherein no other services were provided" (Jessup et al., 2003, pg. 293), and were therefore not perceived to be of major assistance to them during pregnancy. For some participants who experienced intimate partner violence, they did not believe that mental health counselling would help them "as it would not be able to change their dependence on their abusive partners" (Abrahams et al., 2023, pg. 7), perhaps highlighting that the services that they felt would be most likely to meet their needs (for e.g., financial or housing support) were less available to them.

Three of the four quantitative findings in this category measured 'opposition to treatment' with four items; 'didn't think treatment was needed at the time', 'could handle problems without treatment', 'didn't think treatment would help', and 'fear of being committed/medicated' (Salameh et al., 2019, 2021). These findings are presented in this category to be consistent with their presentation by the study authors (as 'opposition to treatment'), however, there is variability of concepts within this measure, and some of these items are relevant to Category 1.4 regarding medication concerns, and Category 2.2 regarding the need for support.

Category 1.4: Medication Concerns – Not Wanting to be Medicated, Distrust of Medication Providers

Category 1.4 shows how pregnant women's concerns with being medicated, as well as the distrust that women have for medication prescribers, impacts their engagement with services. Not wanting to be medicated, or being untrusting of medication prescribers, was reported by participants with mental health concerns regarding psychotropic medications (Kemet et al., 2022; Kopelman et al., 2008; Sacks et al., 2015), and was reported by participants who use substances with regards to opioid replacement therapy (Chan & Moriarty, 2010; Curran, 2022, Oni et al., 2022). Pregnant women with mental health concerns voiced concern about the effect of psychotropic medications on their unborn babies, and voiced distrust in healthcare providers regarding their honesty about the safety of medications. In two findings, participants with mental health concerns described their desire to engage in psychotherapy while feeling that medication was the only option made available to them. As one participant stated:

> *"And they rush to just throw you medicine. It's like, I could not even need medicine. I might just need somebody to talk to for like an hour, and it's like ... I might just need that good 45 minutes, to just let go. Oh no, no, no, no, no. We going to send you out of here with two prescriptions. But I don't really think I need all of this. I think I might just need someone to talk about things that I build on up in my head. And I really think their paycheck is based on how many medicines they give out"* (Kemet et al., 2022, pg. 783).

For women using substances, they expressed concern about the addictive nature of opioid replacement therapy, and the effect of opioid replacement therapy on their unborn babies. Participants again described feeling that medication was the only option available to them, and in some cases, women described abstaining from use without support due to concern about the negative effects of opioid replacement therapy. As one participant described:

"… for me, I basically go cold turkey because if you have the suboxone during pregnancy, it may affect the baby… also the nurses don't know what suboxone could actually do to my baby" (Oni et al., 2022).

Category 1.5: Confidentiality Concerns and Distrust

Category 1.5 illustrates how concerns regarding confidentiality and feelings of distrust can create barriers to pregnant women engaging with support services. Issues of confidentiality and distrust are present within other categories; confidentiality concerns and the sharing of information with child protection and law enforcement agencies are encompassed within fears of child removal and prosecution (Category 1.1), and distrust of services was discussed with regards to the experience of racism in the healthcare system (Category 1.2) and with regards to the provision of medication (Category 1.4). In this category, issues of confidentiality and distrust are identified more explicitly, and in more general terms.

"…especially in a community where everyone knows everyone, I just don't trust them [nurses]" (Abrahams et al., 2023, pg. 6).

The two quantitative findings within this category are consistent in demonstrating that privacy and confidentiality concerns were reported to be of lower perceived impact on pregnant women than other barriers included in the studies (see Table 8; Logan et al., 2003; Shenai et al., 2019). However, the findings in Shenai et al (2019) are of low quality as the measurements and items used were not reported.

Table 3.9

Synthesized Finding 2: Pregnant Women's Emotions and Beliefs Create Psychological Barriers to Engagement.

Findings	Categories
Qualitative	Self-judgement, shame, and guilt
Self-judgement and low self-worth (U)	
Guilt (U)	

Societal stigma and self-guilt (U)	
Perceived betrayal of partners (U)	
Low agency and self-worth (C)	
Shame and responsibility (C)	
Qualitative	Normalisation of issues, beliefs about the need for support
Not thinking treatment is needed or warranted (U)	
Normalisation of intimate partner violence (U)	
Normalisation of domestic violence (U)	
Quantitative	
'Perceived absence of problem': endorsed by 0% of participants, ranked 8th of 8	
'Lack of knowledge about the dangers of alcohol': endorsed by 78% of participants (clinicians), ranked 5th of 11	
'Denial/unwillingness to quit or receive help': endorsed by 31.2% of participants (clinicians) ranked 2nd of 11	

U, unequivocal. C, credible.

Synthesized Finding 2: Pregnant Women's Emotions and Beliefs Create Psychological Barriers to Engagement.

This synthesized finding again includes factors that create hesitancy among pregnant women to engage with services, and that affect their decision and motivation to engage. In contrast to attitudes and perceptions of, and experiences with services highlighted in Synthesized Finding 1 (service level psychological barriers), the individual level psychological barriers in this synthesized finding are concerned with pregnant women's negative perceptions of, and beliefs about

themselves, and about their issues and need for support. While the psychological barriers identified in this review have been separated into those more focused towards support services vs the self, in should be noted that many of the factors included in this synthesized finding – such as shame and guilt, for example – are internalized beliefs and experiences that are influenced by societal norms and stigma, and by interpersonal relationships and prior experiences, and are therefore not independent from one another. This synthesized finding was created from 2 categories and 12 findings (Table 3.9).

Category 2.1: Self-judgment and Guilt

Category 2.1 highlights how pregnant women's self-judgement, and resulting emotions such as shame and guilt, impacts their motivation to engage with support services when they are at-risk of child removal. In the findings within this category of women who use substances (Chan & Moriarty, 2010, Curran, 2022, Oni et al., 2022), women reported feeling guilt and shame about their substance use, and discussed how this impacted upon their engagement by limiting their disclosure to services, or by believing that they deserved poor treatment.

> *"It's just me who does this to myself. I choose to use substances and so I always feel like I deserve to be looked down upon by these doctors and nurses"* (Chan & Moriarty, 2010, pg. 65).

In one finding, participants who experienced intimate partner violence discussed the guilt that they experience for their partners if they were to seek help and expressed feeling as though seeking help from services would be a betrayal.

> *"So now you're in this situation and you're holding on to what they used to be and you're holding on to the potential of what they can be and not really living in the present and realizing what they actually are. And that's when the guilt comes in with maybe I should wait, maybe he can change"* (Hasselle et al., 2020, pg. 294).

Participants also described how previous traumatic experiences and negative evaluations about themselves led to low self-agency and self-worth and led them, and other women, to distance themselves from support.

> *Some women are so traumatized by what they've been through, so it does help to build walls and probably overcompensate… they're not, you know, they do not have a healthy sense of self-esteem right now* (Haselle et al., 2020, pg. 294).

Category 2.2: Normalization of Issues, Beliefs About the Need for Support

Category 2.2 shows how beliefs about the need for support, influenced by the normalization of intimate partner violence and the belief that mental health symptoms may pass without formal support, can impact the motivation of women to seek support. Participants described how the normalization of intimate partner violence can influence the way that pregnant women understand their experiences and can subsequently impact their motivation to seek support.

> *"Some girls do not know because they're used to the same thing they have seen [growing up] and they think it's okay, but it's not okay. I grew up with my mom being like that and some probably think that's what you're supposed to do. Or yea, you know, some parent I had actually told me that they had someone tell them if you do not do nothing wrong then he will not hit you so stop doing stuff"* (Hasselle et al., 2020, pg. 295).

Normalization of issues did not feature in studies that examined barriers to engagement for women using substances, or for women with mental health issues. For women with mental health issues, participants discussed feeling that they could manage their symptoms on their own and expressed feeling unsure about whether the severity of their symptoms of depression and anxiety warranted treatment.

> *"I wasn't sure if any of those feelings I had were going to last for very long… I've struggled with depression. I also know that I'm a slow processor, and so I was hoping that it was just anxieties and fears that would pass"* (Sacks et al., 2015, pg. 489).

The three quantitative findings within this category demonstrate inconsistency between the perceptions healthcare workers and pregnant women about the extent of the barriers pregnant women experience (Logan et al., 2003; Shenai et al., 2019). Findings from a survey of healthcare workers (Logan et al., 2003) highlight a perception that women's denial or lack of knowledge about certain issues and the need for support is a key barrier to their engagement, however findings from a survey of women (Shenai et al., 2019) – noting this finding is of poor quality due to the lack of reporting of measurements used – found that no participants endorsed the perceived absence of a problem as a barrier they experience (see Table 3.9).

Table 3.10

Synthesized Finding 10: Services are Experienced by Pregnant Women as Inaccessible.

Findings	Categories
Qualitative	Cost and insurance
Insurance and cost (U)	
Cost of treatment (U)	
Insurance related inaccessibility (U)	
Quantitative	
'Money': endorsed by 35.4% of participants, ranked 1st of 8	
'Cost': endorsed by 62.1% of White participants, ranked 1st of 5	
'Cost': endorsed by 35.6% of non-White participants, ranked 2nd of 5	
'Cost': endorsed by 47% of participants in 2008-10, 54.8% of participants in 2011-14, ranked 1st of 5	

	‘Cost of treatment’: *M* = 2.78 on 4-point Likert scale, ranked 1st of 10
	‘Insurance doesn’t cover treatment’: *M* = 2.69 on 4-point Likert scale, ranked 2nd of 10
	‘Cost/no money or insurance for treatment/no funding’: endorsed by18.8% of participants (clinicians), ranked 4th of 11
	‘Cost related to going to the appointment’
Qualitative	Unavailability and inaccessibility of services
	Program requirements that excluded pregnant women (U)
	Inaccessibility of services (U)
	Unavailability of mental health appointments (U)
	Perceived lack of available resources (C)
Quantitative	
	‘Lack of available resources/lack of facilities/lack of treatment facilities’: endorsed by 54.3% of participants (clinicians), ranked 1st of 11
	‘Long waiting list’: *M* = 2.2 on 4-point Likert scale, ranked 4th of 10
	Limited access to opioid replacement therapy in rural Utah
	Significant challenges in the accessibility of perinatal mood and anxiety disorder treatment

	Access to treatment for opioid use is challenging in Missouri and Illinois, and access is limited in rural areas.
Qualitative	Transportation issues
	Transportation issues (U) Transportation (U) Logistical issues (U) Transportation issues (U)
Quantitative	
	‘Transportation’: *M* = 1.85 on 4-point Likert scale, ranked 6th of 10 ‘Transportation’: endorsed by 45.2% of participants, ranked 1st of 8 ‘Time/transportation limitation’: endorsed by 17.6% of White participants, ranked 5th of 5 ‘Time/transportation limitation’: endorsed by 19.1% of non-White participants, ranked 4th of 5 ‘Time/transportation limitation’: endorsed by 14.8% of participants in 2008-10, 16.4% of participants in 2011-14, ranked 5th of 5 ‘Transportation/no way of getting to and from treatment’: endorsed by 30.4% of participants (clinicians), ranked 3rd of 11
Qualitative	Time and childcare
	Time and childcare (U) Lack of time or conflicting scheduling (U)

	Parental responsibilities (U)
Quantitative	
	‘Time commitments’: endorsed by 19.4% of participants, ranked 3rd of 8 ‘Childcare’: *M* = 1.84 on 4-point Likert scale, ranked 7th of 10 ‘Can’t take time off work’ ‘Lack of time’ ‘No one to look after my child(ren) while I’m attending an appointment’
Qualitative	Lack of knowledge of services
	Limited knowledge about local mental healthcare (C)
Quantitative	
	‘Don’t know where to go’: *M* = 2.02 on 4-point Likert scale, ranked 3rd of 10 ‘Not knowing where to go’: endorsed by 19.3% of White participants, ranked 4th of 5 ‘Not knowing where to go’: endorsed by 17.2% of non-White participants, ranked 5th of 5 ‘Not knowing where to go’: endorsed by 21.5% of participants in 2008-10, 18.6% of participants in 2011-14, ranked 4th of 5
Qualitative	Staffing and service issues
	Staff discomfort with mental health issues (U) Ineffective screening and referral processes (U)

	Staff shortages and staff turnover (C)
	High workload (C)
Quantitative	
	'Poor assessment/inefficient ways of screening/no screening tool or method/lack of assessment': endorsed by 8% of participants (clinicians), ranked 9th of 11

U, unequivocal. C, credible.

Synthesized Finding 3: Services are Experienced by Pregnant Women as Inaccessible

This synthesized finding includes factors that make it challenging for pregnant women who are at-risk of child removal to access, attend, and engage with services. These are issues that, independent of the psychological barriers that impact women's motivation and decision to engage with support, occur on a more practical level to impact women's access to services, and the ease at which they can attend appointments and engage. These factors include issues such as the availability of services, cost, transport, childcare, and staffing issues. Some of these factors are relevant to the features of both services and of women's personal circumstances; for example, the barriers of cost and transportation relate to the costs imposed by services and the location of services, but also to women's financial disadvantage and access to resources. This synthesized finding was created from 6 categories and 48 findings (Table 10) from predominantly quantitative research, most of which reflect barriers that were proposed by researchers and healthcare workers in questionnaire style surveys, rather than those that were offered voluntarily by pregnant women and healthcare workers via qualitative interviews.

Category 3.1: Cost and Insurance

Category 3.1 demonstrates how the cost of services and insufficient insurance coverage creates a financial barrier for pregnant women to engage with support services. In addition to the cost of accessing services, participants identified the cost of opioid replacement medication that was

not covered by insurance, and how this created financial strain and increased the stress associated with receiving treatment (Curran, 2022). Other participants spoke about the challenges they experienced finding therapists that accept insurance and spoke about the preferential treatment that they perceive those with insurance or the financial means to pay for treatment receive by support services (Kemet et al., 2022; Kopelman et al., 2008). All but one finding that identified cost and insurance as a barrier were from studies conducted in the United States, suggesting this is an issue most relevant to countries that do not have socialized systems of public health care.

> *"I was seeing a lady, but I had issues with my insurance… my therapist wasn't getting paid for our sessions, so I had to stop seeing her. And I didn't know what to do in terms of finding a therapist that my insurance covered... A lot of back-and-forth, you know, calling this person saying to call that person"* (Kemet et al., 2022, pg. 781).

The cost of treatment and insurance related barriers were amongst the highest endorsed throughout the quantitative findings in this review, and this was consistent across studies that surveyed pregnant women (see Table 10). The study that surveyed healthcare workers (Logan et al., 2003) found that healthcare workers perceive cost and insurance issues to have a lesser impact on women than as reported by women themselves.

Category 3.2: Unavailability and Inaccessibility of Services

Category 3.2 highlights how the inaccessibility and unavailability of services makes it challenging for women to engage with support. Participants described how they faced long waiting lists for providers that accepted insurance and reported that there was an absence of services that were able to meet their needs. Some women discussed feeling that services were only available when their issues were acute, or when they were in crisis, and described feeling like they needed to regulate their language and behavior in order to access support.

> *"…if I come in here talking to you with some common sense of attitude, calmly, respectfully, and ask 'can you help me?' you're just going to send me packing. But if I come in here and just yell and scream and I'm just jumping off the walls acting like I might hurt myself, or*

somebody else, you're going to get me some help. I don't think that's the way it has to be" (Kemet et al., 2022, pg. 782).

Participants also described the inaccessibility of substance use treatment services, particularly residential treatment, for pregnant and parenting women. Some participants spoke of treatment services that did not allow dependent children, did not accept pregnant women, and if they did accept pregnant women, did not provide the appropriate level of nutrition, bedrest and prenatal care required (Jessup et al., 2003).

Within the quantitative findings, clinicians rated the unavailability of services and resources as the most significant barrier they perceive pregnant women to face (Logan et al., 2003). The three studies that used a simulated patient paradigm to assess the accessibility of services found 50-60% of services included to be unavailable or to have additional access barriers (such as the requirement of prior engagement with tertiary services) for pregnant women (Bedrick et al., 2020; Kelley et al., 2022; Morain et al., 2022).

Category 3.3: Transportation Issues

Category 3.3 illustrates how issues with transportation to and from appointments and the location of some services creates a barrier for pregnant women to engage with support services. Participants reported that issues with finances made transportation more challenging, and that having to rely on public transport was often a time-consuming process. They discussed that transportation was more challenging when services were in areas that were not well serviced by public transportation, and that any walking involved in this process became harder as their pregnancies progressed.

I would have to walk all the way to the front of the building to try and catch a bus just to get a bus a mile down the street then have to wait a whole other hour to get back on the bus (Hasselle et al., 2020,pg. 295).

The quantitative findings in this category suggest variability in the extent to which transportation is a barrier for pregnant women (see Table 3.10). Partial explanation for this may be

in the way that transport issues are recorded. Transportation and time concerns, while unique concerns, are indistinguishable in reporting within Salameh et al. (2019, 2021), and the findings by Shenai et al. (2019) are of low quality as the measures and items used are not recorded.

Category 3.4: Time and Childcare

Category 3.4 highlights how a lack of time as well as the demands on time created by primary caregiving and a lack of childcare make it challenging for pregnant women to engage with support services. Participants spoke about the challenges that they experienced with demands on time, with appointment scheduling that was not accommodating of their schedules, and of the additional burden that caregiving placed on these issues.

> *"Yeah, more than one [session option], like having those days but more than one group on those days so that way different hour people could go. So, that way at least they know, "if I can get out on Tuesday I can go to this group or this group"* (Hasselle et al., 2020, pg. 295).
>
> *"I have three kids and a million things going on so… I just didn't have any time"* (Sacks et al., 2015, pg. 488).

Two of the five quantitative findings in this category resulted from survey studies exploring the endorsement of a list of barriers and found somewhat inconsistent results regarding the extent to which time and childcare were an issue for pregnant women (see table 10; Kopelman et al., 2008; Shenai et al., 2019). One of these findings is of poor quality as the measures and items used were not reported (Shenai et al., 2019).

Category 3.5: Lack of Knowledge of Services

Category 3.4 shows how a lack of knowledge about local services and where to go for support can create a barrier to engagement with support service. Participants reported not knowing where to go for mental health support, and that this was compounded by their own and their health care providers' lack of knowledge about depression during pregnancy (Kopelman et al., 2009). The quantitative findings in this category show inconsistency with regards to the extent of the influence that a lack of knowledge has on pregnant women's engagement (see Table 3.10).

Category 3.6: Staffing and Service Issues

Category 3.6 illustrates how staff shortages and high workloads, staff discomfort, and screening and referral processes create barriers to engaging pregnant women with support. Clinicians discussed how high workloads and staffing pressures stopped them from administering screening to all pregnant women and caused them to overlook women who were not forthright about their challenges and needs.

> *"If she's not gonna ask you or tell you about her problem then you oversee that—you overlook that, because she looks happy, she's not looking stressful"* (Abrahams et al., 2023, pg. 6).

Clinicians also discussed how staff turnover impacted their capacity to engage with pregnant women, and this was confirmed in interviews with women who spoke about the negative effect that seeing new workers each visit had on their level of engagement (Chan & Moriarty, 2010). Inadequacy of referral processes was another issue that was raised by clinicians and pregnant women, which was attributed, in part, to the discomfort that healthcare workers had discussing substance use with women.

> *"I can talk and everything but there's a point where right, I'm not trained for this … I don't want to take in so much because it also takes so much out from you"* (Abrahams et al., 2023, pg. 6).

In one finding, it appeared that the insufficient screening processes and referral pathways meant that pregnant women who needed support were not offered it.

> *"There was no counselling, nothing!… Yet on my maternity book it states that I needed counselling yet I did not get it"* (Williams et al., 2023, pg. 5).

When compared with other barriers presented to them, clinicians within the quantitative finding in this category endorsed poor screening and referral to be of lesser impact (see Table 3.10; Logan et al., 2003), however this appears to be at odds with the qualitative findings of clinicians' experiences within this category.

Table 3.11

Synthesized finding 4: Challenges Unique to the Circumstances and Needs of Pregnant Women at Risk of Child Removal Serve as Barriers to Engagement.

Findings	Categories
Qualitative	Fear of violence from partner
Controlling partners (U)	
Fear of repercussion from partners (U)	
Concerns about consequences from violent partners (U)	
Relationships with partners (U)	
Domestic violence and partner substance use (C)	
Quantitative	
'Fear of partner/spouse abuse if help is sought/partner won't allow client to obtain help': endorsed by 5.8% of participants (clinicians), ranked 11th of 11	
Qualitative	Mental and physical health issues
Physical and mental ill-health (U)	
Pregnancy and other physical health concerns (U)	
COVID-related health concerns (U)	
Depression and anxiety (U)	
Mental health problems (U)	
Qualitative	Social disadvantage

	Difficulty in everyday life and meeting daily needs (U) Social determinants of health (U) Poverty, homelessness and incarceration (C)
Qualitative	Unsupportive social networks
	Unsupportive family (U)
Quantitative	
	'Negative social supporters': endorsed by 16.1% of participants, ranked 4th of 8 'Partner opposed': *M* = 1.56 on 4-point Likert scale, ranked 9th of 10 by participants 'Lack of support from family or friends': endorsed by 11.6% of participants (clinicians), ranked 6th of 11

U, unequivocal. C, credible.

Synthesized Finding 4: Challenges Unique to the Circumstances and Needs of Pregnant Women at Risk of Child Removal Serve as Barriers to Engagement

This synthesized finding includes factors that simultaneously create a need for, while also creating challenges to, engagement with support by pregnant women. These factors make it hard for pregnant women to access, attend, and engage with services, despite their desire or motivation to engage, but in addition to the material and access barriers reported above, are more specific to the issues faced by pregnant women who are at-risk of child removal. These are issues that often constitute risk-factors for child removal and necessitate pregnant women's access to support, such as poor mental and physical health, lack of or negative social supports, violence from partners, and social disadvantage. This synthesized finding was created from 4 categories and 18 findings (Table 3.11).

Category 4.1: Fear of Violence from Partner

Category 4.1 highlights how, in the context of intimate partner violence, a fear of violent retribution from pregnant women's partners can impede their access to support service. Pregnant women expressed fear that their partners would retaliate with violence towards them and their children if they were to seek support as a victim/survivor of intimate partner violence, or if they were to disclose the abuse that they were experiencing to services. Participants discussed the risk that this presents if the services they engage with are not able to provide safety from these potential repercussions, and how women prioritize their and their children's immediate safety and lives over their engagement with support programs and services:

> *"It's definitely, that is the first priority, to save her and her baby's life 'cause all it takes is one push, one hit, a car accident, him losing his temper and he hits her stomach, out of a rage, just throwing his arms. You cannot change that"* (Hasselle et al., 2020, pg. 295).

Participants also discussed how women's partners control where they access, and with whom they engage with, and that this affected their engagement with prenatal care (Williams et al., 2023), substance use (Jessup et al., 2003), and mental health (Williams et al., 2023) services. The one quantitative finding in this category was a survey of prenatal healthcare providers, whereby only 5.8% of participants endorsed fear of partner retaliation or controlling partners as a barrier to care for pregnant women (Logan et al., 2003).

Category 4.2: Mental and Physical Health Issues

Category 4.2 shows how mental and physical health challenges make it difficult for pregnant women at risk of child removal to attend appointments and to engage with services. With regards to mental health issues, participants reported feeling anxious about engaging with services and feeling low about the circumstances that they were in, and described how these feelings of anxiety and depression reduced their motivation to engage with support.

> *"After I went through all of that, with me I just didn't care a lot about doing other stuff. Anything that was outside, especially after it happened, I was sad so I sat in the house and*

didn't do anything, 'cause I was like "this sucks, I do not want to do this right now" (Hasselle et al., 2020, pg. 294).

With regards to physical health issues, participants discussed how pregnancy related illness and reduced mobility towards the end of their pregnancies made it hard to attend appointments. *"I was sick every day of my pregnancy. I threw up every day….but they just took so long to find someone who could counsel me, and I was just too sick to even follow through with it"* (Sacks et al., 2015, pg. 489).

Participants in one finding also spoke about the health implications of contracting COVID-19 during pregnancy, and how this was an additional barrier to care during the Coronavirus pandemic (Curran, 2022).

Category 4.3: Social Disadvantage

Category 4.3 illustrates how the level of social disadvantage that pregnant women experience can increase the challenges that they experience in attending and engaging with support services. While many categories within this review mention aspects of social disadvantage, or issues exacerbated by social disadvantage – for example, mental and physical health issues, racism, stigma, poor social supports, cost and insurance, transport issues, lack of childcare – this category contains findings that report these issues within a broader analysis of the disadvantage and social determinants of health and wellbeing that pregnant women experience. In addition to the barriers mentioned are issues of homelessness, poverty, food insecurity, and incarceration, that participants reported create additional challenges to their access to and engagement with support services. It was reported that the experience of incarceration during pregnancy, coupled with poverty and homelessness, required a focus on daily survival that made regular engagement with therapeutic support services difficult for women (Jessup et al., 2003). Participants also discussed how issues of homelessness and financial insecurity created a sense of unpredictability that made it hard to plan for the future and to access care.

"If you've got drug issues you've got other problems as well that normal women wouldn't have such as sleeping rough and not knowing where you're going to end up when you have your baby" (Oni et al., 2022, pg. 570).

Category 4.4: Unsupportive Social Networks

Category 4.4 highlights how unsupportive social networks – being either the absence of positive social support or the presence of oppositional or negative social networks – make it harder for pregnant women who are at risk of child removal to engage with support services. Clinicians discussed how pregnant women's families are initially unsupportive of their engagement due to their attitudes about drug use and pregnancy.

"They're (the client's family) usually too angry to be receptive in those cases… eventually they come around when they see the benefits" (Chan & Moriarty, 2010, pg. 64).

The quantitative findings in this category reported some variability with regards to the extent to which unsupportive social networks are a barrier to engagement for pregnant women (see Table 3.11).

Table 3.12

Synthesized Finding 5: Pregnant Women's Perceived Need for Support, as well as Encouragement by Close Social Supporters, Facilitates their Engagement

Findings	Categories
Qualitative	Perception of need and desire for support
An internal sense of need (U)	
Self-reporting to child protection services (U)	
Pregnancy (U)	
Concern of harm to the baby (U)	
Quantitative	
'Worried about your mental health'	

	'Previously suffered from mental health issues'
	'Wanting support/counselling'
	'Previous good experiences with mental health services'
Qualitative	Encouragement from social networks
	Encouragement by family, friends and partners (U)
	Social support and peer support (U)
Quantitative	
	'Encouragement by family'

U, unequivocal. C, credible.

Synthesized Finding 5: Pregnant Women's Perceived Need for Support, as Well as Encouragement by Close Social Supporters, Facilitates their Engagement.

This synthesized finding includes factors that increased motivation among pregnant women to seek support from and engage with services. These factors were often those that motivated initial attendance at, or engagement with support services, and are often independent from the subsequent interaction between women and services that then impacts the duration and quality of their engagement. These factors therefore occur at the individual level and are primarily concerned with the beliefs, attitudes and experiences of pregnant women that facilitate their decision and motivation to seek help from services. This synthesized finding was created from 2 categories and 11 findings (Table 3.12).

Category 5.1: Perception of Need and Desire for Support

Category 5.1 shows how pregnant women's internal sense of need for support motivated them to engage with services. Participants spoke about the concern that pregnant women have for the health and wellbeing of their unborn babies, and therefore cited their pregnancy as a strong

motivator for their engagement with support services. Prenatal healthcare staff discussed how women have a "heightened sense of responsibility" (Chan & Moriarty, pg. 64) during pregnancy that motivates them to seek support, and discussed how this sense of responsibility and care for their unborn babies impacts the treatment that they seek for their substance use.

> *"Even though they are having withdrawals they don't want to increase… Their concern is that they want their baby to be born as healthy as possible with as little opioid dependence as possible"* (Chan & Moriarty, 2010, pg. 64).

Participants in one finding described feeling a need to self-report to child protective services with the support of clinicians, in the hope that taking a proactive approach and demonstrating their responsibility would reduce the likelihood that child protective services would intervene to remove their baby from their care.

> *"My other two daughters for taken away because I did marijuana. I asked the public health nurse, when I was pregnant… if she could help me so I wouldn't have to go through it again. And with him, I volunteered to do it just in case they asked so that I could show… that I was clean"* (Lefebvre et al., 2010, pg. 52).

Category 5.2: Encouragement from Social Networks

Category 5.2 illustrates how support and encouragement from pregnant women's partners, family, and friends, can facilitate their engagement with support services. Participants reported that having their family or their partner encouraging them to seek support and to remain in treatment, and in some cases helping with the cost and transportation to appointments, had supported pregnant women to engage with support (Curran, 2022; Sacks et al., 2015).

> *"It was my family encouraging me to go get help. My family knows me pretty well"* (Sacks et al., 2015, pg. 487).

Table 3.13

Synthesized Finding 6: Service Delivery Factors Motivate and Facilitate Pregnant Women to Engage

Findings	Categories
Qualitative	Safety and trust
Warm and welcoming approach (U)	
Establishing trust with providers (U)	
Providers creating a sense of safety (U)	
Being able to approach child protection services without threat/fear (U)	
Collaboration, inclusion in treatment goals (U)	
Consistency and continuity (U)	
Qualitative	Lack of judgement, stigma, and racism
Lack of negative judgement by staff (U)	
Lack of stigma by staff (U)	
Racial concordance and/or anti-racist care (U)	
Accountability without judgement (U)	
Qualitative	Encouragement and education
Encouragement by professionals (U)	
Recognition of strength and effort (U)	
Respectful and knowledgeable communication and referrals (U)	
Quantitative	
‘Encouraged by midwife/GP/obstetrician’	
Information session about PTSD and substance use	

Qualitative	Peer, gender, and racially specific
Peer support groups (U)	support
Black advocacy in mental healthcare (U)	
Gender specific and peer recovery programs (C)	

U, unequivocal. C, credible.

Synthesized Finding 6: Service Delivery Factors Motivate and Facilitate Pregnant Women to Engage

This synthesized finding includes factors that increased motivation among pregnant women to maintain their engagement with services. These factors relate to the way that services and clinicians engage with women, and are comprised of the attributes, approaches, and features of clinicians and services that facilitate women's sustained engagement with them. These are factors such as respectful and collaborative communication and engagement, encouragement and knowledge sharing, and gender specific and peer support. This synthesized finding was created from 4 categories and 18 findings (see table 3.13).

Category 6.1: Safety and Trust

Category 6.1 shows how the attributes and approaches of clinicians that support pregnant women to feel safe, respected, and to develop trust, facilitates their ongoing engagement with support services. Participants in this category spoke of collaboration and inclusion in treatment, consistency from staff, and warmth from providers as aspects of their treatment that either supported their engagement, or that they anticipate would have supported their engagement if they had been treated in this way when they accessed support.

> *"At first, I was shy, I didn't really want, you know. I know [they were] friendly to me, and this really got me interested in going, making sure, because the encouragement I get from them every day then when I was pregnant. They're very friendly to me. So, I haven't gotten any negative behavior from them"* (Curran, 2022, pg. 110).

Participants spoke specifically about developing trust with clinicians, and about feeling a sense of safety with clinicians and services. Participants reported that being able to build relationships with clinicians and being given transparent information about their treatment either did, or would, increase their trust and their sense of safety in services (Curran, 2022; Kruk & Banga, 2011). Participants in one finding also discussed the importance of feeling that they could approach child protection services for support without the threat of child apprehension (Kruk & Banga, 2011). These participants reported perceiving a need for support during pregnancy, and a belief that they would have engaged with child protection services had they felt supported and not threatened by them.

Category 6.2: Lack of Judgement, Stigma, and Racism

Category 6.2 highlights how an explicit lack of judgement and stigma from service providers, as well as the presence of racially concordant or anti-racist care, facilitates pregnant women's engagement with service. In addition to the importance participants placed on feeling respected by services (Category 6.1), participants in this category explicitly highlighted the absence of stigma and judgement by service providers as an important factor that facilitates their engagement. Participants reported that this was particularly important as they were often anticipating being stigmatized or judged due to prior experiences with services and within other interactions and relationships.

> *"I don't use [any] more except for the methadone. I go to the hospital and the doctor, who doesn't know me, just like that [says] ''You're a heroin addict.'' They treated me like garbage, but when I see my doctor here, it's different. Very different. I can see it in how my doctor looks at me. Somewhere else they don't look at you at all . . . here, they understand you . . . you're somebody"* (Lefebvre et al., 2010, pg. 50).

Participants also reported that a non-judgmental approach by clinicians fostered a relationship that allowed them to be challenged and to be held accountable by clinicians in a way that supported their recovery (Kruk & Banga, 2011).

With regards to racially concordant and anti-racist care, one or both of these features were important to all participants within one finding that focused specifically on the experiences of Black pregnant women.45 Antiracist care in this context referred to an explicit acknowledgement and exploration of the way that racism impacted pregnancy and birthing for Black women, couple with support that alleviated these burdens. With regards to racial concordance, while some participants discussed wanting to receive care from Black clinicians, others expressed that it was more important to them to receive care from clinicians that were not White.

> *"You're so lucky, I was in hospital like, I don't want no more White people coming in here. Pilipino. Mexican. Anything but White. Put a sign on my door* (Kemet et al., 2022, pg. 783).

Category 6.3: Encouragement and Education

Category 6.3 illustrates how encouragement from clinicians and the provision of education about women's concerns and their avenues for support, can promote women's engagement with support services. With regards to encouragement, participants expressed feeling that if they were encouraged to attend support services by their medical providers, that they would do so and that the recognition of their strengths and achievements by clinicians would help to encourage them to continue to engage with support services (Sacks et al., 2015).

> *I needed the social worker to make me feel competent – like anything is possible… someone who is going to say that there's a way… there is hope and they can point you in the right direction and give you options* (Kruk & Banga, 2011, pg. 84).

Participants also reported how being provided information from clinicians about concerns for the health and wellbeing of themselves and their unborn babies facilitated their engagement with support. They noted that it was particularly helpful when this information was provided in a respectful and supportive manner and was coupled with referrals to support services (Lefebvre et al., 2010). One quantitative finding from within this category reported on the effect of a brief information session about PTSD, substance use, and treatment options on pregnant women's motivation to pursue treatment (Shenai et al., 2019). All participants in this study who were not

already receiving treatment reported that the intervention had helped influence their decision to pursue further treatment, however, this finding is of poor quality as the measure used to record this outcome was not reported.

Category 6.4: Peer, Gender, and Racially Specific Support

Category 6.4 shows how support tailored to women's gendered and racialized experiences, and which utilizes lived experience and peer support, is an aspect of care and of support services that facilitates pregnant women's engagement with them. Participants identified the need for support and recovery programs that were gender specific, and that utilized peer support and peer support groups to develop a sense of safety and to learn from lived experience.

> *"I think it would be more comfortable because you're around people who are sharing the same experience . . . you're at ease to express your issues because people are going through the exact same thing as you"* (Lefebvre et al., 2010, pg. 46).

Black pregnant women discussed the importance of Black healthcare provider advocacy in the field of mental health, reporting that healthcare providers advocating for the specific needs and experiences of Black pregnant women would increase their access to quality mental health care during pregnancy (Kemet et al., 2022).

Table 14

Synthesized Finding 7: Service Delivery Factors Increase the Engagement of Pregnant Women by Increasing the Accessibility of Services

Findings	Categories
Qualitative	Material needs over small monetary incentives
Compensation or incentive (U)	
Voucher incentive (U)	
Support with instrumental needs (U)	
Quantitative	
Ineffectiveness of incentive	

	Ineffectiveness of incentive
	Ineffectiveness of incentive
	Incentive as a facilitator in those already engaging
Qualitative	Flexible and holistic approaches
	Communication between care team (U)
	COVID related changes – takeaways and
	telehealth (U)
	Support with mental health (U)
	Treatment that accommodated children (U)
Quantitative	
	‘An appointment time that suits me’

U, unequivocal. C, credible.

Synthesized Finding 7: Service Delivery Factors Increase the Engagement of Pregnant Women by Increasing the Accessibility of Services

This synthesized finding includes aspects of service provision that facilitate pregnant women’s engagement with services by increasing their access to them. These aspects of service provision are commonly those that aim to reduce the material barriers that some women face in accessing services when they may otherwise engage with them (i.e., in the absence of psychological barriers to engagement). These aspects of service provision therefore attempt to meet women’s basic instrumental needs and address issues like transportation, childcare, and co-occurring mental and physical health issues. This synthesized finding was created from 2 categories and 12 findings (see Table 3.14).

Category 7.1: Material Needs Over Small Monetary Incentives

Category 7.1 suggests that while small financial incentives are not effective alone in facilitating pregnant women’s engagement with services, that supporting women’s more significant instrumental needs can facilitate their engagement with support. The three quantitative studies

within this category tested the effect of a small financial incentive ranging between $5-$10 in vouchers or cash, for each appointment session attended with mental health or substance use services (Jones et al., 2000; Sacks et al., 2015; Svikis et al., 2007). Two of these studies found no difference in attendance, completion or drop-out rates between the incentive and control conditions, proving the vouchers ineffective in increasing engagement (Jones et al., 2000; Sacks et al., 2015). The remaining study found no difference in treatment retention and length of stay between control and incentive conditions but found that amongst those that did not drop out of treatment, those in the incentive condition averaged more frequent appointment attendance (Svikis et al., 2007). Together, these studies suggest that small monetary incentives alone are not enough to facilitate engagement amongst pregnant women who would otherwise not engage in treatment but may increase attendance and/or engagement amongst those already engaging with services. These findings are consistent with those from the qualitative component of one of the studies.

> *"[It was] just a little extra motivation. I was probably going to go anyway; it was just a little bonus."* (Svikis et al., 2007, pg. 32).
>
> *"Really there was nothing that was going to motivate me to go, because every time I called somebody, they wanted to give me pills and I wasn't going to take them"* (Sacks et al., 2015, pg. 489).

Conversely, participants reported that support with more significant material needs such as safe housing and transportation made it easier for them to engage with support. With regards to housing, participants reported that having safe housing provided them with the stability to be able to engage with longer term support (Kruk & Banga, 2011). With regards to transport, participants highlighted how the co-location of services can ease this burden, in addition to more assertive outreach.

> *"I was very sick all the time [during pregnancy]. You know she actually came and picked me up, right at my door"* (Kruk & Banga, 2011, pg. 87).

Category 7.2: Flexible and Holistic Approaches

Category 7.2 highlights how flexibility and holistic service provision can facilitate the engagement of pregnant women with support services. With regards to flexibility, participants discussed how changes implemented during the COVID-19 pandemic, such as telehealth appointments and takeaway medications eased their access to and engagement with support services (Curran, 2022). Participants reported that support services that accommodated dependent children saw them engage with treatment where they otherwise would not have, and that including children in their recovery was a strong facilitator and motivator for their engagement (Kruk & Banga, 2011).

Participants also discussed how holistic and multi-disciplinary care, including effective communication between their care team and support with underlying issues such as mental health and past trauma, would, or did, facilitate their engagement with support. Participants in one finding expressed feeling that the services provided to them by child protection services were not meeting their needs, and that recovery programs that included support for past trauma and that addressed underlying mental health issues would support their engagement (Kruk & Banga, 2011). Consistent to this, participants in another finding expressed that having a multi-disciplinary team supporting them, with effective communication within their team, facilitated their engagement and supported them to feel that their needs were being met.

> *"If someone didn't have the answer, they made sure they got the answer for me from someone else. Which, again, reinforces the team"* (Lefebvre et al., 2010, pg. 50).

Discussion

The purpose of this systematic review was to better understand the factors that influence pregnant people's engagement with support services when they are at risk of child removal. When given the opportunity to identify and speak of their perceptions and experiences qualitatively, pregnant women gave detailed and nuanced accounts of their experiences with services, their hesitations and fears, the practical challenges that they encounter, as well as the factors that assist them to overcome these challenges and engage with support. We characterized these accounts,

along with accounts from clinicians and the quantitative findings within this review, as pertaining to either the psychological factors that affect pregnant women's motivation and desire to seek out and engage with support, or the more practical factors that affect women's capacity and ability to access support.

The qualitative findings from pregnant women and clinicians were mostly consistent. Whilst pregnant women reported a much more exhaustive list of barriers and facilitators to their engagement, those that were reported by clinicians were also reported by pregnant women. One point of difference, however, is the source of stigma and judgement reported. Although both clinicians and pregnant women reported stigma and judgement as a concern, clinicians did not recognize that clinicians were a potential source of stigma and judgement for pregnant women. While clinicians noted societal stigma and judgement as a barrier for pregnant women, pregnant women appeared more concerned with the experience of being stigmatized and judged by clinicians within support services. Findings from the only quantitative study of clinician perspectives (Logan et al., 2003)(Logan, Walker, Nagle, Lewis, & Wiesenhahn, 2003) were inconsistent with those from the qualitative findings of pregnant women, in that clinicians endorsed issues like stigma, distrust, fear of repercussion, child removal and criminal prosecution amongst the factors of lowest influence on women, despite these being amongst the most frequently cited issues by pregnant women across the included studies.

Whilst nearly all findings from the surveys completed by pregnant women were reported in qualitative findings, there were significant omissions in the findings from survey studies when comparing the two. For example, no survey studies of pregnant women included fear of child removal, fear of criminal prosecution, stigma, judgement and/or racism from clinicians, fear of violent retribution from partners, shame and guilt, mental and physical health issues, and social disadvantage as barriers for participants to endorse, despite these issues being of key concern to women when asked qualitatively. The items for most questionnaire surveys were collated by researchers, or by researchers with input from clinicians, highlighting a risk of bias whereby

service-related issues, such as negative treatment by clinicians, were not identified. Additionally, the way that some quantitative findings were categorized may have obscured their meaning. For example, in both studies by Salameh et al. (2019, 2021), the survey item 'fear of being committed or medicated' was categorized under 'opposition to treatment', however it can be argued that this represents a significant fear or hesitation associated with seeking treatment rather than simply an opposition to it.

The findings from experimental and quasi-experimental studies were consistent with the qualitative findings from pregnant women, and with the quantitative survey studies. For example, issues such as the unavailability and inaccessibility of services was sighted frequently as a barrier across findings of various methodologies. The most commonly tested facilitator across experimental studies was the effect of a small financial incentive for attending appointments with support services, however, these studies were consistent in showing little to no effect of these incentives. Given the severity of some of the perceived consequences of, and barriers to engagement reported by pregnant women – for example, child removal, criminal prosecution, judgement and discrimination, and violent retribution from partners – it is perhaps unsurprising that $5-10 incentives failed to ameliorate these concerns, and to have any effect on engagement.

Barriers

The synthesized findings of barriers within this review relate to the experienced or anticipated consequences of engaging with services, views about the self and services that question the need for, or utility of, service engagement, and the practical and/or instrumental issues that can create additional challenges to accessing and engaging with services. These issues were categorized as psychological or material barriers and occurred at both the service and individual level.

The findings suggest that the consequences – both experienced and anticipated – of pregnant women's engagement with support services are significant. The consequences of service engagement reported by pregnant women included: having children removed by statutory child protection services, facing criminal prosecution for drug use during pregnancy, experiencing

stigma, judgement, racism, and discrimination within services, having confidentiality and privacy breached, being medicated for mental health or addiction issues when other forms of treatment are desired, and experiencing violent repercussions from partners. In these cases, pregnant women face a challenging decision in weighing up the potential benefits and consequences of seeking support and engaging with services during pregnancy. Whilst issues such as stigma, judgement and racism, the medicalization of mental health and addiction, and partner control or repercussion are common concerns cited by people with substance use, mental health, and domestic and family violence concerns when seeking support from services (Farhoudian et al., 2022, Staiger et al., 2017; Wright et al., 2022); the concerns of child removal and criminal prosecution are additional issues experienced specifically by pregnant women at risk of child removal.

The issue of child removal and criminal prosecution highlights the tension between care and control that has been a central aspect within the social work, social welfare, and child protection fields since their inception (Alfandari, 2023; Day, 1979). This tension is exemplified in the case of mandatory reporting, whereby services tasked with providing care and support to families in need are concurrently required to report families to statutory child protection services for the very issues they may be seeking support for. As such, mandatory reporting has been found to contribute to a distrust of services amongst parents, and reduced or concealed engagement with services that precludes the provision of support to families who need it most (Fong, 2020). Likewise, a recent systematic review conducted on the public health impacts of state policies in the United States that criminalize prenatal substance use found these punitive policies were associated with null or poorer outcomes in the domains of antenatal healthcare engagement, pregnancy and birth related outcomes, neonatal drug withdrawal, and child maltreatment and foster care (Bruzelius et al., 2024). This is understood to be due to the effect that such policies have on reducing the help-seeking and engagement of pregnant people with services that again hold the dual responsibility of providing care and reporting them to state authorities. These issues suggest that any meaningful attempts to prevent child harm and child removal by increasing parental engagement with support must come

with a renewed consideration to repeal policies that concurrently deter parents from engaging with support (Raz, 2020).

The material and access barriers experienced by pregnant women within the findings of this review relate to issues such as the limited availability, accessibility, and suitability of support services. This was due to issues such as the lack of specialized services for pregnant women, in addition to the secondary issues such as cost, limited insurance coverage, transportation issues and a lack of time and childcare that created additional challenges in accessing services when they were available and suitable. The limited accessibility of services may be reflective of the funding allocated for child protection across Anglophone countries, whereby most funding remains to be spent on statutory services, with much less allocated to primary and targeted prevention services (Human Rights Watch, 2022; Higgins et al., 2019; Lonne, 2009). In addition to the general accessibility of services were issues more specific to pregnant women who are at risk of child removal that create additional barriers to service access, such as poverty, homelessness, incarceration, physical and mental health issues, and limited social supports. Such issues highlight the need for increased universal health and welfare provisions that reduce inequality, meet basic needs, and promote health and wellbeing more broadly.

Facilitators

The synthesized findings of facilitators in this review relate to issues categorized as occurring at the individual or service level. For individual women, their internal motivation and sense of need for support, as well as external encouragement by close supporters, act as facilitators to their engagement with support services. The findings suggest that pregnancy and concern for the unborn baby are key motivators that drive women's sense of need for support, consistent with research demonstrating that concern for one's unborn baby is a key motivator for health promoting behavior change during pregnancy (Kazemi et al., 2016).

The qualities of services and clinicians that foster safety and trust, are free from stigma, judgement, and discrimination, are encouraging, provide population specific support, are flexible

and holistic in their provision of support, and seek to meet women's core material needs, were those factors that facilitate pregnant women's engagement with them. Notably throughout the findings, was that pregnant women not only spoke of the presence of commonly reported factors such as clinician warmth, respect, collaboration, and consistency, that support service users, clients, and patients to develop a sense of safety and trust when accessing support services (Holdsworth et al., 2014), but that women also made specific mention of the absence of factors such as stigma, judgement, discrimination, and racism. Frameworks and approaches to care provision such as anti-oppressive practice in the social work and welfare fields (Burke & Harrison, 1998), and anti-racist care in the mental health (Cénat, 2020) and medical (Crear-Perry et al., 2020) fields, are approaches that aim to explicitly recognize and address the ways in which marginalization and oppression – across society and within health and welfare services – impact the health and wellbeing outcomes of clients and patients. Such approaches may be particularly relevant for work with pregnant women who are at risk of child removal as they often experience multiple, intersecting forms of marginalization and oppression.

Pregnant women reported the need for support that was tailored to their circumstances. Of relevance was support that accommodated pregnancy and children, support that was gender specific, and recovery programs that considered and addressed previous trauma and mental health concerns. These findings are consistent with research on the benefits of gender specific recovery programs for women that highlights women's roles as caregivers and mothers, and women's experiences of sexual and gender-based violence, as examples of the need for tailored support that is often not found in mainstream recovery programs (Covington, 2002).

Strengths of the review

According to our knowledge, this is the first systematic review that has explored and synthesized the factors impacting pregnant people's engagement with a range of support services, for a variety of concerns, and across several countries and contexts. This review therefore allowed an analysis of the factors that influence the engagement of pregnant people at risk of child removal

that are both specific to their circumstances (for e.g., fear of repercussions from violent partners for women seeking domestic and family violence services), and that were applicable to most circumstances studied (for e.g., fear of stigma and discrimination). To our knowledge, this is also the first review to synthesize these factors as reported by pregnant people and healthcare workers, and as reported across a range of study designs, including quantitative, qualitative, and mixed methods studies. The integration of findings of different participant groups and across a range of study designs provided an extensive and diverse set of findings for synthesis. The integrative synthesis of these findings allowed for an analysis of the consistency of barriers and facilitators as reported across participant groups and across study designs. This allowed for a comparison of findings that, in addition to demonstrating their validity relative to the consistency and/or variability they are reported across participants and study designs, provides implications for clinicians and researchers regarding the way that barriers and facilitators to engagement are conceptualized, understood, and researched.

Limitations of the review

The review did not include any studies from the United Kingdom, despite the United Kingdom facing similarly high rates of child maltreatment substantiations and removals as the other Anglophone countries represented (Department of Education, 2023). The high proportion of studies from the United States highlighted contextually relevant issues, such as the criminalization of prenatal drug use and cost and insurance constraints. These issues may not be as generalizable to countries that do not criminalize prenatal drug use, and that have more socialized systems of public health care.

The studies that focused on engagement with mental health support services focused predominantly on support for anxiety and depression, and there were no studies that explored engagement with services for pregnant people experiencing more significant mental health issues. This may present a limited view of the factors impacting pregnant people's engagement with mental health support services. The review aimed to include pregnant people – women, gender diverse

people, and transgender men – however, the studies included were conducted solely on women participants. This may therefore miss the unique barriers experienced by pregnant people who are gender diverse.

Pregnant women at risk of child removal anticipate and experience significant consequences of their engagement with support services. They therefore face challenging decisions when weighing up these consequences against the potential benefits of service engagement. If and when pregnant women decide to seek support, services are often experienced as inaccessible. This inaccessibility is often exacerbated by women's experiences of social and financial disadvantage. Support services that reduce the perceived and actual consequences of women's engagement with them, and that increase accessibility by meeting women's needs, facilitate pregnant women's engagement with support.

Recommendations for practice and policy

Meaningful attempts to reduce child harm and child removal by increasing pregnant people's engagement with support services must attend to the practices and policies that concurrently deter pregnant people from engaging with support. Most notably from the findings, these are mandatory reporting policies and the criminalization of drug use during pregnancy. Additionally, there is a need not only to challenge practice approaches that create stigma, shame, judgement, and discrimination, but to adopt approaches that take into account the effects of these factors on pregnant people's lived experiences. Universal welfare initiatives are required to lift people out of disadvantage, as are targeted approaches that increase the accessibility of services by addressing the specific social and financial needs of pregnant people at risk of child removal. These approaches are in addition to common practice approaches that support therapeutic engagement such as the development of trust and safety, respect, and collaboration. Clinicians within statutory child protection services should consider the significant and nuanced reasons for pregnant people's non-engagement with support services as encapsulating much more than their lack of acknowledgement of the problem, or their resistance to change. On the contrary, many of the

barriers experienced by pregnant people are within the control of policymakers, service providers, and clinicians. Change can therefore be implemented at this level to facilitate the engagement of pregnant people with support when they are at-risk of child removal.

Recommendations for research

Quantitative research that uses survey designs to identify barriers and facilitators to engagement with support services must do more to ensure that the survey items used in these studies reflect the barriers and facilitators experienced by pregnant people. None of the quantitative survey design studies of pregnant women included in this review identified issues such as fear of child removal, fear of criminal prosecution, and stigma and discrimination from clinicians, despite these being the most commonly cited barriers that women reported qualitatively. An omission of these issues within quantitative research will bias findings towards more generalized, instrumental barriers such as transport and cost, and will do little to identify the factors most specific to engaging pregnant people at risk of child removal.

Experimental research that tests the effect of facilitators of engagement is narrow in focus. Given the ability for this research to make causal conclusions regarding the impact of facilitators on engagement, more research of this nature that tests facilitators beyond small monetary incentives is warranted. Qualitative research focusses on clinicians' perspectives of pregnant women's engagement in two ways; by exploring clinicians' views on what they believe are the barriers and facilitators to engagement that pregnant women experience, and by exploring the barriers and facilitators that clinicians themselves experience in engaging pregnant women. It is recommended that research that takes the former approach is clear that clinicians' perceptions of pregnant people's experiences are, indeed, their perceptions, and cannot be taken as a proxy for the lived experience of pregnant people themselves. It is therefore also recommended that more research of clinicians focuses on their own experiences in engaging pregnant people.

CHAPTER 4. A Dyadic Exploration of Engagement During Parenting Capacity Assessments

During a Parenting Capacity Assessment (PCA) interview conducted following the removal of a child, clinicians are examining ongoing risk to the child (protective aim) and identifying ways to support the capacity of the parent to care for their child safely moving forward if reunification is deemed possible (therapeutic aim). Clinicians are tasked with exploring with the parent(s) the nature of the child protection concerns and the factors impacting parenting capacity. However, the findings I presented in Chapter 2 highlighted how engagement in the PCA process is particularly challenging for mothers, that the engagement between clinicians and mothers often deteriorates during PCAs, and that this deterioration in engagement appears to be most pronounced during conversations that were challenging for mothers – most notably, during conversations that related to the child protection concerns. Given that most children who enter out-of-home care in Australia are not reunited with their parents and families (Delfabbro & Fernandez, 2024), the ability of clinicians to effectively engage with parents during PCAs seems pivotal to ensuring quality decision making and the best outcomes for children and families. Potentially, the engagement between clinicians and parents during a Parenting Capacity Assessment (PCA) holds significant consequences for the reunification between parents and their children. The goal of this current chapter was to further explore engagement as a socially dynamic process that is shaped by the interactions between both parties. Given the often-sensitive nature of the child protection concerns, as well as the high-stakes context of PCAs, the threat posed to parents in these assessments is high. How clinicians navigate these conversations is likely to be highly influential to the engagement and motivations of parents during PCAs, and may influence the subsequent assessments and recommendations of clinicians regarding reunification. The aim of this chapter is to therefore explore the approach that clinicians take to discussing the child protection concerns with parents during PCAs. In taking a dyadic approach to this analysis, an additional aim is to explore how parents respond to the approaches of clinicians, and how clinicians appraise and assess parents' responses.

The Parenting Capacity Assessment Process

Once a child is removed from the care of their parents by statutory child protection services, parents are often mandated to engage in a PCA. Statutory child protection services in Australia remove children on temporary orders, during which there is a process of investigation into the possibilities for reunification or long-term removal (AIHW, 2024). PCAs form a key part of this investigation process, whereby statutory agencies refer parents to attend PCAs, with attendance at PCAs oftentimes mandated within the investigation order. For mandated assessments, non-attendance is punishable by law, and often holds a maximum penalty of imprisonment. The main aim of PCAs is to assess a parent's capacity to parent their children by gaining a sense of the risks of harm towards a child (referred to as 'child protection concerns'), the parent's understanding of these risks, and the capacity and motivation of a parent to make changes to alleviate any risks of harm to a child (Tustin & Whitcombe-Dobbs, 2024). The recommendations included within PCAs are used for two main purposes. First, they provide recommendations as to further court orders to be applied for by statutory services and are used as evidence in these cases. Second, they provide statutory services with a list of recommendations regarding the possibility and timeframes for reunification, as well as a list of focus areas regarding the behaviour change and service engagement of parents that is deemed necessary for reunification to be viable. The common outcomes of PCAs are recommendations that a child is reunified to the custody of their parents, that statutory services apply for an interim order to keep the child in state custody for a period of time (generally up to 12 months) whilst the parents engage in the recommended actions after which reunification is to be considered, or that statutory agencies apply for long-term removal orders (AIHW, 2024). While specific processes vary between jurisdiction, PCAs exist within all Anglophone countries – Australia, New Zealand, United States, England, and Canada – that adopt a 'child protection' orientation towards child welfare.

In South Australia, PCAs are conducted by psychologists within the Department of Child Protection (DCP), by social workers and psychologists at Child Protection Services (SA Health;

CPS), and by private psychologists. Parents have the right to request a second assessment via a private psychologist should they wish a second opinion regarding the PCA report's findings, however the high costs of these assessments would likely act as a barrier for many families. The PCA process is multifaceted, and the assessing clinician will often collate information gathered via interviews with services and family members, case file records from external agencies (for e.g., statutory services, police and correctional services, state health departments, non-government agencies), parent-child observations, child interviews, and parent interviews (Department for Child Protection, 2022). While assessing clinicians may tell parents that they have collated relevant background information, the extent of this information is not commonly known to parents prior to the parent interviews. The DCP have published clinical guidelines about undertaking PCAs, however all information regarding the content for parent interviews during PCAs, as well as what formal assessment measures may be included during PCAs have been publicly redacted from this document (Department for Child Protection, 2022). That this information is not publicly available suggests that the content and process of PCAs is to an extent withheld from parents prior to the assessment taking place.

While each service will differ to an extent in the nature and content of parent interviews, they are generally conducted to explore the history and allegations of child harm, a parent's personal and developmental background, the parent's current functioning (including cognitive functioning, mental health, drug and alcohol use), the parent's relationships (including the presence of domestic violence), the family's current living situation, the parent-child relationship, and the parents' prior and current engagement with supports (Budd, 2001, 2005); all of which broadly constitute the child protection concerns. In raising these issues with parents, clinicians are assessing a parents' potential or capacity to change, and in doing so, are seeking a sense of acceptance of, or insight into, these issues from parents, as well as a sense of responsibility to make change (Budd, 2005; Gray, 2014; Tustin & Whitcombe-Dobbs, 2024). In this way, there is little room for parents to contest the truthfulness of the issues raised – their responses are assessed with regard to their

level of understanding, acceptance, insight, and responsibility for the issues put to them. Raising these issues with parents, and seeking and assessing their responses to them, has two main aims; to assess the level of risk posed to a child to support decision-making regarding reunification (a protective aim), and to guide treatment planning by assessing a parents' therapeutic and other support needs (a therapeutic aim; Tustin & Whitcombe-Dobbs, 2024).

Engagement During PCAs

The findings from Chapter 2 suggest that there is often a significant breakdown in engagement between clinicians and mothers during PCAs, and that engaging in PCAs is a particularly challenging experience for mothers. Specifically, it was reported that mothers showed signs of distress such as crying, trembling, becoming angry, becoming unresponsive, speaking rapidly to avoid certain conversation topics, and self-medicating following the interviews. Overall, it was found that engagement commonly deteriorated as the interviews progressed. This deterioration in engagement likely does not bode well for the kind of responses sought from parents during PCAs that would be supportive of reunification recommendations. For example, parents becoming angry or unresponsive when child protection concerns are raised would likely not allow for the demonstration of acceptance or responsibility that clinicians are seeking, to conclude that there is a potential for change and therefore reunification. Likewise, if mothers are experiencing considerable distress during PCAs, this could act as a barrier to the collaboration required for clinicians and parents to identify further support needs and to guide further treatment and reunification planning. Moreover, the extent of mothers' distress – whereby some reported needing to self-medicate post interview to manage their distress – becomes an ethical issue for both social workers and psychologists who have a mandate to do no harm (AASW, 2020; APS, 2007).

To understand engagement as socially dynamic and interactionist, is to consider that one's actions cannot be seen in isolation of their context and of their social interactions (Reynolds et al., 2021). Put simply, if mothers are noted to have become angry, unresponsive, to withdraw, etc. is to understand that this behaviour is influenced by their interactions with clinicians, and by the context

of the assessment interview. The topics raised during PCAs are of a sensitive nature and have the potential to be quite psychologically threatening to parents. Parents' developmental histories are often characterised by abuse and relational trauma (Mason et al., 2020; Stephens, 2018; Suomi et al., 2021; Tutty & Nixon, 2020), the issues that comprise the child protection concerns are often highly stigmatised (Battle, 2019; Kenny & Barrington, 2018; McGrath et al., 2023; Wolfson et al., 2021), and the very nature of child protection involvement that assumes one to have caused harm to their child is often shame inducing (Gibson, 2015, 2020; Monheim, 2019). Additionally, a parent's performance during PCAs can result in the long-term and permanent loss of child custody. As clinicians are tasked with raising these issues with parents during the PCA interview, the approach that they take to these conversations has the potential to either buffer against these psychological threats, or to exacerbate them. For example, the findings from Chapter 3 suggest that while stigma, judgment, and racism from clinicians is a key barrier to engagement as reported by pregnant women, clinicians fostering a sense of safety and trust, and providing support that is free of stigma, judgment and racism, was reported as a facilitator of engagement.

The findings from Chapter 2, which suggest that engagement during PCAs deteriorated throughout the assessment process, highlight the dynamic nature of engagement that changes over time. It is not just the approach that clinicians take, but how parents respond, how clinicians appraise these responses, and how these appraisals inform subsequent approaches and interactions throughout the interviews, that determines the quality of engagement over the assessment process. For example, whether a mother responds by crying and expressing remorse, or by shouting and expressing disagreement, will likely influence the subsequent approach of clinicians. Indeed, it has been found that clinicians withdraw relationally from the therapeutic alliance and exert more control over their clients when they become challenged by a client's presentation (Reyre et al., 2017). The extent to which clinicians can adjust their behaviour in session and foster collaboration with their clients, based on their client's presentations during sessions, is termed Therapeutic Responsiveness (TR; Calaboiça, et al., 2024). However, the extent to which clinicians during PCAs

see this as their role may depend on the extent to which they take a protective or therapeutic aim to their role as assessors. Nevertheless, understanding how clinicians during PCAs are appraising parents' responses during interviews may provide insight into their subsequent approaches, which may help to explain why there is often a deterioration in engagement during PCAs (see Chapter 2). Additionally, clinicians' appraisals and assessments during PCAs, as influenced by parents' presentations during the interviews, influence the PCA recommendations and is therefore an important avenue of exploration as it relates to rates of family reunification.

The current research

The aim of the current study is to explore how clinicians engage with parents during PCAs, and during discussions of the child protection concerns. In considering the dyadic nature of engagement, the current study seeks to explore both parties' engagement during PCA interviews, and to consider, in relation to one another, how clinicians raise the child protection concerns with parents, how parents respond, and how clinicians then appraise parents' responses. While the findings from Chapter 2 reported on mothers' presentations and engagement by extracting the summative paragraph in PCAs that report on their engagement during the interviews, this chapter focusses on a smaller subset of PCA reports and I consider the full report. In doing so, I adopt a dyadic and social interactionist lens where I consider the full interaction between the two parties, in context, as described by the clinician in the report. Qualitative data analysis was used to capture the nuanced and contextualised nature of engagement as written within PCA reports. The overarching questions guiding this study are:

(1) How do clinicians engage with mothers during PCA interviews, and during conversations about the child protection concerns?

(2) How do mothers respond to clinicians' approaches to engagement during PCA interviews?

(3) How do clinicians appraise the responses and engagement of mothers during PCA interviews?

Method

Sample of case records and data collection

This study was reviewed by the relevant local health network's Clinical Human Research Ethics Committee (HREC) and was found to meet the criteria for a clinical audit. A sample of 10 PCAs conducted at a child protection service in South Australia, during a five-year period between 01/01/2015 and 31/12/2019, and for children aged 2 or under were retrieved. The child protection service audited was a state-based public health service connected to a metropolitan public hospital. The service conducts parenting capacity assessments, forensic assessments, and provides therapy to children and their parents. They sit alongside the DCP and private psychology clinics in conducting PCAs for parents within their local catchment area, and are used to advise the DCP on recommended actions regarding further custody arrangements, and to act as evidence in family court proceedings. The sample of 10 was randomly selected from the same data set that was used in Chapter 2. A random number generator was used to identify records that were numbered between 1 and 135 in an excel spreadsheet, with each number relating to a dataset that included a full, deidentified PCA report that was extracted for analysis. While fathers' involvement in the PCA interview varied within reports, all reports included an interview with the child(ren)'s mother. For this reason, as well as the iterative nature of this study as following on from Study 2.2 that focused only on pregnant women/mothers, only interviews with mothers were extracted for analysis.

Data analysis and analytic approach

Data included the full text of PCA reports and were entered into NVivo (Version 12.6) for analysis. Thematic analysis was conducted following Braun and Clarke's (2022) six-phase approach. First, I familiarised myself with the data, which involved reading through each PCA and making notes about my impressions, thoughts, and responses. Second, I generated initial codes which I then grouped into broad themes. I reviewed the themes in reference to my research aims and reviewed them with my supervisor to seek feedback and reflect on my impressions of the data.

This process was iterative, and led to defining and naming the themes, and to the presentation of results. My theoretical approach to data analysis was informed by aspects of Conversation Analysis (CA; Goodwin & Heritage, 1990) and Discursive Psychology (DP; Edwards & Potter, 1992). While CA is generally applied to naturally occurring, spoken interactions, I adopted principles of CA to explore how the PCA reports reflect interactional, conversational dynamics. Informed by a CA approach, I attended to the interactive, collaborative, and sequential nature of conversation as written in reports (Tietbohl et al., 2022). Additionally, DP offers a framework for analysing how psychological concepts – such as emotions or motivations – are constructed in language. In DP, words and text are not viewed as neutral expressions of internal psychological states but as context-specific actions that serve social functions (for e.g., to seek explanation, justify actions, attribute responsibility, or explain behaviour). My approach to this analysis was to assume that clinicians' reports of their approach to conversations and their assessments of mothers' presentations were more or less reflective of what was either occurring during the PCA interview, or how clinicians were appraising these interactions. However, as the PCA report is written for a professional audience, and as evidence that is often contested by parents, I also considered the way that issues were framed, mothers were presented, and the extent to which this was constructed for the purpose of the PCA report.

Results

Descriptive results

Mothers ranged in age from 18-36, with an average age of 27.5. 30% of mothers were Aboriginal or Torres Strait Islander, and 70% were White/Caucasian. 40% of mothers had previous children removed, and 20% had been under long-term guardianship orders themselves. 100% of mothers had experienced interpersonal violence and abuse; 60% had experienced childhood sexual abuse, 60% had experienced childhood physical abuse, 90% had experienced childhood emotional abuse, and 90% were victim/survivors of domestic violence. 80% of clinicians were social workers, 40% were psychologists, and 20% of assessments were conducted by a social worker/psychologist pairing.

At the time of the assessments, the full sample of mothers had experienced the removal of their child and were mandated to attend the assessment. 40% of the assessments related to a child that was removed at birth, and 60% were related to a child that was removed within the first two years of birth. 40% of assessments recommended long-term loss of parental custody, 50% recommended that the DCP apply for a 12-month care and protection order during which time mothers must prove their capacity for change before reunification is considered, and 10% recommended that the DCP apply for a 12-month care and protection order whilst working towards reunification.

Results and Discussion of Thematic Analysis

My thematic analysis of the approach taken by clinicians to engagement during PCA interviews included 3 themes: (1) Personal Responsibility is Paramount, (2) Reflective Capacity and Insight are probed, and (3) Implicit Demand for Non-reactive Participation. I provide a description of these results – including a description of each theme, subtheme, and illustrations – below, and provide an interpretation and discussion of these results in the context of prior research and with consideration for their implications.

Theme 1: Personal Responsibility is Paramount

From the perspective of clinicians, responsibility acceptance from a parent was paramount to assessing ongoing risk (protection aim) or commitment to change (therapeutic aim). However, the nature of interactions to assess this were often confrontational, lead to distress in the mother, and mothers often misunderstood the nature of responsibility the clinicians were really looking for (indeed this may not have been clear even to clinicians). Consequently, mothers sort to explain the broader context of historical events, which was in turn attributed as defensiveness by clinicians.

Clinicians took a confrontational approach when discussing mothers' previous histories, current circumstances, and the child protection concerns. Indeed, throughout the reports, clinicians noted how mothers responded to what they described as their *'questions of a challenging nature'*. Clinicians appeared to ask questions in a way that would reveal any inconsistencies between

mothers' responses and the information they had gathered from other sources, in a way that focused on mothers' personal responsibility and blame for their circumstances, as well as their responsibility to explain, understand, and resolve their experiences of past trauma. Consistent with the findings from Chapter 2, these approaches appeared particularly challenging for mothers, who were noted to have become distressed and/or withdrawn during these conversations.

In seeking a sense of responsibility taking from mothers, clinicians noted in the reports that they withheld the information they had received from external sources – for example, the Department of Child Protection, SA Police, SA Health – from mothers, to identify inconsistencies in mothers' responses. In response, mothers limited disclosures or provided information that was inconsistent with that sourced during the investigation, and clinicians appeared to then raise these inconsistencies with mothers directly as a way to challenge them on the information they had provided. For example, one clinician wrote:

> *"When asked about her current substance use, she said she was not currently using any drugs and had ceased five to six months ago. The clinician told her that it was understood she had returned a number of positive drug tests through Correctional Services and asked how it came that each of the random drug tests were returned positive given she had reported she had not used regularly, however she was unable to provide an explanation."* (Report 8)

As mothers are attending interviews without knowing what information the assessor has sought and received from various government and non-government agencies, they are likely attempting to withhold information that they believe would reduce their chances of reunification. Indeed, fear of child custody loss was found to be one of the most significant barriers to engagement in Chapter 3, and it is likely that this fear would be compounded in a cohort low in trust (Mason et al., 2020), and who report a low sense of confidence and self-efficacy in managing child protection proceedings (Buckley et al., 2011). This speaks to the complexity of the double-mindedness required by clinicians as a result of the dual protection and therapeutic outcomes: the

parent could be an offender, and the offender needs to be 'caught out'. Only if not 'caught out' can the parent be supported therapeutically. While it is of course important to have honest and truthful discussions about the child protection concerns, the absence of honesty and transparency from clinicians may seem fundamentally at odds with the aspects required to develop a therapeutic alliance with mothers that would then encourage their open and honest responding. For example, in this case, the clinician could tell the mother at the outset that information on drug tests has been provided. This may enable a conversation about the reality of the drug use, and may be more supportive to building engagement, responsibility taking, and the identification of the mother's support needs.

Issues of responsibility were often investigated by clinicians with what appeared as an expectation that mothers accep full personal responsibility for issues in their past and present. These issues of personal responsibility were raised during conversations about child protection concerns as they pertained mostly to circumstances such as mothers' poor mental health, addiction, homelessness, experiences of domestic violence, and their own childhood and upbringing. In these cases, mothers often appeared to want to share blame – or perhaps contextualise the events of their lives. Blame was attributed onto their families that were a source of childhood abuse and trauma, their partners that perpetrated violence against them, the people in their lives who introduced them to drugs and alcohol or the circumstances that triggered their use, and the services that they often expressed a sense of dissatisfaction with, or a sense that they are being mistreated by. In these circumstances, it appeared that clinicians redirected these issues back to mothers' personal responsibility. For example, one clinician wrote:

> *"Within the assessment, it was recognised that she externalised blame for many of her personal functioning deficits. This included that she felt that her partner had negatively "changed" her mental health. The writers were mindful of the often-long-term mental health effects of domestic violence, however based on her self-disclosures, and information from*

the DCP and from health records, it was noted that her mental health difficulties were long-standing and entrenched." (Report 1)

In many of the reports, it appeared that clinicians sought a sense of personal responsibility from mothers for failing to protect their children from witnessing domestic violence, for not leaving violent relationships, or for the issues arising from their experiences of domestic violence, such as mothers' poor mental health, financial instability and/or poverty, or transience, such as in the illustration above. In redirecting these issues back to mothers' personal responsibility for them, it is unclear whether clinicians validated mothers' experiences or concerns, or whether their own experiences of abuse were acknowledged within these conversations. In the illustration above, there also appears to be little room for subjectivity or a difference in opinion regarding explanations for the mother's poor mental health. It may very well be the case that the mother in this instance, irrespective of her mental health history, is experiencing a current exacerbation in mental ill-health due to her recent experience of domestic violence. While the outcome – a recommendation or referral to mental health support – would likely be the same regardless of where blame is attributed, whether the clinician in this case takes the mother on her word, or whether they seek a sense of personal blame for her mental ill-health in this instance, will likely affect their capacity to collaborate with the mother regarding therapeutic needs and support options. Further, there was no reflection from the clinician that the context of a PCA may not enable the sort of self-distanced reflections sought from mothers, especially from those with histories of complex trauma, mental health concerns, and the immediate threat of ongoing child removal.

The extent to which clinicians sought personal responsibility and blame from mothers is evident in the following illustration. In this case, it is unclear what may be achieved by requesting that a mother accepts personal responsibility for feeling distrustful of services or having worries about confidentiality. Considering that reporting to statutory services likely occurred without her knowledge, and that she is currently in an interview for which clinicians have sought her personal

information from various sources without her full consent, it could be argued that the clinicians in this instance are avoiding taking any responsibility for these concerns:

> *"Her history also evidenced a pattern of difficulties maintaining working relationships and managing the "pressure" of ongoing involvement with services. In this context, she also referred to lacking trust in professionals due to her long history of involvement with services and her worries about confidentiality, but she demonstrated little ability to reflect on any contribution she herself made to this history or how she could approach future relationships differently."* (Report 7)

This example makes explicit the two types of responsibility that seems to be required from mothers; blame and responsibility for prior circumstances, and to take responsibility for making positive change moving forward. It appears that in the context of the PCA interview, clinicians seek the former as a requisite for the latter, and the focus is largely on the past.

A focus on, and expectation that mothers accept personal responsibility and blame for their behaviours, experiences, or circumstances, led clinicians to assess that mothers were being defensive when they provided further explanation or context to these issues. For example, in the following illustration, the assessment made by the clinician that the mother is "seeking to justify or excuse her actions in some way" appears grounded in an assumption that this is a situation for which she must take personal responsibility for:

> *"The CPS was particularly concerned by her comments regarding her history of engaging in a sexual relationship with her brother in her early adolescence. When reflecting on this relationship and trying to make sense of its origins and the factors that perpetuated it, she was able to somewhat accept a degree of responsibility, suggesting she was "in some way to blame", however she sought to predominantly place responsibility on her mother. She expressed that children who were raised in a good home would not engage in this behaviour... and voiced her belief that if her mother had met her emotional needs, she would not have felt the need to turn to a sexual relationship with her brother. The CPS was of the*

view that although she was able to acknowledge her part in this behaviour (and the CPS shared the view that the emotionally abusive home environment had likely contributed to what had occurred), she simultaneously presented as seeking to justify or excuse her actions in some way." (Report 2)

Regarding the above illustration, social workers and psychologists working in another context (e.g. therapy for post-traumatic stress disorder) would likely not see this situation – occurring during a woman's childhood – as one for which she must take full responsibility. Indeed, if she did take full responsibility a therapist may see this as inappropriate. In a therapeutic context, a client may be encouraged to explore these other contextual explanations, and they may be seen as helpful in providing insight into this experience and may be utilised to reduce a sense of self-blame and shame. Indeed, challenging notions of responsibility and self-blame is seen as a key focus in therapeutic responses aimed at reducing shame, and at reducing trauma symptomology (Kline et al., 2018; Lee et al., 2011), reducing depression and anxiety (Kim et al., 2011), and reducing avoidance and improving help-seeking and recovery (Tipsword et al., 2021). In the above illustration, the mother is arguably demonstrating a rather balanced view of the situation and is demonstrating insight into the factors that led to her behaviour. Yet, the clinicians response to this is likely shaped by the assessment context, and the expectation that mothers accept full responsibility. In the above illustration, the extent to which the mother's explanation is affirmed by clinicians is likely to influence her willingness to continue to open up to the clinician and reflect on her prior experiences, and to do so in a way that a sense of self-blame or shame does not become a barrier to her open engagement.

Theme 2: Reflective Capacity and Insight are Probed

Alongside and overlapping this theme of seeking personal responsibility from mothers, clinicians asked questions to assess a sense of reflective capacity in mothers; that is, their capacity to understand their child's experiences and to demonstrate empathy for them (Luyten et al., 2017). However, the clinicians appeared to underestimate the stigmatising, shaming, and ultimately,

psychologically threatening nature of these lines of questioning especially in the context of the mother's life and current situation. Mothers responded to the stigmatising and shaming content as we might expect - angry, wanting to explain or justify, and by disengaging. Clinicians interpreted this behaviour as defensiveness.

Clinicians reported asking questions that prompted mothers to consider the impact of their choices or circumstances on their children. However, this approach did not appear to be effective in revealing reflective capacity. For example, one clinician wrote:

> "*With regards to her relationship with her baby's father, she said this had been a "one night stand". She said she did not know anything about this man other than his name was "John*[2]*" but did not know his surname and had not seen him again. When asked to talk more about this, she became agitated and defensive, particularly when the clinician asked her to consider what it would be like for her baby to grow up not knowing his father's identity. She struggled to see this from her baby's perspective as she continued to state she did not know who his father was and would not be able to find him.* (Report 4)

In this case, the clinician is asking one question, do you understand the pain your child may experience, but because the issue is socially stigmatised (having a 'one night stand'), this issue is likely quite threatening for the mother. The clinician seems unaware that this line of questioning is likely to induce feelings of social devaluation, stigma, and, consequently, illicit shame in mothers. Indeed, rather than following the clinician in this cued reflection in an empathetic and yet cognitively detached way, the parent interprets the question as asking the impossible – to fix something that she has no power to fix (i.e., the relationship of the child to the unknown parent). In this particular example, we see how the threat and shame is heightened when mothers perceive aspects of their situation to be outside of their control or when they perceived aspects of their situation to be unresolvable. In these instances, they instead respond with anger, defensiveness, and withdrawal.

[2] Name has been changed.

This issue is perhaps best illustrated in the disconnect between the way that clinicians approach the issue of domestic violence, and the way that this impacts on the responses of mothers. For example, one clinician writes:

> "*With regards to the violence within her relationships, she said she did not report this to SAPOL (local police) because she was scared and because her partner had threatened her, and she believed she would get hurt. When asked to consider the impact of domestic violence on the children, she struggled to talk about this and minimised their experiences. When specifically asked to consider how the children would have felt witnessing violence, she minimised this and focused on herself and struggled to focus on the children and their experiences."* (Report 8)

Again, we can see the disconnect, between what the clinician is seeking (empathy for the children) and what the mother appears to feel she is being accused of – causing that suffering to her children. Nowhere in the notes is any reflection from the clinician on how difficult it might be for the mother to acknowledge that suffering, how ashamed she might feel, or how much there is an implied pressure to take responsibility for something in the past that the mother cannot change.

In several cases clinicians reported similar approaches to the issue of domestic violence and in each it appeared that mothers found this line of questioning challenging, focused on their own experiences of victimisation in these situations, and implied a perception that they were being blamed for their circumstances. In each case, it appears that the clinicians miss the highly stigmatising and shaming nature of their questioning, and miss reflecting on (or normalising for the mother) how natural defensive responses are in shame inducing contexts, particularly when the cause of the shame seems irreparable (Cibich et al., 2016), and one is experiencing a social threat to one's core identity and relationships (Wenzel, et al., 2020). Furthermore, there is some evidence to suggest that clinicians may lean into shaming responses even further when shame is not apparent. In an observational case study of approaches taken by statutory child protection clinicians in England, Gibson (2020) found that clinicians made assessments about the level of shame expressed by

parents, and that if they perceived this shame to be low, they then used shaming approaches as a way to communicate the significance of the concerns to parents. He termed this approach "shaming the shameless" (2020, pg. 226). It's possible that in seeking a sense of empathy – or reflective capacity – from mothers of their children's experiences, that clinicians are indeed seeking a sense of guilt, remorse, or shame from mothers. However, it is also possible that this very experience of guilt and shame within mothers could be hiding any outward displays of remorse or empathy. Shame is understood as a painful emotion that leads to avoidance when the source of shame is perceived as unresolvable (i.e., when one cannot alleviate shame by changing their behaviour, changing the circumstance, making amends; Cibich et al., 2016). In the above illustrations, as the mothers in these cases had little capacity to find her child's father, or little agency or control over her own position as a victim of domestic violence, it's likely that feelings of shame in these circumstances may be expressed by defensiveness, avoidance, or by highlighting their lack of agency or control.

Clinicians requested responses from mothers that recognised aspects of their developmental history that may compromise their parenting, for which they must take responsibility to resolve. Time is spent throughout the assessment process to explore mothers' developmental experiences, including their experiences of being parented as well as their formative relationships and adversities. Within PCA reports, this is explained as important in order to understand the template for parenting that parents have developed, as well as to identify any longstanding issues related to adverse childhood experiences and trauma that may impact upon their parenting capacity, and which may require therapeutic support to address (Tustin & Whitcombe-Dobbs, 2024). However, it appeared that these issues were particularly distressing and traumatic for mothers:

> *She appeared to avoid intense emotions and managed them by utilising maladaptive strategies, which will be discussed later in this report. She demonstrated limited insight into how her adverse childhood experiences had impacted upon her personal functioning and struggled to discuss her experiences in detail, being somewhat guarded and avoidant in her responses.* (Report 8)

Mothers have reported feeling unsure about why their adverse histories and experiences of childhood trauma were raised throughout child protection proceedings, and have reported that this process was painful and felt like a form of punishment towards them (Mason et al., 2020). While clinicians may be raising these issues to identify a mother's support needs, it appears that clinicians may need to explain the relevance of these discussions to mothers, as well as their intentions in raising these issues.

Additionally, Mason et al. (2020) suggest that while mothers' avoidance in these contexts is often assessed in terms of their resistance, that these responses can be seen as an understandable response in a cohort of women with low levels of trust due to repeated victimisation and trauma histories. In the illustration above, the clinician concludes that the mother demonstrated limited insight into the lasting impact of her childhood experiences. This again highlights the challenge in the dual protective and therapeutic aims of the interview, and indeed how clinicians appear to be heavily favouring the protective aims. To demonstrate insight into these issues would likely require the mother to feel psychologically safe, to feel a sense of trust with the clinician, and to be therapeutically guided or supported in her exploration of her adverse childhood experiences. In absence of this, the mother's guarded response is perhaps understandable. This may be demonstrative of one of two things, both of which highlight the need for a more therapeutic approach; that the mother does have insight into these issues but may be avoiding an in-depth discussion, or that the mother requires more support to make the connection between her childhood and current experiences. In the case of the latter, this is something that often occurs throughout the course of therapy, and it is a rather high expectation that she does this on her own, and without such structured therapeutic support.

Theme 3: Implicit Demand for Non-Reactive Participation

During the interviews, clinicians raise issues that are likely quite shame inducing for mothers, that may invoke a sense of sadness and/or guilt, and that relate to a mother's experiences of relational abuse and trauma. The way that mothers managed their emotions throughout the

interviews appeared to impact upon clinicians' assessments of their responsibility taking, defensiveness, insight into the child protection concerns, and motivation to change. Indeed, clinicians seem to have an implicit expectation that mothers demonstrate the appropriate emotions of sadness and remorse, and that they otherwise participate in the assessment process without becoming emotionally heightened and reactive.

When mothers were able to name self-conscious emotions such as guilt or verbalised a sense of distress at their own behaviour, this was assessed positively by clinicians:

> *"The CPS considered she had demonstrated remorse about her drug use and its role in having her baby removed from her care. She stated that she felt "sick" and "guilty" at the thought that her behaviour had resulted in his removal... The CPS considered that she was genuinely concerned for her baby's well-being and appeared to demonstrate relative empathy and insight regarding the reasons her baby was removed from her care."* (Report 4)

This was the only case in which a clinician noted that a mother was able to explicitly name her guilt. In all other cases, clinicians reported that mothers expressed sadness, anxiety, anger, emotional lability, and were emotionally distant or blunted in affect. As one clinician reported:

> "*During the second interview, while she was initially flat and somewhat withdrawn, when questions of a challenging nature were asked, she became angry and began to swear and shout. During the course of this assessment, she demonstrated limited reflective capacity, and she struggled to be child focused. The clinician also noted at times she appeared somewhat disinterested in talking about her baby as her descriptions about him appeared to lack emotion.*" (Report 8)

While the above illustration suggests that the mother became angry and began to swear and shout in response to questions of a challenging nature, the clinician nevertheless concludes that her heightened state is demonstrative of a lack of reflective capacity or child-focussed behaviour. With regards to the clinicians' challenging questioning, while it's possible that the mother's heightened

response could indeed be indicative of deeper feelings of distress, including feelings of guilt or shame (that indeed may indicate insight or remorse), this is not considered within the clinicians' report. As shame is understood as a painful emotion that is often not openly identified and named by those experiencing it (Tagney et al., 2007), it is suggested that when working with shame in a therapeutic context, that practitioners are aware of presentations such as anger, aggression, despair, contempt, helplessness, avoidance, and withdrawal as potential indicators that someone is experiencing shame (Morrison, 2011). Additionally, emotional withdrawal, and presenting as emotionless or flat in affect, is common in those who have experienced trauma and who have PTSD and is understood as a way to dissociate and protect oneself from harmful traumatic memories and events (Mucci & Scalabrini, 2021; Music, 2022). Indeed, mothers becoming emotionally heightened in response to discussions of their trauma were common in reports. As one clinician reported:

> *The CPS attempted to discuss the recommendations with her but she seemingly did not seem to hear these and instead went on to talk about her experiences during the assessment, which she described had led to perhaps a visual flashback from her childhood. As a result of her emotional state the CPS ended the feedback session early.* (Report 2)

Following the completion of the assessment interviews, parents are invited to a feedback session where the clinicians discuss their report recommendations. It appears that in this case, the mother is preoccupied with the challenges that she experienced during the interview. Indeed, had the mother experienced visual flashbacks to her childhood during the assessment, it would be reasonable to assume that she was not fully psychologically present during the interview, and may find it hard to accept recommendations that arose from her engagement in this context. It's unclear from this report how much the clinician was willing to hear these concerns from the mother, whereby it appears that they were not able to reconcile this issue prior to instead ending the session early. While the mother in the above illustration was able to verbalise, during the feedback session,

that she had experienced a visual flashback during the interview, most mothers demonstrated some signs of acute stress:

> *She presented as emotionally labile, appearing in turns as heightened, tearful, defensive, and even angry on occasion. Her narrative was tangential, chaotic, and sometimes incoherent, and she remained difficult to intercept or redirect, talking over the clinician at times.* (Report 5)

It is unclear what measures are put in place to protect the psychological safety and wellbeing of mothers who have significant trauma histories, and who are requested to discuss these during PCAs. Indeed, while there are several publications that suggests methods for conducting PCAs, there appears to be limited considerations for managing re-traumatisation in parents, despite many suggesting that a key avenue of exploration with parents during interviews is their adverse childhood experiences and childhood trauma (Budd, 2005; Houston, 2016; Smith & O'Donnell, 2023; Tustin & Whitcombe-Dobbs, 2024). While an article by Smith and O'Donnell (2023) does mention parents' trauma responses during PCA's, they discuss this in the context of challenges during the interview process, stating that parents might experience "acute stress and posttraumatic responses that contribute to explanations and behaviours that are incongruent with what is known of the situation" (pg. 822). In this way, the issue is not how to avoid re-traumatisation in parents in a way that may also support a more effective engagement with them, but how to discern the truth from parents who are in a state of acute stress and experiencing posttraumatic symptomology during the interview.

The extent to which PCAs are conducted in a trauma informed manner, and indeed, how this can be managed in a context whereby women with histories of extensive interpersonal abuse and trauma are mandated to attend an assessment and required to discuss these experiences, is a significant ethical consideration for both social workers and psychologists conducting PCAs. Indeed, how these issues are managed (and whether they cause psychological harm) is likely to be highly influential to a mother's motivation to engage with professionals in the future.

In one case where a mother was able to engage in a manner that wasn't emotionally heightened or reactive, clinicians noted scepticism in the level of truth she shared, and rather suggested that she may have been in a position to manipulate the findings of the assessment:

> *Whilst she did present as engaging and frank in her discussion, the CPS was aware that Ms Mother was very familiar with 'the system', having spent a significant number of years in the Adelaide Women's Prison (AWP) and had some previous involvement with child protection growing up. As such, it was postulated that she may have provided information which portrayed her in a positive light.* (Report 3)

Mothers' heightened responses were often decontextualised when clinicians made assessments of their character and considered their capacity for change and for reunification. For example, presentations such as defensiveness, despite often being a natural human tendency when under psychological threat (Wenzel et al., 2020; Woodyatt & Wenzel, 2013), were assessed at the individual level, and without consideration for the ways in which the assessment context, or the clinicians' line of questioning, may have influenced this response in mothers. In one case, a clinician implied that a mother's defensiveness was indicative of a pathological trait-based characteristic:

> *Her current personal functioning, mainly her difficulties in taking responsibility for her own actions, tending to blame others and deny the presence of problems, maybe a consequence of personality dysfunction.* (Report 9)

In most of the reports, mothers' heightened presentations, as well as their avoidance of certain issues and their defensiveness, led to attributions from clinicians that mothers had limited insight and limited capacity to change:

> *She was defensive in her presentation, and this, as well as her overall lack of frankness in her engagement with CPS indicated a lack of insight into the child protection concerns, and a limited capacity for change.* (Report 7)

Conclusion

The aim of the current study was to explore how child protection clinicians engage with mothers during PCAs regarding conversations related to the child protection concerns and how they appraise the responses of parents to these conversations. The findings of this study suggest that clinicians took a confrontational approach to their engagement with mothers and were approaching these conversations with a narrow view of individual responsibility and blame. It appeared that mothers found this approach challenging, and managed this by providing inconsistent information, providing further explanation, becoming angry or emotionally withdrawn, and becoming avoidant or defensive, in addition to displaying signs of acute stress or re-traumatisation. These presentations of mothers were assessed negatively, whereby most reports concluded that mothers were being defensive, did not demonstrate insight into the concerns, and had limited capacity for change.

While it has been proposed that PCAs have a dual protective and therapeutic aim, whereby clinicians are tasked with assessing risk as well as identifying parents' therapeutic and support needs, it appears that the approaches of clinicians in this study fall well within the protective aim. It appeared that clinicians were sceptical of mothers' responses and avoided taking an approach that would support engagement and collaboration if that came at the expense of identifying risk. However, as all reports that didn't recommend long term custody loss suggested a further 12-month care and protection order (i.e., no immediate reunification), this focus on risk above all else is questionable. If there is to be a further 12-month care and protection order in place while a parent has the opportunity to make change (at which point they are reassessed prior to reunification), is it necessary for a clinician to, for example, withhold information from parents to detect their dishonesty? If clinicians were to instead work with parents to foster an honest response, identify the need for support to remove the risks of harm posed, and then create a plan for service engagement over the 12-month care and protection order prior to reassessment, this arguably does not appear to constitute an unacceptable risk. Rather, such an approach may fulfil dual protective and therapeutic aims, while also increasing the potential for family reunification over the longer term.

For some parents, the PCA interview is the first time that the child protection concerns are raised with them in detail (Higgins et al., 2019). This is also an opportunity where a trained professional can speak with parents about their own childhood adversities, relational traumas, experiences of violence, of mental health challenges, and of addiction, amongst other issues. How clinicians raise these issues can be highly influential on the willingness of parents to discuss these issues, reflect upon them, be motivated to engage in a process of change, and be motivated to seek support in future (Holdsworth et al., 2014). Organisations conducting PCAs may hold a concern that adopting a more therapeutic approach to conducting PCAs may influence parents' behaviours, or allow for a 'disguised compliance', rather than to simply assess – without influencing – a more objective judgment of parenting capacity at the point of the assessment. The product of this, however, appears to be an assessment that acts as a test of whether parents can withstand and provide the correct responses during an often traumatising and psychologically threatening process. Of course, such an approach is also likely to influence a parent's behaviours (but towards withdrawal and disengagement), which raises questions about objective judgments of parenting capacity as assessed during a dynamic and interactive interview process upon which a clinicians' influence cannot be extracted. Given the low rates of family reunification, as well as the potential for psychological harm to parents and particularly mothers during the assessment process, a PCA process that fulfils both protective and therapeutic aims is warranted.

The use of assessment reports in this study is both a strength and a limitation. On the one hand, the use of reports may provide a more accurate and nuanced representation of the appraisals and assessments made by clinicians than interviews, and therefore the self-reporting of clinicians, may provide. On the other hand, the level of extrapolation regarding the approach of clinicians or the responses of mothers from written text, and from reports written for a particular professional audience, leaves room for inaccuracies in findings. The potential for this was mitigated by drawing findings from parts of reports that reported verbatim questions or responses, and by contextualising the findings (and the consistency of these findings) within the broader child protection research

field. Conducting in-person observations of parent interviews, as well as interviewing clinicians and parents of their approaches to, and experiences of, PCAs, are opportunities for future research aimed at improving the process and outcomes of PCAs.

CHAPTER 5. Examining the Role of Defensiveness Perceptions in Approaches Towards Child Protection Proceedings and Decision Making

> *Assessors are not scientists. They are just professionals with a different training than lawyers or judges. They bring a different set of values and norms to the analysis of parents' behaviours. Their views are opinions and opinions only, just as the judge and lawyers will have opinions about the parents (or about the social workers, or other witnesses in the case). The assessor's views are not scientific findings* (Curtis, 2009, pg. 10).

When clinicians conduct a Parenting Capacity Assessment (PCA), they seek a sense of responsibility from parents for the issues that pose harm to their child, as well as for engaging in a process of future change (Budd, 2005; Gray, 2014; Tustin & Whitcombe-Dobbs, 2024). Whether or not a parent takes responsibility for these issues, or responds by denying blame, denying responsibility, and by being defensive, influences the extent to which a clinician deems that the parent can work towards change, and that reunification is a possibility. However, whether a parent is being defensive is somewhat of a subjective judgment. In Chapter 4, I found that clinicians took a narrow focus on individual responsibility and blame, and that when mothers sought to provide further explanation, clinicians deemed this as mothers being defensive. Likewise, when clinicians deemed that a mother was being defensive, they attributed this to her not having insight into the situation, which appeared to negatively influence decisions regarding reunification. However, a clinician's approach towards individual responsibility and blame could affect the extent to which they perceive a parent as being defensive when they provide further explanation of their circumstances. For example, if a clinician assumes that a parent isn't fully to blame for their circumstances, they might accept a parents' explanations as providing further context, or by rightly sharing blame with aspects of their situation for which they are not individually responsible. Further, the extent to which a clinician perceives a parent as either being defensive or as providing further context may influence their attributions of a parent's understanding and insight into the related issues, which may then influence reunification decisions. If an approach towards individual

responsibility does affect perceptions of a parents' defensiveness, as well as downstream attributions and decisions, this raises issues with the subjectivity of these assessments. The aim of the current chapter is to test whether an approach that assumes a parent to bear full responsibility and blame for their circumstances influences perceptions of defensiveness, attributions of insight, and downstream decision-making. Given that approaches towards individual responsibility and blame are likely influenced, in part, by organisational cultures, values and attitudes I sought to test whether altering the extent to which one is directed to take an approach that assumes a parent is individually responsible for their circumstances affects their perceptions of a parent's defensiveness, and their subsequent approach towards the interaction. This research therefore explores subjective elements of PCAs that may influence recommendation outcomes.

Individual Responsibility in Child Protection

Consistent with neo-liberal understandings and expectations of individual responsibility, and rooted in a conceptualisation of child harm as resulting from the individual actions and pathology of parents (Kempe, 1962), contemporary child protection systems have continued to adopt practices that attribute blame and responsibility for the conditions that cause child harm (or risk of harm) to parents (Featherstone, 2016; Hyslop & Keddel, 2018; Lonne, 2009; Morris et al., 2018). In these cases, the broader economic and social inequalities that may contribute to risk and harm, such as poverty and discrimination, are often overlooked. Indeed, in their research on the approaches of child protection social workers, Morris et al. (2018) suggest that workers actively avoid an analysis of the influence of issues such as poverty on child abuse and neglect, for fear of increasing stigmatisation. However, they argue that this only contributes to a child protection practice that does not account for structural disadvantage, and that rather focuses on managing individual risk in absence of a consideration of the broader context of injustice and harm. Likewise, there is a significant body of literature documenting the issue of attributions of responsibility in cases of domestic violence within child protection contexts. Recent review articles (Humphreys & Absler, 2011; Deblasio, 2022), studies of child protection policies and case files (Azzopardi, 2021; De

Simone & Heward-Belle, 2020; Grace, 2022), and studies of the experiences of mothers and service providers (Wild, 2023; Stewart & Arnull, 2022; Cramp & Zufferey, 2020), have found that victim-blaming or mother-blaming in instances of domestic violence is a significant issue within child protection practice with mothers. This is often attributed to an underlying assertion or belief that mothers are responsible for protecting, and therefore for failing to protect, their children from harm, despite often being in situations outside of their choosing, and for which they find it hard to escape (Storer et al., 2018). Indeed, it appears that child protection workers are not immune from the tendency found in healthcare workers (Martinez-Garcia et al., 2021), police (Serrano-Montilla et al., 2023), and the general public (Policastro & Payne, 2013; Valor-Segura et al., 2011), to blame female victims of domestic violence for their circumstances.

While attitudes towards individual responsibility in child protection contexts are consistent with attitudes of individualism found across Western, neo-liberal societies, the extent to which these attitudes influence practice approaches may vary across sub-disciplines. For example, in the addiction field, there has been a shift away from the moral/choice model of addiction that places blame solely on the individual experiencing addiction, and which is understood as a source of stigma that acts as a barrier to help-seeking and recovery (Rundle et al., 2024). Rather, contemporary alcohol and other drug practitioners commonly adopt a medical or psychosocial model to understanding and treating addiction (McKillop & Ray, 2017) that considers the drivers of addiction to be issues such as trauma and mental ill-health (Moustafa et al., 2021), lack of belonging and isolation (Dingle et al., 2015), loss and grief (Parisi et al., 2019), and poverty and disadvantage (Galvão et al., 2018), rather than simply to the poor choices of immoral actors. Such an approach still views one's sense of choice and agency over their situation, in addition to a sense of self-efficacy and accountability, as key aspects to develop within therapeutic responses towards addiction recovery (McKillop & Ray, 2017). However, personal blame and responsibility for developing an addiction is not placed solely on the individual and in absence of consideration for contextual factors that influence one's behaviour. In this way, it is not seen as necessary to seek full

blame and responsibility – and indeed, would be understood as counterintuitive to engagement in recovery due to resultant issues of shame and avoidance (Dolezal & Gibson, 2022) – from people who use drugs or experience addiction, in order to gain a commitment and sense of responsibility from them towards engaging in behaviour change and recovery.

This approach to addiction – that sole responsibility or blame are not required for behaviour change and recovery – as well as common therapeutic approaches to issues of trauma, mental ill-health, and domestic violence, appear at odds with the approaches of clinicians within PCAs. Rather, what I found in Chapter 4, was that clinicians took an approach to PCAs that assumed that a mother needs to bear full responsibility for her experiences, behaviours, and circumstances. As it was an expectation from clinicians that mothers accept full responsibility and blame, where they instead sought to explain their circumstances within a broader context, or sought to share blame, this was assessed by clinicians as mothers not taking responsibility, and rather, as being defensive. This makes intuitive sense – if the clinician takes an approach that in essence requests full blame and responsibility from the parent, and the parent's response is rather to provide an explanation that shares this blame or responsibility amongst broader contextual factors, they are in essence deflecting some of the blame or responsibility they are expected to take on. Therefore, I suggest that if a clinician is to take an approach towards a child protection assessment that assumes a parent to bear full, individual responsibility and blame, this will cause them to perceive a parent's explanation as defensiveness.

Perceptions of Defensiveness and Appraisals of Insight

While defensiveness is expressed outwardly as a denial of responsibility and blame, it is the internal psychological processes that accompany this expression that constitute psychological defensiveness (Wenzel et al., 2020). Psychological defensiveness is understood as a 'psychological immune response' that protects the self against the threat to one's identity as a moral person, the threat of social rejection, and the associated feelings of guilt and shame when one has transgressed (Woodyatt & Wenzel, 2013). To be defensive is not just to deny the presence of a problem or of a

wrongdoing, which could occur in both instances where one does, or does not, believe that they are responsible. Rather, it is to believe that one is guilty or blameworthy, and to deny guilt and responsibility as a way to protect oneself from the threat this brings (Wenzel et al., 2020). However, to the eye of the perceiver, these two processes – denial of guilt and/or responsibility because one doesn't believe they have wronged, or because one doesn't want to openly accept they have wronged – may look very similar.

In the context of PCAs, the findings of Chapter 4 suggest that when clinicians were perceiving that a mother was being defensive, they were then attributing this to her lacking insight into the concerns raised. In this case, there is a sense that the mother simply does not understand what is wrong with her situation or her behaviour. However, this raises issue with the accuracy of these appraisals. In the absence of a clear verbal expression of guilt and of responsibility taking, how is one to know whether this is because a person simply does not believe that there is a problem, or whether they do indeed feel guilty and/or blameworthy (and therefore understand the concerns) but are defending against this as a mechanism of self-protection? In the case of PCAs, it appears that there is a propensity for clinicians, at least in their reports, to not consider the psychological aspects of defensiveness. That is, to not consider defensiveness as a protective mechanism, and as a reflection that one does indeed feel guilt and shame, and that they do have an understanding of the issue being raised. This may be representative of a more lay understanding of the defensiveness of others. While perceptions of defensiveness have, to my knowledge, never been explored empirically, research on interpersonal conflict has found that victims of interpersonal transgressions often perceive that offenders of those transgressions feel less guilty than they report feeling (Adams & Inesi, 2016). Perhaps there is a tendency to think that those we perceive as responsible for wrongdoings simply don't share the same normative values or sense of morality that would lead them to feel guilt and shame. Therefore, and consistent with the findings from Chapter 4, I propose that when clinicians perceive a parent as being defensive, they will appraise this as the parent not having insight into the issues being raised.

Approaches Towards the Interaction and to Decision Making

How one perceives and appraises the defensiveness of others will be consequential for how they may then respond. In a therapeutic context, if a clinician believes that a parent does not have insight into the concerns being raised with them, an appropriate next step may be to continue efforts to promote this understanding in parents, or to try to come to a shared understanding of the issue. Conversely, if a clinician believes that a parent does have insight into the issues and is rather being defensive to protect themselves against the threat of consequence – for example, in the form of child removal, social rejection, shame or stigma, etc. – it may be counterproductive to continue to explain the concerns. Rather, reducing the perceived threat would be more effective in reducing defensiveness and promoting responsibility taking in this case (Cornish & Wade, 2015; Wenzel et al., 2020; Woodyatt & Wenzel, 2014). However, the extent to which people are attuned to the need for, or utility of, these different responses to perceived defensiveness is unclear. Indeed, it appeared from the findings from Chapter 4 that in the PCA context, whereby clinicians appeared to come from a less therapeutic orientation, that parental defensiveness was often met with a more confrontational approach, perhaps regardless of appraisals of their insight. I therefore propose that when clinicians' both perceive that a parent is being defensive, and appraise that the parent has low insight into the concerns being raised, that they will take a more confrontation approach towards the interaction. This would provide some explanation for the deterioration in engagement over the course of the assessment that was found in Chapters 2 and 4.

The findings from Chapter 4 suggest that appraisals by a clinician of a mothers' defensiveness, as well as the associated appraisal that she had little insight into the concerns being raised, was a key factor influencing recommendations regarding the viability of family reunification. It appeared that clinicians concluded that where a mother cannot come to an understanding of the issues presented to her, she will have little capacity to make change. Regardless of appraisals of insight, defensiveness in the child protection context is also viewed as a form of resistance to engage or to comply with plans and recommendations, and is a factor involved

in reunification decisions in its own right (Donnelly, 2023). I therefore propose that clinician's both perceiving a parent as being defensive, and appraising that they have low insight into the concerns, will influence their decisions not to reunify the parent's child.

The subjectivity of decision making in child protection is a significant concern, particularly due to the often life-long consequences these decisions hold. Research suggests that clinicians' attitudes regarding child removal (Davidson-Arad & Benbenishty, 2008, 2014), their perception and tolerance of risk (Keddell 2017; Keddel & Hyslop, 2018), and racial, gender, and class bias (Middel et al., 2022; Pryce et al., 2018) are just some of the factors influencing decision making processes in child protection contexts. I suggest that another factor that may influence the subjectivity of child protection decision making is the approach that clinicians take towards individual responsibility and blame, how this approach may influence their perceptions of parental defensiveness and appraisals of parental insight, and how these perceptions and appraisals shape their subsequent approach to the interaction, and their decision making.

The Current Research

The aim of the current studies is to explore whether perceptions of a parent's defensiveness and appraisals of their level of insight when they provide explanations or give further context, is shaped assumptions about the level of individual responsibility and blame that a parent holds for their behaviour and circumstances. An additional aim is to explore how these perceptions of defensiveness and appraisals of insight influence the subsequent approach to the interaction with the parent, and influence decision making regarding family reunification. In both studies, participants either watched a video or read a scripted interaction between a child protection clinician and a parent, and responded to measures of their perceived defensiveness, appraisals of insight, endorsement of confrontational response, and reunification decision.

To investigate how people appraise the defensiveness of others, in Study 5.1, I used an experimental paradigm within an online survey completed by lay participants. Lay participants were sampled because the lay population may not already be trained to take an approach that assumes a

particular orientation towards parental responsibility in these contexts, which allows for a test of the malleability of these approaches based on instructions within the experiment. Additionally, in the broader psychological research context this was the first study, to my knowledge, to investigate the malleability of the perception of defensiveness. To test whether varying the instructions about the importance of individual responsibility (versus shared, contextual responsibility) would impact upon perceptions of defensiveness, appraisals of insight, endorsement of confrontational approach, and reunification decision, participants were randomly allocated to one of two conditions. In the individual responsibility condition, they were instructed that they are to approach the interview with the assumption that the mother holds full responsibility and blame for the issues that cause harm to her child. In the shared responsibility condition, they were instructed that they are to approach the interview with the assumption that while the mother is responsible for her behaviour, as the issues that cause harm to her child are often influenced by broader environmental factors, they should not be seen as her sole burden and responsibility. Participants then watched an interview snippet of an (acted) child protection interview before completing the study measures. In Study 5.2, I tested the relationships between individual responsibility beliefs, perceptions of defensiveness, appraisals of insight, endorsement of confrontational approach, and reunification decision in a sample of child protection workers to test the replicability of the effect in those with experience in the field. In study 5.2, participants read the scripted interview used in Study 5.1 before completing the measures.

Study 5.1

Summary of Hypotheses

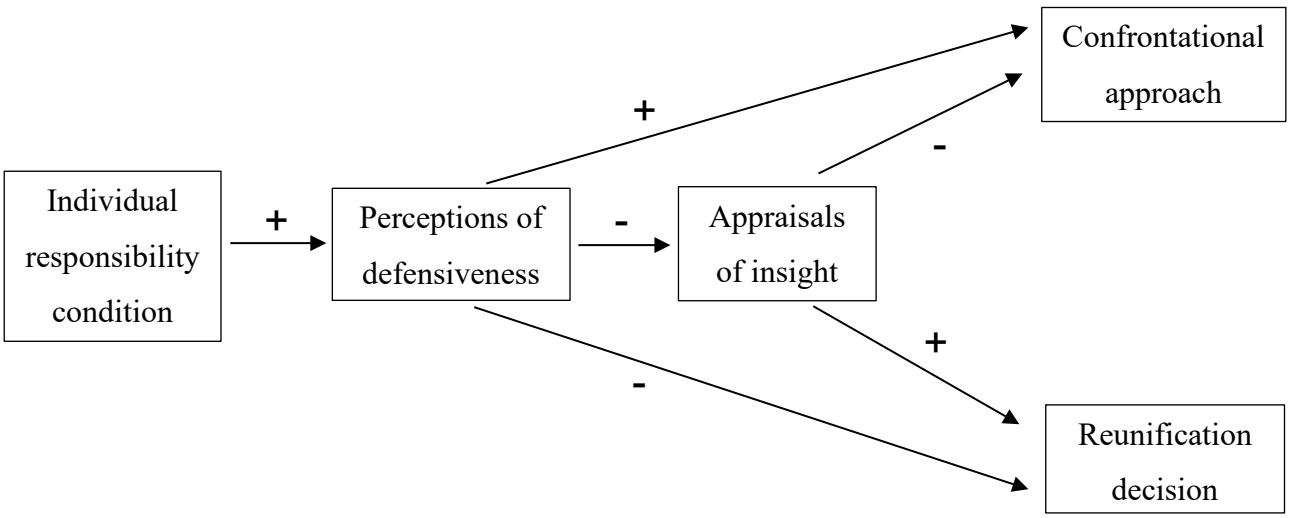
As illustrated in Figure 5.1, I hypothesised that:

1. There will be a significant indirect effect of responsibility condition on endorsement to take a confrontational approach through perceptions of defensiveness and attributions of insight.
2. Participants randomised to the individual responsibility condition will score higher on perceptions of defensiveness than participants randomised to the shared responsibility condition.

3. Perceptions of defensiveness will have a significant negative direct effect on appraisals of insight, and appraisals of insight will have a significant negative direct effect on endorsement of confrontational approach.
4. Perceptions of defensiveness will have a significant positive direct effect on endorsement of confrontational approach.
5. There will be a significant indirect effect of responsibility condition on reunification decision through perceptions of defensiveness and attributions of insight.
6. Appraisals of insight will have a significant positive direct effect on reunification decision.
7. Perceptions of defensiveness will have a significant negative direct effect on reunification decision.

Figure 5.1.

Proposed Serial Mediation Analysis Examining the Effect of Responsibility Condition on Confrontational Approach and Reunification Decisions through Perceptions of Defensiveness and Appraisals of Insight.



Method

Participants

A power analysis was conducted using Monte Carlo simulation to determine the number of participants required to detect a moderate relationship between variables (r = .30) and a small effect of the proposed moderation (r = .15). It revealed that a sample size of N = 300 would provide sufficient power to detect relationships for all paths in the hypothesised parallel-serial mediation model. 300 participants (50.7% male, 48.3% female, 1% non-binary) were recruited via Cloud Research from a United States sample and reimbursed $2USD for an estimated survey time of 12 minutes. Participants ranged in age from 20 to 84 years old (M = 41.24, SD = 13.16). Participant ethnicity was White (68.3%), Black or African American (17.3%), Asian (5.3%), Hispanic (5.0%), multiracial (2.0%), and Native American or Alaska Native (1%). Participants were randomly allocated to either the individual responsibility condition (n = 149) or the shared responsibility condition (n = 151).

Design and Procedure

The study used a two-cell, between groups design. Participants completed the study via a Qualtrics survey on their own computer or tablet. Participants were randomly allocated to one of two conditions (individual vs shared responsibility prompt) with the manipulation embedded within the instructions that they were provided regarding the approach they are to take to when watching the video. All participants completed the same manipulation check, watched the same video stimulus, and completed the same measures of dependant and moderator variables. Two attention checks were included throughout the survey. Participants were provided a warning if they failed one attention check and were discontinued from the survey if they failed both attention checks. Participants that were discontinued from the survey were not counted within the final participant numbers.

Manipulation. Participants were randomly allocated to one of two groups. All participants were provided with the following instructions: *"In a moment, you will watch a short video in which a mother is being assessed for her capacity to retain ongoing custody of her child. You will be asked to imagine you are a social worker employed by the child protection service conducting this*

assessment. The objective of your role is to assess whether the mother has the capacity to change her behaviors or circumstances, and whether her child should be reunified to her care." In the individual responsibility condition, participants were instructed: *"When making this assessment, it is important to consider that the mother is responsible for her own behaviors, for her situation, and for making changes to benefit the wellbeing of her children. As a social worker in child protection, you are to work under the assumption that responsibility and blame for the issues that cause harm to a child sit solely with the child's parents."* Whereas in the shared responsibility condition, participants were instructed: "*When making this assessment, it is important to consider that while a mother holds responsibility for her own behavior, for her situation, and for making changes to benefit the wellbeing of her children, that some of the challenges that a mother may face can be influenced by factors outside of her control. As a social worker in child protection, you are to work under the assumption that responsibility and blame for the issues that cause harm to a child should not be seen as solely a mother's burden. The issues that cause harm to a child are shaped by both the mother's actions and the societal factors influencing her circumstances. These factors may be things like inadequate housing, financial instability, and gendered violence.*"

Manipulation check. Following the manipulation script, and prior to watching the video stimulus, three items assessed participants' understanding of the instructions they received, and to the approach they are to take to the assessment (e.g., *assume the mother to hold sole responsibility for behaviors and the situation, assume the mother does not hold the sole burden of responsibility for her behaviors and the situation, I'm not sure*)

Video Stimulus. Participants then watched a 3.5-minute video stimulus filmed with two actors, and showing an interview between a child protection social worker and a mother engaged in an assessment. Both actors were White, female, and around 30 years of age. The script for the mother was written to provide a moderate level of explanation and defensiveness from the mother, including providing a backstory, sharing blame, disagreeing with aspects of the child protection concerns, and providing information that was inconsistent with the information gathered by the

child protection social worker. The issues raised included allegations of domestic violence that were confirmed via police report, followed by a short stint of homelessness and the mother living in a tent with her children before returning to the home she shared with her partner. These issues were chosen to represent concerns that could be attributed to the mother's actions, or issues that could be attributed to her broader context, such as gendered violence and housing instability. Full text of the video script and a screenshot of the video can be found in Appendix D.

Dependent measures

All measures except for the contextualisation measure were captured on a 7-point Likert scale ranging from (1) *strongly disagree* to (7) *strongly agree.* The measure of contextualisation was captured on a 5-point Likert scale ranging from (1) *strongly disagree* to (5) *strongly agree.*

Perceptions of Defensiveness. A nine-item scale was used to measure the extent to which participants perceived the mother as being defensive after watching the video stimulus (e.g., "I believe the parent is shifting blame away from themselves", "I believe the parent is denying the accusations" $\alpha = .92$). The measure was adapted from the Perceived Apology Sincere Measure (Schumann & Dragotta, 2020), which measures perceptions of apology, responsibility, and aspects of defensiveness.

Appraisals of insight. A six-item scale was created to assess participants' appraisals regarding the level of insight the mother has of the child protection concerns being raised. The items aimed to capture insight as it related to the seriousness of the situation, as well as their understanding of the child protection concerns (e.g., "The parent is lacking insight into the seriousness of the situation", "The parent understands the concerns being raised", $\alpha = .92$).

Confrontational Approach. Four items assessed the approach that participants endorsed taking with the parent in response to their presentation during the assessment. The items aimed to capture broad conversational aspects of the approach (e.g., "I would become harsher in my approach to the parent", "I would soften my approach to the parent") as well as to aspects of the approach related to understandings of the child protection concerns (e.g., "I would challenge the

parent on discrepancies in our understanding of the situation", "I would try to find common ground or agreement with the parent in our understanding of the situation", α = .75).

Removal decisions. Two items assessed whether participants endorsed returning the child to the care of the parent, or keeping the child in state custody (e.g., "At this point in time, the child should be returned to the full care of the parent", "At this point in time, the child should remain in the care of the state", α = .92).

Exploratory Measures

Responsibility beliefs. A three-item scale was created to assess participants' beliefs about the mother's individual responsibility and blame for her situation (for e.g., "The parent is responsible for the circumstances that put their child at risk of harm", α = .90)

Results

Manipulation Check and Analysis of Between Group Differences

T-tests were performed to test the effect of the responsibility condition on perceptions of defensiveness. There was a significant effect of responsibility condition on perceptions of defensiveness $t(298) = -2.09$, $p = .04$, and no significant effect of responsibility condition on appraisals of insight $t(298) = -1.84$, $p = .07$, despite the means being in the predicted direction. While the results suggest that the manipulation was effective, it is worth noting that 59 participants did not select their understanding of the instruction that corresponded with the instruction provided to them in their manipulation script and this was not evenly distributed between conditions. 7 participants (4.7%) who were in the individual responsibility condition selected that they understood that their approach to the assessment is to assume that the mother does not bear full responsibility for her behaviour and circumstances. 52 (34.4%) participants who were in the shared responsibility condition selected that they understood that their approach to the assessment is to assume that the mother holds full, personal responsibility for her behaviour and circumstances. This suggests that, in addition to any errors of understanding that existed for participants in both experimental conditions, there was a strong propensity for those in the shared context condition to

assume, regardless of their instructions, that their role as a child protection worker was to assume the mother to hold full responsibility and blame.

Descriptive Statistics

Table 5.1 reports the means, standard deviations and correlations for the dependent variables. Perceptions of defensiveness were negatively related to appraisals of insight and removal decisions and positively related to endorsement of a harsh approach. Appraisals of insight were negatively related to endorsement of a harsh approach and positively related to reunification decisions. There was a negative relationship between endorsement of a harsh approach and reunification decisions.

Table 4.1

Means (Standard Deviations) and Zero Order Correlations for all Dependent Variables

	Individual responsibility (n = 149)	Shared responsibility (n = 151)	1.	2.	3.
1. Defensiveness	5.50 (1.03)	5.26 (1.00)	*		
2. Insight	4.74 (1.42)	4.44 (1.36)	-.76**	*	
3. Approach	3.84 (1.18)	3.51 (1.19)	.49**	-.46**	*
4. Decision	4.43 (1.76)	3.90 (.84)	-.67**	.65**	-.57**

Note. Defensiveness = perceptions of defensiveness, Insight = appraisals of insight, Approach = endorsement of confrontational approach, Decision = reunification decisions. ** p <.01, * p < .05.

Model Testing

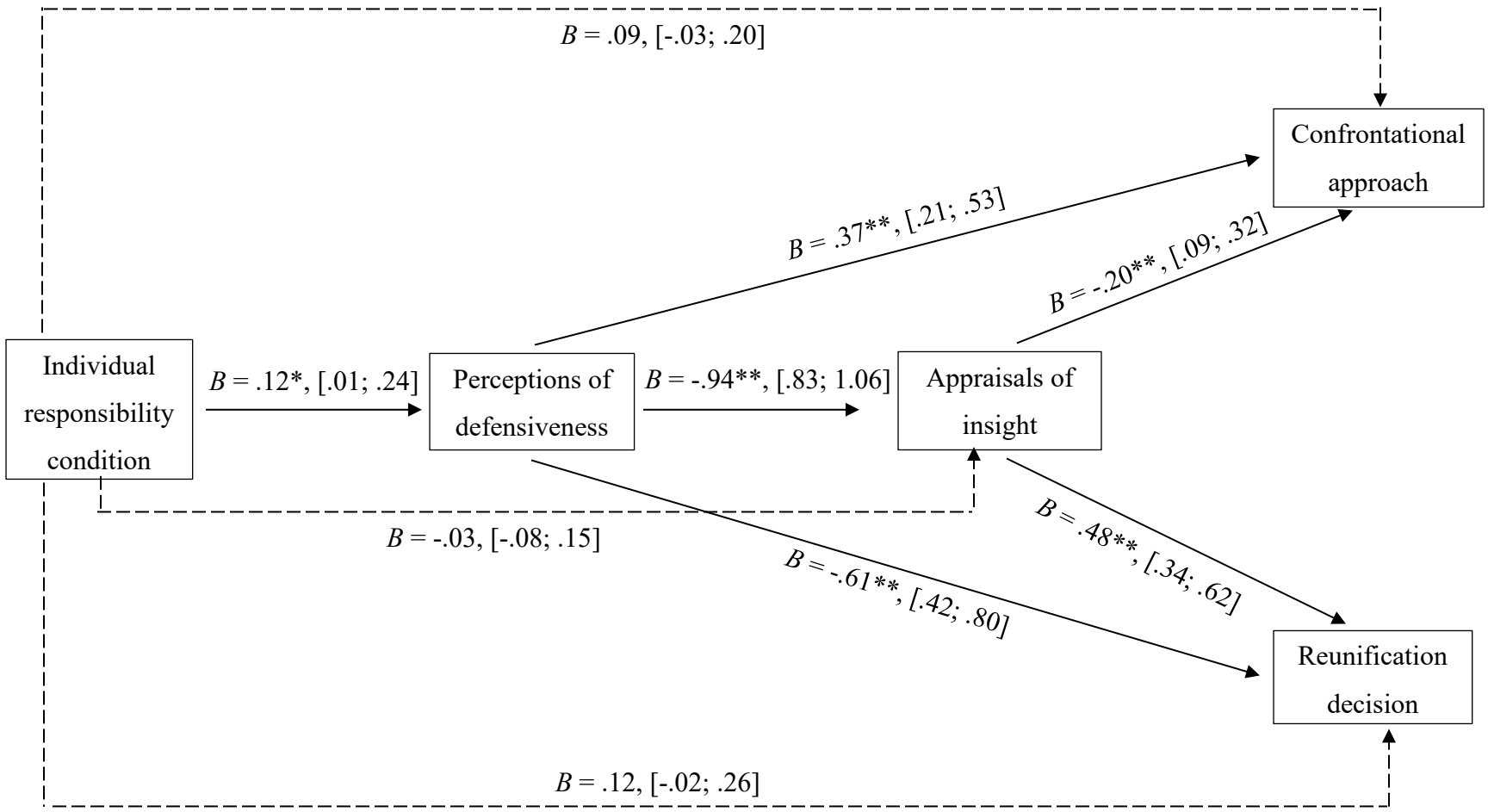
Model 6 of the PROCESS macro (Hayes, 2018) with 95% confidence intervals was used to test the serial mediation model with two mediators. 10,000 bootstrap samples were used as recommended for smaller sample sizes (Preacher et al., 2007). The dichotomous experimental condition (responsibility condition) was represented using contrast coding (shared responsibility -1; individual responsibility 1).

According to the findings, the hypothesised model was supported. Overall, the model accounts for a significant amount of variance in appraisals of insight R^2 = .48, F(2, 297) = 137.71, p = <.001, and endorsement of a confrontational approach R^2 = .27, F(3, 296) = 37.13, p = <.001. When testing the same model for the outcome variable of removal decisions, it accounts for a significant amount of variance R^2 = .50, F(3, 296) = 98.65, p = <.001.

Investigation of relationships within the model show that, as predicted, there was a significant indirect effect of responsibility condition on endorsement of a confrontational approach B = .02, CI_{95} = [.01; .05], and reunification decision B = .06, CI_{95} = [.01; .11]. All hypothesised direct effects were significant, and consistent with predictions (see Figure 5.2). There were no significant direct effects of responsibility condition on appraisals of insight, confrontational approach, and reunification decision (see Figure 5.2).

Figure 5.2

Effects for Serial Mediation Analysis Examining the Effect of Responsibility Condition on Confrontational Approach and Reunification Decision through Perceptions of Defensiveness and Attributions of Low Insight.



Note. Dotted lines = non-significant relationships, 95% confidence intervals, ** $p < .01$, * $p < .05$

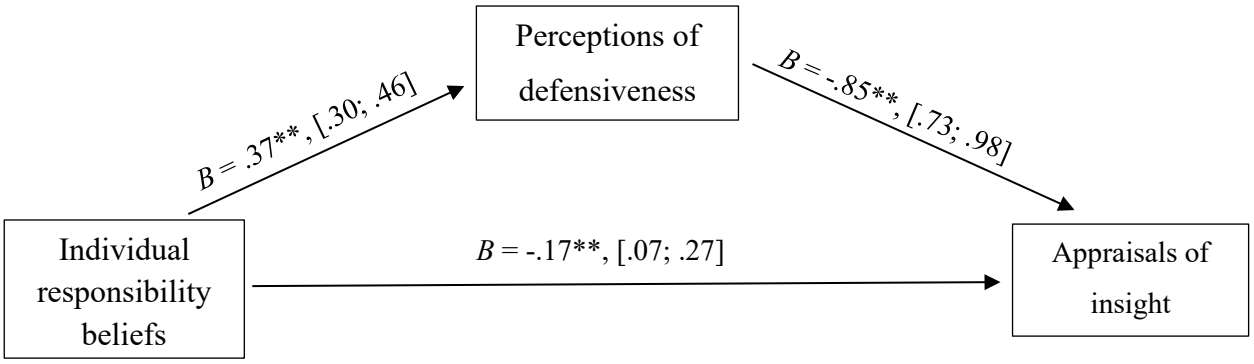
Exploratory analyses

While hypothesis testing demonstrated a small, casual effect of responsibility instructions on perceptions of defensiveness, it was notable that 34.4% of participants in the shared responsibility condition incorrectly indicated their instruction was to assume the mother to bear full responsibility and blame. As only 4.7% of participants in the individual responsibility condition incorrectly indicated their instruction in the opposite way, this suggests a propensity for participants to have assumed an approach towards individual responsibility regardless of instruction. It is possible that instructions at one short time point produce only weak change in deeply held, and indeed culturally imbedded, beliefs about individual responsibility. Therefore, I conducted exploratory correlational analyses to test the relationship between measured (rather than manipulated) responsibility beliefs, perceptions of defensiveness, and appraisals of insight.

Overall, individual responsibility beliefs were high in the sample (M = 5.31, SD = 1.26). Model 4 of the PROCESS macro (Hayes, 2018) with 95% confidence intervals and 10,000 bootstrap samples was used to test a serial mediation model with responsibility beliefs as the predictor variable, appraisals of low insight as the outcome variable, and perceptions of defensiveness and contextualisation as two serial moderators. Results suggest that the model accounts for a significant amount of variance in appraisals of low insight R^2 = .50, F(2, 297) = 147.91, p = <.001. All relationships in the model are significant (see Figure 5.3).

Figure 5.3.

Relationships for Parallel Mediation Analysis Examining the Relationship Between Individual Responsibility Beliefs and Attributions of Low Insight Through Perceptions of Defensiveness and Perceptions of Contextualisation



Note. 95% confidence intervals, ** $p < .01$, * $p < .05$

Discussion

Study 5.1 investigated whether being instructed to take an approach towards a child protection assessment interview that assumed that a mother was fully responsible and to blame for the issues that pose harm to her child, would affect perceptions of her defensiveness and appraisals of her insight when she provided explanation. An additional aim was to investigate the relationship between perceptions of defensiveness and appraisals of insight, and endorsement of a confrontational approach to the interaction and reunification decisions. The data provided support for all predictions. Participants who were instructed to take an approach towards the interview that assumed the mother was fully responsible perceived the mother as more defensive when she provided explanation than participants who were instructed to take an approach that assumed the mother to not be fully responsible. When participants perceived the mother as being defensive, they made low appraisals of insight, were more likely to take a confrontational approach to the interaction and were less likely to recommend reunifying her child. The relationship between perceiving the mother as defensive and making low appraisals of her insight was very strong.

As the present study used a lay population, while it nevertheless sheds light onto the effect of individual responsibility instructions on perceptions of defensiveness and appraisals of insight, it does not provide an ecologically valid representation of how these perceptions and appraisals influence the approaches and decision making of child protection clinicians. To address this limitation, I aimed to test the current model again using a survey design, but with a population of child protection workers. However, rather than manipulating the individual responsibility

instructions, I instead used the measure of individual responsibility beliefs. I sought to test the relationship between individual responsibility beliefs, perceptions of defensiveness, appraisals of insight, confrontational approaches, and removal decisions, in a sample of child protection workers.

Study 5.2

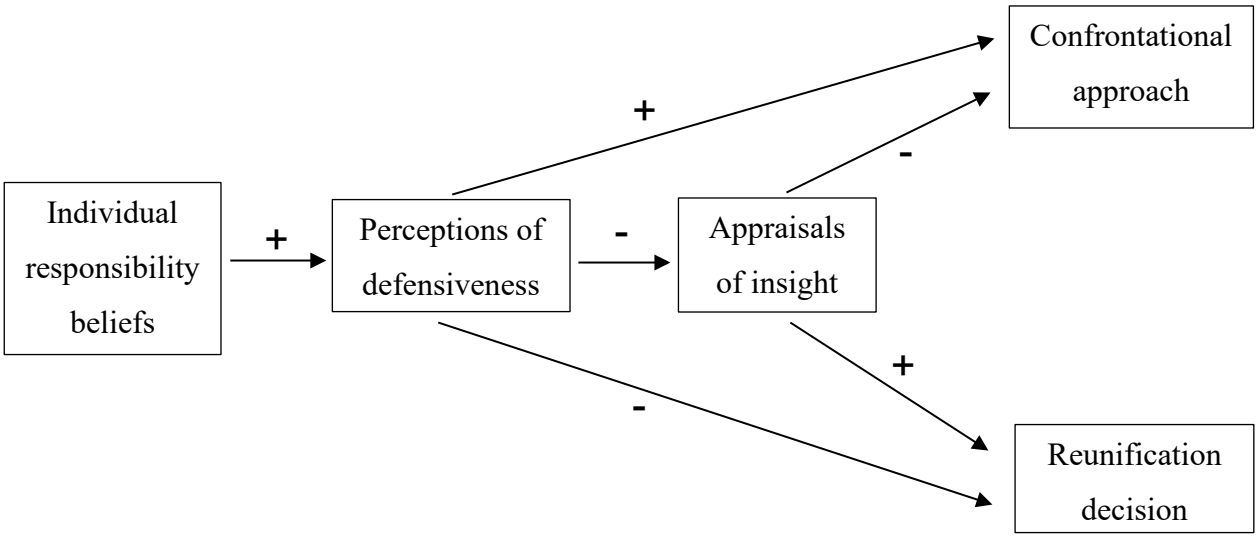
Summary of Hypothesis

As illustrated in Figure 5.4, I hypothesised that:

1. There will be a significant indirect effect of responsibility beliefs on endorsement to take a confrontational approach through perceptions of defensiveness and attributions of insight.
2. Individual responsibility beliefs will have a significant positive direct effect on perceptions of defensiveness, perceptions of defensiveness will have a significant negative direct effect on appraisals of insight, and appraisals of insight will have a significant negative direct effect on endorsement of confrontational approach.
3. Perceptions of defensiveness will have a significant positive direct effect on endorsement of confrontational approach.
4. There will be a significant indirect effect of responsibility beliefs on reunification decision through perceptions of defensiveness and attributions of insight.
5. Appraisals of insight will have a significant positive direct effect on reunification decision.
6. Perceptions of defensiveness will have a significant negative direct effect on reunification decision.

Figure 5.4.

Proposed Serial Mediation Analysis Examining the Relationships between Individual Responsibility Beliefs, Perceptions of Defensiveness and Appraisals of Insight, and Confrontational Approach and Reunification Decisions.



Method

Participants

A sample of *N* = 75 participants (53% female, 44.3% male, 2.7% non-binary) were recruited from the United States via the online platform Cloud Research. The survey was targeted towards participants who registered onto Cloud Research as working in the community services sector. Eligibility criteria for the study was set for participants who had work experience in the child protection field, and those that selected at the beginning of the survey that they had no experience in the field were discontinued from the survey. Participants ranged in age from 20 to 74 (*M* = 34, *SD* = 14.2). Participants held qualifications in social work (53.3%), community work (16%), youth work (10.7), and psychology (12%), with a further 10% indicating an 'other' qualification. Participant education level was undergraduate degree (66.7%), postgraduate degree (24%), tertiary and further education college (4%), certificate (4%), and high school (1.3%).

Design and Procedure

The study used a single, between groups design. Participants completed the study via a Qualtrics survey on their own computer or tablet. All participants read the same script and completed the same measures of dependant and mediator variables Two attention checks were included throughout the survey. Participants were provided a warning if they failed one attention check and were discontinued from the survey if they failed both attention checks. Participants that were discontinued from the survey were not counted within the final participant numbers.

Stimulus and Variables

Participants were shown a script that was a verbatim copy of the script used in the video stimulus in Study 5.1. I chose not to use the video stimulus as I felt that for a participant group of child protection workers, it might be more difficult for them to imagine themselves in the scenario or to avoid forming judgments about the worker's approach if incongruent with their own. Due to the small sample size, I measured this with the individual responsibility measure used in Study 5.1. All other variables – perceptions of defensiveness, appraisals of insight, confrontational approach, and removal decision – were measure using the same scales in Study 5.1.

Results

Descriptive Statistics

Table 5.2 reports the means, standard deviations, and correlations for all study variables. All correlations were significant. Individual responsibility beliefs were positively related to perceptions of defensiveness and endorsement of a confrontational approach and negatively related to reunification decisions. Perceptions of defensiveness were negatively related to appraisals of insight and reunification decisions, and positively related to endorsement of a confrontational approach. Further, appraisals of insight were negatively related to endorsement of a confrontational approach and positively related to reunification decisions. Endorsement of a confrontational approach was negatively related to reunification decisions.

Table 5.2

Means (Standard Deviations) and Zero Order Correlations for all Dependent Variables

	M (SD)	1.	2.	3.	4.
1. Responsibility	5.20 (1.06)	*			
2. Defensiveness	5.31 (.94)	.40**	*		
3. Insight	4.84 (1.09)	-.43**	-.54**	*	
4. Approach	3.44 (1.08)	.24*	.33**	-.23*	*
5. Decision	4.21 (1.60)	-.36**	-.61**	.35**	-.46**

Note. Responsibility = Individual responsibility beliefs, Defensiveness = perceptions of defensiveness, Insight = appraisals of insight, Approach = endorsement of confrontational approach, Decision = removal decisions. ** p <.01, ** p < .05.

Model Testing

Model 6 of the PROCESS macro (Hayes, 2018) with 95% confidence intervals was used to test the serial mediation model. 10,000 bootstrap samples were used as recommended for smaller sample sizes (Preacher et al., 2007).

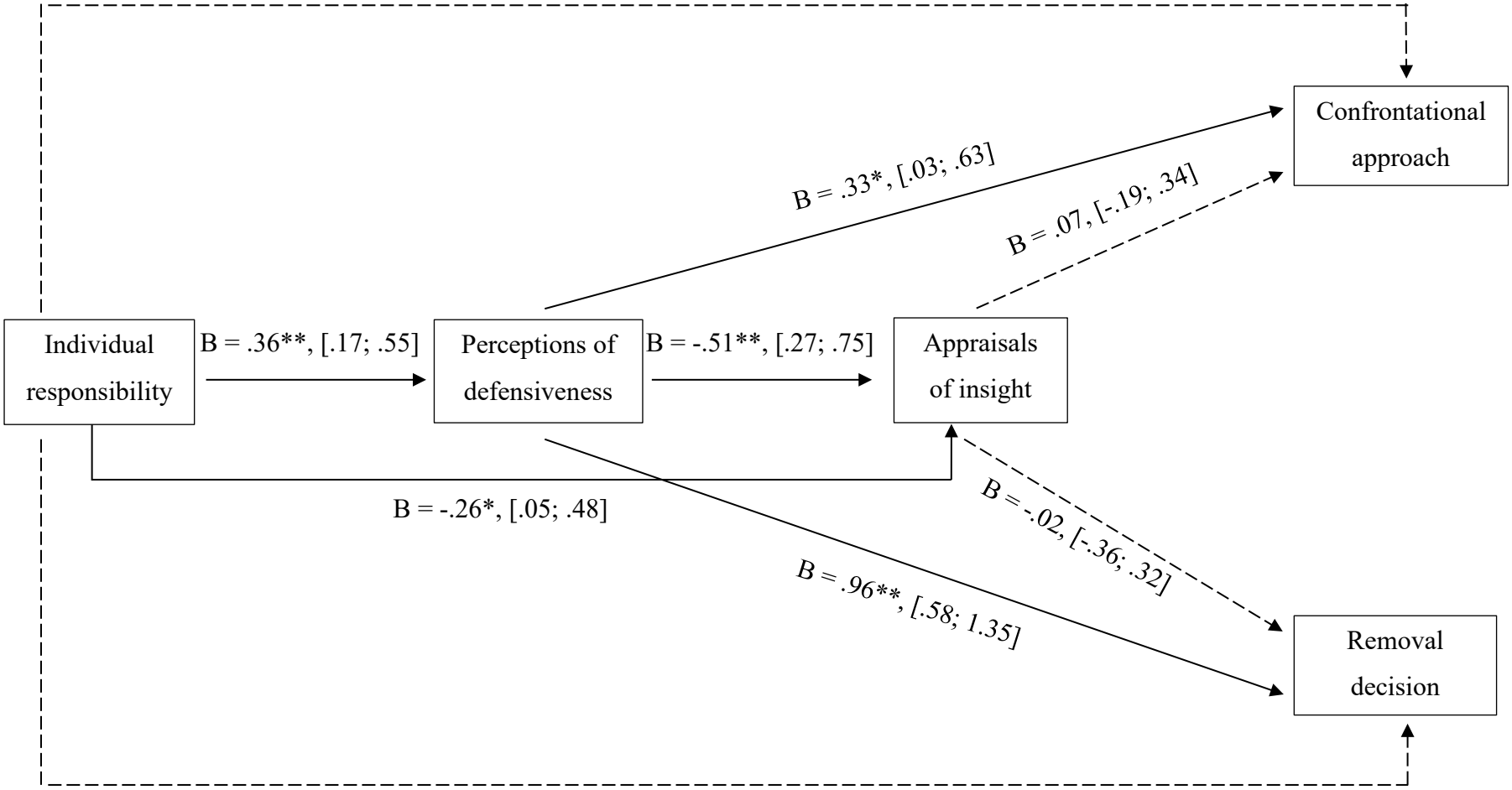
According to the findings, the hypothesised model was partially supported. Overall, the model accounts for a significant amount of variance in appraisals of insight R^2 = .35, F(2, 72) = 19.04, p = <.001, and endorsement of a confrontational approach R^2 = .11, F(2, 72) = 4.52, p =.01. When testing the same model for the outcome variable of removal decisions, it accounts for a significant amount of variance R^2 = .34, F(3, 71) = 15.00, p = <.001.

Investigation of relationships within the model show that, contrary to predictions, individual responsibility beliefs did not have a significant indirect effect on endorsement of a confrontational approach through perceptions of defensiveness and appraisals of insight. Rather, there was no direct effect of appraisals of insight on endorsement of a confrontational approach. Again, contrary to predictions, individual responsibility beliefs did not have a significant indirect effect on reunification decision through perceptions of defensiveness and appraisals of insight as there was

likewise no direct effect of appraisals of insight on reunification decision. Individual responsibility beliefs did however have a significant negative indirect effect on reunification decision through perceptions of defensiveness $B = .34$, $CI_{95\%}$ [.11; .64]. As predicted, perceptions of defensiveness had a significant negative direct effect on appraisals of insight, a significant positive direct effect on endorsement of a confrontational approach, and a significant negative direct effect on reunification decisions (see Figure 2). While not hypothesised, individual responsibility beliefs had a significant negative direct effect on appraisals of insight (see Figure 5.2).

Figure 5.5.

Effects for the Serial Mediation Analysis Examining the Relationships between Individual Responsibility Beliefs, Perceptions of Defensiveness and Appraisals of Insight, and Confrontational Approach and Reunification Decisions.



Note. Dotted lines = non-significant relationships, 95% confidence intervals, ** $p < .01$, * $p < .05$

Discussion

Study 5.2 investigated whether beliefs about a mother's level of individual responsibility and blame for her behaviour and circumstances would predict child protection workers' perceptions of her explanations as being defensiveness and of having low insight, and whether this would lead them to take a confrontational approach towards the interaction, and to take the decision not to reunify her child. The study found that beliefs about the mother's individual responsibility and blame did lead child protection workers to perceive that she was being defensive, and these perceptions were related to appraising that she had low insight. While perceiving that the mother was being defensive was a strong predictor to take a more confrontational approach towards the interaction, and to not reunify her child, appraisals of low insight were not related to endorsement of either of these actions.

General Discussion

In both studies, a belief that a mother was individually responsible for the circumstances that posed risk to her child was a significant predictor of the perception that she was being defensive when she provided an explanation. In study 5.1, when participants were instructed to take an approach that assumed the mother was individually responsible, this affected participants' perceptions that she was being defensive. While the effect of this was small, it does provide evidence of causality. As attitudes towards individual responsibility are deeply culturally imbedded within Western societies and influence psychological processes and understandings of the self (Collardeau, 2022; Kanagawa et al., 2001) and others (Becker et al., 2021), it may be the case that a more extensive intervention is needed to strengthen this effect. Indeed, in Study 5.1, as over thirty percent of participants who were in the shared responsibility condition continued to assume their role was to assume a mother to bear sole responsibility and blame suggests perhaps the culturally imbedded nature of these beliefs. Additionally, is that mean individual responsibility beliefs were high for both samples.

The results suggest that in a lay population and in a population of child protection workers, there is a tendency to appraise the defensiveness of a mother in a child protection proceeding as being demonstrative of her lacking insight into the issues being raised. The relationship between perceptions of defensiveness and appraisals of insight was stronger in the lay sample (Study 5.1), and it could be the case that child protection workers held stronger alternative views about the mother's defensiveness – perhaps, for example, as being driven by psychological threat and fear of consequence. While it is not possible to make definitive comparisons between the lay population in Study 5.1 and the population of child protection workers in Study 5.2 as these were not otherwise matched samples, it is possible that this difference was due to work experience in the field. However, this must be taken with caution, and such a conclusion could be more definitively reached in future research by employing a matched sample for comparisons. The low sample size and self-selection of child protection workers, as well as the correlational design in Study 5.2, presents a limitation to the current research. Nonetheless, the relationships hold across two samples and two different sets of stimuli (watching a video and reading a interview transcript). Manipulating the approach to individual responsibility in a child protection worker sample, verifying the work experience of participants, and replicating the study outside of the United States context, are avenues for future research to bolster the current findings. Additionally, investigating differences in approaches towards, and perceptions of, client defensiveness across sub-disciplines in the social work/psychology fields using a matched sample, as well as investigating differences in approaches between child protection investigators and child protection clinicians in more supportive roles, may be useful to determine the subjectivity of these perceptions, and of context-specific approaches to perceived parent/client defensiveness.

In the sample of child protection workers in Study 5.2, perceiving that a mother was being defensive was a very strong predictor of the decision to not reunify her child. This is consistent with the findings in Chapter 4, whereby a mother's defensiveness appeared to factor heavily in the recommendations made in PCA reports. Interestingly, in the current study, appraisals of insight

were not related to reunification decisions. Defensiveness in a child protection context may imply that a parent is resistant to, and is not willing to work or comply with, clinicians and with any recommendations or child protection plans. Indeed, managing parental resistance and compliance is a key issue in child protection work (Broadhurst et al., 2017; Forrester et al., 2012), and parental resistance or non-compliance weighs heavily on removal decisions (Donnelly, 2023). In the case of perceptions of defensiveness, the results of the current study suggest that it is not appraisals of insight related to these perceptions that influence child protection workers' decisions. Rather, the results suggest that it may be other aspects of defensiveness – perhaps aspects that are more demonstrative of resistance, a belief that a mother understands the issues and is not taking responsibility (psychological defensiveness), or a sense that she is not being truthful – could be more important factors here than simply thinking that a parent does not know any better. While the population and service context is of course different in this study, in the findings from Chapter 4, clinicians' appraisals that a mother did not have insight into the issues raised with her appeared to be a key factor determining PCA recommendations. In the case of PCA reports, it is unclear from the findings of Study 4 whether clinicians' reports on a mother's level of insight and the extent to which this factored into decision making was reflective of their true beliefs of the situation (i.e., did they really believe that the mother simply had no understanding of the concerns) or was this influenced by report writing conventions (i.e., is it convention to conclude that a parent has no insight if they do not explicitly state their full understanding and acceptance of the issues raised with them).

Interestingly, the findings suggest that when child protection workers perceive that a mother is being defensive, that they are more likely to endorse taking a more confrontational approach to the interaction. This is consistent with the findings from Chapter 4, whereby I observed that clinicians took a challenging approach to their engagement with mothers. Concerningly, this approach is likely to only make matters worse – to increase the threat a mother feels (Woodyatt & Wenzel, 2013), and to lead to a deterioration in engagement between the pair. Clinicians in a child

protection context are – or should be – operating with a goal to maintain a level of engagement with parents. This should involve working to understand the reactions of parents and to diffuse conflicts when they arise. That clinicians would endorse taking a more confrontation approach when met with parental defensiveness implies more of a 'power over' orientation (Saar-Heiman, 2023). In this case, less work is spent building an alliance to work with parents, and there is instead an expectation that they comply, rather than engage, with clinicians. This 'tit-for-tat' approach to engagement – that a parent becoming defensive be met with a harsh approach rather than a more conciliatory response – perhaps meets expectations for an interpersonal interaction amongst peers. However, in a context where one party is in a professional role, and in a higher position of power, a more conciliatory approach in this context is surely warranted.

Research on the experience of parents in child protection assessments and proceedings has highlighted that parents often withhold their true views and opinions for fear of being seen as resistant, non-compliant, and for being met with a harsher approach by clinicians (Buckley et al., 2010; Dumbrill, 2006; Gibbons & Connolly, 2020; Smithson & Gibson, 2016). In this way, parents will often comply, or will 'play the game' (Dumbrill, 2006), but in hiding their true feelings and views, it's likely that little in the way of true collaboration or engagement can be achieved. The findings from the current study confirm this concern of parents – indeed, when clinicians perceive a mother as being defensive when she provides explanation, including alternative views of the situation, this leads them to take a more confrontational approach to the interaction, and to make less restorative decisions. This presents parents with a delicate balance to make – how can they provide their side of the story without coming across as defensive, resistant, and non-cooperative, and is this a worthwhile risk to take, given the consequences? To not take this path may mean to not explain themselves, to not reveal any inaccuracies in understandings, and to not have a say in decision making that affects them. The concept of 'voice' – of participants in proceedings having the opportunity to voice their perspective – is a significant predictor of perceptions that the proceeding was fair and just, of satisfaction with the process, and of a willingness to cooperate with

the outcomes (Folger, 1977). Additionally, having a sense of voice in a therapeutic context has been found to be a key predictor of a strong therapeutic alliance (Lee et al., 2022). Clearly, creating environments where parents can share their views and provide explanation, and where, in the case that this is perceived as defensiveness, effort is taken to find common ground with a more conciliatory approach, is necessary. Otherwise, the risk to parents in sharing their voice is quite high, and there is a likelihood that parents will continue to feel disempowered, unheard, and unfairly treated, and that any recommendations will not have the necessary buy-in to be successful in supporting families and promoting meaningful engagement and change.

The findings of the current study have implications not only for the child protection context, but for conflict resolution more broadly. The strong relationship between perceptions of defensiveness and appraisals of insight in the lay sample in Study 5.1 suggest a propensity to consider defensiveness as a lack of understanding. A mismatch in appraisal and subsequent response – for example, incorrectly assuming that a person doesn't understand the issue and therefore continuing to express it to them – may lead to a deterioration in relations and may act as a barrier to restoration. Additionally, the current findings suggest that perceptions of defensiveness are in part influenced by the approach one takes to the situation. Recent work on offender narratives has found that there is a natural tendency for those accused of a wrongdoing to provide further context to, or explanation of, their circumstances, and that this process reduces threat and promotes responsibility taking (Harous, 2025). If, when one does this, it is perceived as defensiveness and met with a harsh approach, this has significant implications for restoration and justice processes more broadly. As the current study has explored the effect of assumptions of individual responsibility on perceptions of defensiveness, there are likely many other predictors of these perceptions that are yet to be explored, and which present avenues for future research.

The current studies found that taking an approach that assumes a mother to bear full responsibility and blame for the issues that pose harm to her child affects the extent to which she is perceived as defensive when she provides explanations. The current study also found that in

perceiving a mother as being defensive, child protection workers were more likely to take a confrontational approach to the interaction and to make a decision to not reunify her child. The findings therefore suggest that the orientation or approach towards parental responsibility may affect child protection decision making. Moreover, the findings provide evidence for a confrontational approach to parental defensiveness and resistance that holds consequences for the capacity or perhaps willingness of clinicians to engage with parents during assessments and proceedings.

CHAPTER 6. General Discussion

In this thesis, I investigated the engagement between early intervention services and mothers who had experienced, or were at risk of experiencing, the removal of their child by statutory child protection services. The broad aim of this thesis was to explore the engagement between early intervention services and parents, in a child protection context facing mounting calls to reduce high rates of child removal by providing more support to families, but where rates of removal are continuing to rise. Specifically, I sought to explore the nature of engagement and support provision within early intervention services and contexts that holds a dual aim of detecting and managing risk, and of providing or referring to support. I took a mixed-methods approach to exploring the dyadic nature of engagement throughout this thesis, whereby each empirical chapter focused on the engagement of women and mothers, the approaches to engagement of clinicians, or a combination of both. In this final chapter, I will draw together these findings and consider the ways in which women, clinicians, and the broader service context interact, and how this shapes the provision of support to families at risk of child removal. I will begin by providing a summary of the findings throughout the thesis. Then, I will discuss these findings and the practical and empirical implications of this thesis' findings on the service level, clinician level, and parent level. Overall, the findings of the thesis contribute to our knowledge of the engagement between parents and clinicians in an early intervention context, with significant implications for policy, practice, and future research.

Summary of Findings

When engagement with support services is voluntary for pregnant women at risk of child removal, many do not engage with support. Indeed, the findings from Chapter 2 suggest that just under one third of pregnant women who went on to have their child removed within the first two years of birth attended an appointment with support services when they were referred during pregnancy. While attendance trends in Chapter 2 suggest that women's attendance with support services was driven by need, there was nonetheless a large proportion of women who may have

benefitted from support during pregnancy who did not engage with it. The findings from Chapter 3 provide explanation for this. Pregnant women at risk of child removal fear for the consequences of engaging with services. These consequences include the experience of stigma, judgment, and racism from clinicians, the removal of their child(ren) by statutory services, having their privacy breached, and experiencing retribution from violent partners. Additionally, are issues such as guilt and shame, previous negative experiences with services, the normalisation of violence, a belief that services can't meet their needs, and a lack of financial resources and social support contributing to an overall inaccessibility of support services.

The findings from Chapter 2 and 4 suggest that when attendance at assessment services was involuntary for mothers, many attempted to withhold their engagement during their attendance at appointments. Overall, this appeared to be a strategy for managing the distress that mothers experienced during these appointments, which were marked by a deterioration in engagement throughout the process. The findings from Chapter 4 suggest that the sensitive issues discussed with mothers during mandated assessments, such as their own abuse histories as well as the harms posed to their child(ren), were particularly challenging and/or traumatic, and that mothers often provided explanation, withdrew, avoided, became heightened and defensive, and that this did not bode well for reunification recommendations. Following child removal, the grief and loss that mothers experience, as well as their loss of trust in professionals and in services, creates a challenging foundation for engagement with support. The extent of this was demonstrated in Chapter 2, whereby mothers were noted to have expressed that their trust in professionals was broken after their disclosures during antenatal appointments led to prenatal reporting, and after experiencing traumatic practices of infant removals at birth.

When services have the dual aim of detection and protection, and engagement and support, the findings from this thesis suggest that clinicians defer to detection, sometimes at the expense of support. The findings from Chapter 2 suggest that while the antenatal early intervention service audited does well at detecting risk and reporting to statutory child protection services, that they are

not as affective at offering support to pregnant women to ameliorate this risk. In a sample of pregnancies for which a child was removed within the first 2 years of birth, 91% were detected for risk and given a birth alert status, yet in only 63% was a pregnant woman offered a referral to support services. The patterns of referral provision in this study offered some interesting and concerning insights – for pregnancies deemed most at risk, whereby there was a plan in place for the continued monitoring and reporting of the pregnancy and birth with statutory services, women were less likely to be offered referrals to most supports.

In assessments contexts that likewise hold dual protective and therapeutic aims, the findings from Chapter 4 suggest that clinicians again defer to protection, often with what could be deemed anti-therapeutic and indeed harmful consequences for mothers. The findings from Chapter 4 suggest that clinicians approach assessments with scepticism and with a narrow focus on individual responsibility for risk and harm. This focus on individual responsibility leads to the blaming and shaming of mothers, and as the findings in Chapter 5 suggest, can lead one to perceive mothers' responses as being more defensive when they provide explanation of their circumstances. Additionally, when perceiving a mother as defensive, the findings from Chapter 5 suggest that clinicians are more likely to take a confrontational approach to the interaction, and to make the decision to not reunify her child. Overall, it appears that this approach leads clinicians away from practices that may support or foster engagement and a sense of responsibility taking from mothers, and towards practices that rather request compliance. In the case of Parenting Capacity Assessments (PCA), it appears from the findings from Chapter 4, that a narrow focus on responsibility and risk leads to an approach whereby clinicians are testing the capacity of a mother to respond to what is likely a psychologically threatening and sometimes traumatic interview, and that – as the findings from Chapter 2 and 3 on mothers' reported barriers to engagement suggest – this may have long-term consequences for the willingness of a mother to engage with support and to work towards change.

System Focused Implications and Future Directions

The service audited within this thesis is a state health-based child protection service (Child Protection Services; CPS). Together with the state statutory agency, the Department of Child Protection (DCP), these two services hold the primary function of child protection. While CPS provide several services to children, there are two cases in which they work with parents and mothers; during antenatal appointments as the 'Early Links' program, and during Parenting Capacity Assessments (PCA). It was at these two points that this thesis was particularly concerned with, and it was at these two points that the service has the capacity to meet supportive aims to parents as well as protective aims to children.

During antenatal appointments, and constituting the work of the Early Links Program, the role of social workers and psychologists within CPS is not a direct client facing role – clinicians within the service are involved with the case management of infants deemed at risk, which includes liaising with DCP staff about statutory intervention during or post birth. Rather, it is hospital midwives who are responsible for screening pregnant women and people for risk during antenatal appointments, and for offering them referrals to further support. The extent to which midwives see it as their role to discuss a pregnant woman or person's drug use, mental health, experience of violence, lack of housing, disability, etc. was not explored in this thesis. However, research on the experiences of midwives, and indeed of midwives in the Early Links program explored in this thesis, suggests that they can feel under-resourced, under-trained, and under-supported in taking on this work (Abrahams et al., 2023; De Backer et al., 2024; Johnsen et al., 2024; Powers, 2007). Indeed, this work often falls outside of the conventional scope of a midwife, which is to ensure the overall health and wellbeing of the parent and child. However, as this more complex work falls outside of the conventional scope of a midwife, the monitoring and surveillance that is simultaneously occurring throughout the antenatal process can still fulfil the core aim of infant and child welfare. In a context where instances of surveillance and reporting are outnumbering instances of the provision of referrals to support, this may provide some explanation as to why. In this case,

there is a mechanism that midwives can fall back on that will still fulfil the protective aims of child protection, which perhaps makes the more supportive work somewhat discretionary, particularly if this feels outside of the scope of one's role.

I suggest that this carries system level implications as it raises the question of why those who are most trained (CPS social workers and psychologists) to engage with pregnant women and people during pregnancy (to discuss their concerns, their needs, and to promote the provision of support) are instead taking on the primary role of surveillance, while this more complex interpersonal work is left to midwives. Perhaps one of the key findings of this thesis is not in the data reported within it, but of the nature of the role, scope, and practices of CPS antenatally, and as part of the Early Links program. As Early Links exists primarily as a surveillance program in terms of the scope and role of CPS's work within it, women rarely come into contact with CPS clinicians or know that they are being case managed. In the one document that can be found online about the work, or indeed the existence, of Early Links – the 2007 evaluation project (Powers et al., 2007) – women who were interviewed of their experiences antenatally reported that while they found the support provided to them by hospital staff helpful, they did not know that they were enrolled in Early Links, and "did not distinguish between being cared for by FMC staff and the effects of being enrolled in Early Links" (pg. 32). Indeed, it appears that the only distinguishing feature between them is that those enrolled in Early Links were being case managed and monitored by CPS clinicians without their knowledge.

There have been several high-profile inquiries and media reports in South Australia's child protection system over the last two years condemning the practice of removals at birth at South Australian hospitals. The most notable of these inquiries was the 'Holding on to Our Future' report by the South Australian Commissioner for Aboriginal Children and Young People (Lawrie, 2024), which confirms the findings of this thesis, in reporting that when a pregnant woman is flagged within the health system, "meetings are held with staff about the management of the woman's case in her absence and without her knowledge" (pg. 71). A key recommendation of this report was that

"The Department for Child Protection's practice of uninformed removals at birth is condemned and must cease immediately" (pg. 72). In their published response to this report, the South Australian Government committed to take efforts to ensure that mothers are informed of plans to remove an infant at birth "where it is assessed as safe and reasonable to do so" (Government of South Australia, 2024). However, this wording allows for discretionary practices against this recommendation and provides no qualitative difference to the guidelines currently in place (SA Health, 2019), which also allow for discretion under the grounds of safety or risk.

The findings from Chapter 3 of this thesis suggest that during pregnancy, when engagement with services is voluntary for pregnant women, the perceived consequences of engaging with support forms a key barrier to engagement. This presents somewhat of a paradox in the current context – pregnant women are not engaging with the support offered for fear of child removal (amongst other barriers) but are likely unaware that they are in fact already under the surveillance of the child protection system, and that in this case, not engaging with professional support may be deemed an additional risk factor for removal. Overall, if the goal is to increase the provision of support to women during pregnancy, to improve the wellbeing of mothers, parents, and their children and to keep families together, perhaps a simple solution or question at this point is – why not tell them the full story? In the present context, it appears that there is a desire to continue to allow for discretionary practices regarding transparency with parents due to concerns of risk, however the extent to which this is supported by research appears lacking. For example, while concerns that telling pregnant women or people of the child protection concerns or plans to remove a baby at birth constitutes a 'flight risk' (Chamberlain et al., 2022; Davis, 2019; Marsh et al., 2019; Wise & Corrales, 2021), there appears to be no empirical basis to this concern. Rather, research suggests that involving parents in decision making during pregnancy will likely increase their engagement where they have otherwise been found to avoid prenatal care and other services (as found in Chapter 2 and 3; Davis, 2019; Krakouer et al., 2024; Marsh et al., 2019).

I suggest that a key implication here for future research is to examine what the barriers are, from a clinician and indeed wider service perspective, to putting mechanisms in place that will ensure that every pregnant woman and person who is flagged for risk during pregnancy is told of these concerns by those best placed to do this work. Additionally, as the presence of mandatory reporting creates a key barrier to engagement with support for parents in need of it, this suggests a re-think of this approach. For example, what would be the consequences of removing mandatory reporting for issues related to emotional abuse and neglect (often due to issues such as parental drug use, violence, and mental ill-health) by clinicians who are in the work of providing support to parents for these very issues? Likewise, as Canada has recently repealed the use of birth alerts due to reports that they were leading to disproportionate rates of Indigenous infants being removed at birth (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019) – an issue also inflicting Australia – should Australia follow suit? Perhaps an important empirical question is, in absence of these reporting and surveillance mechanisms, would clinicians feel more of a responsibility and motivation towards engaging with pregnant women and parents, to provide support, and to ameliorate the risk of child harm? The findings of this thesis suggest that reporting mechanisms or protective orientations may provide a 'fall back', so to speak, and are favoured over methods of more meaningful engagement with parents and the provision of support. This avenue for future research therefore seems important in a context where more significant and systemic changes are required to shift the rates of child removal currently deemed at 'crisis point' (Chamberlain et al., 2020).

Clinician Focused Implications and Future Directions

A significant theme throughout this thesis is how stigma, shame, and blame influence the interactions between clinicians and mothers in the child protection context. In Chapter 4, the approach of clinicians towards seeking full blame from mothers for their circumstances appeared to induce shame in mothers that was often expressed via a range of heightened emotions and displays of distress. Likewise, in Chapter 3, societal stigma and indeed stigma from clinicians were the most

commonly cited barriers to engagement by pregnant women with support services. Further, in Chapter 4 and 5, I found that this process of blame and of shame was somewhat dynamic in that it not only leads to avoidance and distress from mothers, but that it also affects the perceptions of clinicians and their subsequent approach to their interaction with mothers. This leads to two important lines of consideration and of future research; first, to what extent are clinicians aware of the functions and expressions of shame and how this may influence parent's defensiveness, (dis)engagement, and responsibility taking, and second, to what extent do clinicians, particularly in an assessment context, see it as their role to manage this shame and to support the therapeutic engagement of parents?

While the findings from Chapter 3 suggest that stigma was a key barrier for pregnant women in engaging with support, Dolezal & Gibson (2022) suggests that concerns of stigma in clinical encounters is best understood in psychological terms as a "chronic anticipation of shame" (pg. 855). That is, that where stigma is the devaluation of a person on the basis of their identity or behaviour, that shame is the felt experience of being devalued by others (Robertson et al., 2019). As an emotion that alerts us to our sense of worth in human relationships, and to our sense of belonging as human beings, the experience of shame, particularly when longstanding or persistent, is a considerable source of distress, and indeed a key transdiagnostic factor amongst a range of mental health conditions (Cândea & Szentagotai-Tătar, 2018; Benda et al., 2021; Mortimer, 2019). Additionally, it is an emotion that people often seek to avoid. In the case of voluntary engagement, as the findings from Chapter 2 and 3 suggest, this can simply mean not attending appointments with support services. However, in the case of mandated engagement, as the findings from Chapter 2 and 4 suggest, this can lead to other mechanisms of avoidance, which were highlighted when mothers tried to control the topics of conversation, provided short answers, or expressed signs of distress such as becoming angry, withdrawn, or emotionally labile.

The extent to which clinicians are aware of how shame is experienced by parents (and what exacerbates this experience), how it presents in parents, and the effect of shame on engagement, is

unclear. For example, in Chapter 4, there appeared to be no consideration by clinicians of the role of shame in the presentations of mothers that they were describing in reports. Where clinicians reported that mothers became heightened, avoidant, or defensive, they concluded that mothers were not taking responsibility, did not have insight into the concerns, and did not have a capacity to change. However, to consider the role of shame is to consider the way that a threat of social devaluation, and a threat to social belonging, can drive defensiveness (Cibich et al., 2016; Woodyatt & Wenzel, 2013) and particularly when persistent or chronic, can manifest in presentations of acute distress (Dolezal & Gibson, 2022; Taylor, 2015). Therefore, it could also be concluded that these presentations in mothers were not simply demonstrative of an ignorance or resistance, but of a significant distress encountered throughout the assessment process. Dolezal and Gibson (2022) suggest that as shame is a key feature of post-trauma symptomology, that clinicians must move beyond trauma-informed approaches and towards shame-sensitive practice. Notwithstanding the findings from Chapter 4 that PCAs were likely not conducted in a trauma-informed manner, to move towards shame-sensitive practice is to develop a competent understanding of shame, how it presents, how it impacts the wellbeing and engagement of clients, and how to avoid shaming practices (Dolezal & Gibson, 2022). In the practice of PCAs, this would involve an understanding of how previous traumatic experiences and stigmatised issues may contribute to shame in parents, how this may drive avoidance, and how approaches that intend to seek blame from parents for these issues will likely only increase their distress and their avoidance. Additionally, a deeper understanding of the sources and presentations of shame in parents may elicit a more empathetic understanding in clinicians. As the findings from Chapter 5 suggest that clinicians would respond to a mother's defensiveness with a more confrontational approach, it will be important to identify ways to disrupt what is likely to be a progressive worsening of the interaction between parents and clinicians.

While clinicians' understandings of shame and its effects are important, equally so is the extent to which clinicians feel that it is their role, within an assessment context, to manage or to

mitigate this in any way. Indeed, the findings from Chapter 2 and 4, whereby clinician's noted mothers' reports of visual flashbacks during the interviews and of self-medicating following the interviews, suggest that clinicians are aware of the deep levels of distress experienced by mothers during the PCA process. When removing a child, the risk of harm posed to a child is considered the paramount issue, and the harm caused to parents by this process is seen as an unavoidable consequence to achieve the aim of child protection. However, if a child is removed (and I argue that every step should be taken to avoid this occurring), there should be very little tolerance for further psychological harm experienced by parents during their interactions with professionals. However, the findings of this thesis are consistent with research suggesting that parents feel disempowered (Dumbrill, 2006), disrespected, attacked, and belittled (Smithson & Gibson, 2016), harmed by their interaction with professionals (Dale, 2004), punished and shamed (Mason et al., 2020), made to feel fearful and anxious (Tembo & Studstrod, 2019), and experienced\ coercion in their interactions with child protection clinicians that they report as feeling similar to that experienced in their violent relationships (Family Matters, 2016).

The extent to which clinicians working in an assessment role feel that these psychologically harmful experiences are a necessary byproduct to a thorough assessment that ensures a child's safety, is unclear. Additionally, the extent to which organisational pressure to mitigate risk influences the approaches of clinicians to PCAs is unclear. However, for social workers and psychologists working under an assumption to 'do no harm' (AASW, 2020, APS, 2007), I suggest that this requires an attitude shift that does not tolerate the collateral consequences to parents following the removal of a child (Broadhurst & Mason, 2017). As such, the approaches of clinicians during PCAs warrant further exploration, as do the organisational contexts that may influence these approaches. This thesis has explored the approaches of clinicians via an observational case file analysis, and via an experimental paradigm. While this provides a strength with regards to exploring the otherwise hidden practices of clinicians and of perhaps more subconscious psychological processes, it is also important to hear from clinicians themselves about the approach taken to their

work, the goals and assumptions that drive this approach, and how this is influenced by their organisational context. Such an exploration will provide a fuller perspective of the approaches taken to PCAs by clinicians, and the mechanisms to improve this process at both the individual practitioner and the service level.

Parent Focused Implications and Future Directions

In Chapter 3, pregnant women report that a sense of safety and trust with clinicians, a lack of judgment, stigma, and racism, and encouragement and education, are key facilitators to their engagement with support. This is perhaps not surprising – these factors meet the core psychological needs of agency and autonomy, belonging, and competence, that are key to one's motivation towards positive growth and change (Deci & Ryan, 1985). I suggest that these are not so much implications *for* parents, but rather, what should be core considerations to approaches towards, and effort to engage with, parents. That there must be a shift away from a view of parents as distrustful and as resistant, and towards an assumption that parents will, under the right conditions, be motivated towards positive growth and change. This instead requires a consideration for how to meet one's need to belong (to be free from the threat of stigma and shame), to feel competent (to feel efficacious in navigating services and in making change), and to feel agentic in their lives (to feel empowered and in control; Deci & Ryan, 1985). How these needs can be fostered in a therapeutic environment has been the subject of extensive research and a consideration for practice spanning decades. However, the findings from this thesis suggest that, in a context that balances a protective, risk-oriented aim, and a therapeutic, support- oriented aim, the former is upheld oftentimes to the detriment of the latter. Therefore, I suggest that future research investigates approaches to meeting a parent's core psychological needs in contexts where concerns for risk and protection may currently shape a view that not meeting these needs is a necessary consequence for the primacy of protection. Perhaps, only when tested against concerns for risk, are these approaches more likely to be adopted. For example, does transparent communication during pregnancy increase risky behaviour during pregnancy and after birth? Does it really make pregnant women and parents

flee, or does it increase engagement? If parents are provided with information of the PCA process prior to attending an interview, does this allow them to manipulate this situation, or will a sense of competence and agency in this process make them more likely to engage in a meaningful way? Will validating a mother's own experiences of harm and the aspects of the circumstances outside of her control enable her deflection of responsibility, or will it make her more willing to accept responsibility for aspects of her situation that she can change? These are questions that may support approaches that reduce risk to children not in absence of their parents, but by supporting their parents.

Implications for Empirical Research Approaches and Broader Psychological Theory

I suggest that the ways that issues of engagement are studied is important, and specifically, that taking a more dyadic approach to any analysis of engagement may highlight what is otherwise hidden about the way that services are structured or the way that clinicians approach their interactions. This may be particularly important when a research agenda is guided by industry, and where there is a significant power imbalance between those who are studied and those who are studying. In addition to perhaps being a more just approach to research in this context, such an approach also simply provides a more thorough answer to the research question, and for the potential mechanisms for improvement and change.

In Chapter 5, I explored the beliefs of clinicians, and how they responded to a parent in a scripted interview based on their perceptions and appraisals of the parent's presentation. I believe that this was the first study to test how clinicians perceive and respond to parental defensiveness by using a methodology that taps into less conscious processes, and that therefore provides a strength over – or in addition to – methodologies that rely on self-reported thoughts, perceptions, and intentions. Indeed, when discussing one's own professional practice, there may be a propensity to speak about this in more desirable terms. In finding evidence that clinicians may take a confrontational approach to a parent's explanations, I provided an explanation for when and for why – that it is when a clinician perceives that a parent is being defensive, and in absence of

appraisals they make about a parent's level of insight and understanding of the issues, that is a significant predictor of taking a more confrontational approach. I suggest that it is a strength of the methodology used to discover this 'tit-for-tat' approach by clinicians to meeting resistance with confrontation. Likewise, this approach allowed me to make sense of what was observed, particularly regarding a breakdown in engagement over time, throughout the case file analyses in Chapters 2 and 4, and to extend on these findings. I propose that a strength of the current thesis is in the mixed methods approach to extend upon the observations made in the applied, and real-world context, with more foundational psychological research that provides explanation for, and a deeper understanding of, these observations. I suggest that, given the socially interactionist and dynamic nature of engagement, that this approach may benefit future research in the field of client-clinician engagement, both in the child protection context and beyond.

The studies in Chapter 5 present, to my knowledge, the first to explore predictors of perceiving the defensiveness in others, and the consequence of these perceptions on subsequent appraisals, interaction approaches, and decisions. How one perceives the defensiveness of others, and as a subjective perception, what may further predict these perceptions, is generative for future research with a broad range of applications. For interpersonal conflict, under what conditions will one's explanations be perceived by the other as constituting defensiveness? If the findings from Chapter 5 hold across a range of circumstances to suggest that defensiveness is likely to be met with an exacerbation of the conflict, this raises important considerations for interpersonal conflict and reconciliation research. Particularly as those who have committed wrongdoings have a natural propensity to provide further context to the circumstances surrounding their wrongdoing (Harous, 2025). In other settings where there is a contention regarding responsibility for wrongdoing, for example in the criminal legal system or in organisational, workplace, and educational proceedings, how one perceives the responses of those being investigated is likely to hold consequences for decisions regarding punishment, sanctions, or restoration. Additionally, the findings from Chapter 5 suggest that in the lay population, there is a strong propensity to appraise the defensiveness of

others as a lack of insight into the problem. However, this is inconsistent with research that suggests that it is a feeling of guilt and a threat to one's social acceptance that drives psychological defensiveness (Woodyatt & Wenzel, 2013). This mismatch between one's appraisal of another's experience is likely again to lead to an exacerbation in conflict – for example, to effectively respond to feelings of guilt and shame or to effectively respond to an ignorance of wrong will require a correct appraisal and a matched response.

Conclusion

This thesis contributes knowledge to our understandings of child protection practice and engagement in both an applied context, and in a more foundational sense by providing theoretical insights into the subjective perceptions and actions of clinicians. In the more applied sense, this thesis contributes knowledge of the effectiveness of antenatal early intervention programs that have a dual aim of protection and support. In a state that has more recently seen several media and organisational audits and reports published regarding the practices of child removal at birth (Lawrie, 2024; D'Onise, 2024; Richards, 2024a; 2024b), this thesis is a timely contribution that adds validity to the concerns regarding the level of support offered by South Australian hospitals during pregnancy. While some of the studies in this thesis were conducted in an applied context, I suggest that the findings are nevertheless relevant to all contexts where there are similar early intervention programs that use birth alerts to monitor risk during pregnancy, and where the provision of support to pregnant women and parents is discretionary. With regards to pregnant women's engagement with these and other services, the systematic review in this thesis was the first to my knowledge to synthesise the barriers and facilitators to engagement for pregnant people with a range of support services, spanning several child protection contexts and countries, using a range of methods, and including both clinicians and parents.

With regards to parenting capacity assessments, this thesis contributes to our understanding of the lesser seen interactions between child protection clinicians and parents during the assessment interviews. The findings raise concern regarding the orientation of these assessments towards

practices that threaten the engagement between clinicians and parents that is necessary to efforts towards family reunification. Additionally, the findings shed light on practices that may do more harm, and that may act as a barrier to parents engaging with support in the future. While parenting capacity assessments hold significant weight for the decision making of statutory services, as well as serving as evidence in legal custody proceedings, the findings from this thesis raise question as to the validity of the report findings. This is particularly true for report findings that result from the interaction between parents and clinicians during assessment interviews, and that are influenced by the subjective perceptions of clinicians. The findings related to clinician's perceptions of defensiveness and their subsequent approaches and decision making is a significant contribution of this thesis and it is the first, to my knowledge, to consider and test clinician engagement in this way. These findings have implications not only for the child protection context, but for processes of conflict and reconciliation more broadly. In this way, this thesis contributes foundational psychological knowledge on the perceptions and appraisals of defensiveness and makes way for a new line of research in this area.

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Appendices

Appendix A. Search Strategy (Study 3)

PsycINFO (Ovid)

Search conducted on October 5, 2022

Search	Query	Records retrieved
#1	exp Pregnancy/	46,791
#2	(Pregnan* or maternal or antenatal or prenatal).ab,id,ti.	113,716
#3	1 or 2	127,086
#4	exp Professional Referral/	3,777
#5	exp Participation/	21,078
#6	exp Treatment Barriers/	6,562
#7	exp Treatment Compliance/	17,033
#8	exp Health Behavior/	40,482
#9	exp Prevention/	70,297
#10	(Engag* or Refer* or Participat* or Barrier or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or perspective* or perception* or facilitat* or enabl* or Challenge* or motivat* or help-seeking or "help seeking").ab,id,ti.	1,839,544
#11	or/4-10	1,906,182
#12	exp Protective Services/ or exp Child Welfare/ or exp Domestic Violence/ or exp Community Services/	76,446
#13	(("Early intervention" or "Child protection" or "Child welfare" or "Child protective" or Drug* or Alcohol or Substance or "Family violence" or "Domestic violence" or "Intimate partner violence" or "Mental health" or "Mental illness" or Parenting) adj5 (service* or program* or intervention*)).ab,id,ti.	108,577
#14	12 or 13	171,293
#15	3 and 11 and 14	3,555
Limited to studies published between 2000-2023		3,115

MEDLINE (Ovid)

Search conducted on October 5, 2022

Search	Query	Records retrieved
#1	exp Pregnancy/	981,163
#2	(pregnan* or maternal or antenatal or prenatal).ab,kf,ti.	809,900
#3	1 or 2	1,235,614
#4	exp "Referral and Consultation"/	84,629
#5	exp Patient Participation/	28,923
#6	exp "Patient Acceptance of Health Care"/	170,167
#7	exp Patient Compliance/	84,670
#8	exp Health Behavior/	55,448
#9	exp Primary Prevention/ or Secondary Prevention/	40,783
#10	(Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking).ab,kf,ti.	4,770,548
#11	4 or 5 or 6 or 7 or 8 or 9 or 10	4,946,100
#12	exp Child Protective Services/ or Child Welfare/	23,033
#13	(("Early intervention" or "Child protection" or "Child welfare" or "Child protective" or Drug* or Alcohol or Substance or "Family violence" or "Domestic violence" or "Intimate partner violence" or "Mental health" or "Mental illness" or Parenting) adj5 (service* or program* or intervention*)).ab,kf,ti.	114,852
#14	12 or 13	136,215
#15	3 and 11 and 14	3,735
Limited to studies published between 2000-2023		3,247

ProQuest Central and Social Sciences Premium

Search conducted on October 10, 2022

Search	Query	Records retrieved
#1	noft(pregnan* or maternal or antenatal or prenatal)	405,787
#2	noft(Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking)	7,544,415

#3	noft(("Early intervention" OR "Child protection" OR "Child welfare" OR "Child protective" OR Drug OR Alcohol OR substance OR "Family violence" OR "Domestic violence" OR "Intimate partner violence" OR "Mental health" OR "Mental illness" OR Parenting) NEAR/5 (service* OR program* OR intervention*))	177,734
#4	1 AND 2 AND 3	4,375
Limited to studies published between 2000-2023		3,979

Scopus (Elsevier)

Search conducted on October 10, 2022

Search	**Query**	**Records retrieved**
#1	TITLE-ABS-KEY (pregnan* or maternal or antenatal or prenatal)	1,510,948
#2	TITLE-ABS-KEY (Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking)	12,035,878
#3	TITLE-ABS-KEY (("Early intervention" OR "Child protection" OR "Child welfare" OR "Child protective" OR Drug OR Alcohol OR substance OR "Family violence" OR "Domestic violence" OR "Intimate partner violence" OR "Mental health" OR "Mental illness" OR Parenting) W/5 (service* OR program* OR intervention*))	267,709
#4	1 AND 2 AND 3	5,259
Limited to studies published between 2000-2023		4,791

Search re-run 21st September 2023

PsycINFO (Ovid)

Search conducted on September 21, 2023

Search	**Query**	**Records retrieved**
#1	exp Pregnancy/	49,262
#2	(Pregnan* or maternal or antenatal or prenatal).ab,id,ti.	118,282
#3	1 or 2	132,136
#4	exp Professional Referral/	3,873

#5	exp Participation/	22,117
#6	exp Treatment Barriers/	7,351
#7	exp Treatment Compliance/	17,799
#8	exp Health Behavior/	43,374
#9	exp Prevention/	75,097
#10	(Engag* or Refer* or Participat* or Barrier or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or perspective* or perception* or facilitat* or enabl* or Challenge* or motivat* or help-seeking or "help seeking").ab,id,ti.	1,928,863
#11	or/4-10	1,998,853
#12	exp Protective Services/ or exp Child Welfare/ or exp Domestic Violence/ or exp Community Services/	786,750
#13	(("Early intervention" or "Child protection" or "Child welfare" or "Child protective" or Drug* or Alcohol or Substance or "Family violence" or "Domestic violence" or "Intimate partner violence" or "Mental health" or "Mental illness" or Parenting) adj5 (service* or program* or intervention*)).ab,id,ti.	114,458
#14	12 or 13	178,798
#15	3 and 11 and 14	3,826
Limited to studies published between 2022-2024		352

MEDLINE (Ovid)

Search conducted on September 21, 2023

Search	**Query**	**Records retrieved**
#1	exp Pregnancy/	1,011,985
#2	(pregnan* or maternal or antenatal or prenatal).ab,kf,ti.	849,081
#3	1 or 2	1,281,588
#4	exp "Referral and Consultation"/	86,952
#5	exp Patient Participation/	29,548
#6	exp "Patient Acceptance of Health Care"/	173,170
#7	exp Patient Compliance/	85,836
#8	exp Health Behavior/	56,695
#9	exp Primary Prevention/ or Secondary Prevention/	41,270

#10	(Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking).ab,kf,ti.	5,150,417
#11	4 or 5 or 6 or 7 or 8 or 9 or 10	5,328,290
#12	exp Child Protective Services/ or Child Welfare/	23,140
#13	(("Early intervention" or "Child protection" or "Child welfare" or "Child protective" or Drug* or Alcohol or Substance or "Family violence" or "Domestic violence" or "Intimate partner violence" or "Mental health" or "Mental illness" or Parenting) adj5 (service* or program* or intervention*)).ab,kf,ti.	124,388
#14	12 or 13	145,816
#15	3 and 11 and 14	4,069
Limited to studies published between 2000-2023		686

ProQuest Central and Social Sciences Premium

Search conducted on September 21, 2023

Search	**Query**	**Records retrieved**
#1	noft(pregnan* or maternal or antenatal or prenatal)	435,037
#2	noft(Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking)	7,958,762
#3	noft(("Early intervention" OR "Child protection" OR "Child welfare" OR "Child protective" OR Drug OR Alcohol OR substance OR "Family violence" OR "Domestic violence" OR "Intimate partner violence" OR "Mental health" OR "Mental illness" OR Parenting) NEAR/5 (service* OR program* OR intervention*))	190,042
#4	1 AND 2 AND 3	4,831
Limited to studies published between 2000-2023		328

Scopus (Elsevier)

Search conducted on October 10, 2023

Search	**Query**	**Records retrieved**
#1	TITLE-ABS-KEY (pregnan* or maternal or antenatal or prenatal)	1,580,430
#2	TITLE-ABS-KEY (Engag* or Refer* or Participat* or Barrier* or Enrol* or Non-compliance or Adherence or Recruit* or Obstacle* or Perspective* or Perception* or Facilitat* or Challenge* or Motivat* or help-seeking)	13,166,463
#3	TITLE-ABS-KEY (("Early intervention" OR "Child protection" OR "Child welfare" OR "Child protective" OR Drug OR Alcohol OR substance OR "Family violence" OR "Domestic violence" OR "Intimate partner violence" OR "Mental health" OR "Mental illness" OR Parenting) W/5 (service* OR program* OR intervention*))	286,575
#4	1 AND 2 AND 3	5,820
Limited to studies published between 2000-2023		988

Appendix B. Studies Excluded on Full Text (Study 3)

1. Adjorlolo S, Aziato L. Barriers to addressing mental health issues in childbearing women in Ghana. Nursing open. 2020 Nov;7(6):1779-86.

Reason for exclusion: Ineligible participant group

2. Albaugh AS, Friedman SH, Yang SN, Rosenthal M. Attendance at mental health appointments by women who were referred during pregnancy or the postpartum period. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2018 Jan 1;47(1):3-11.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

3. Andrews NC, Motz M, Pepler DJ, Jeong JJ, Khoury J. Engaging mothers with substance use issues and their children in early intervention: Understanding use of service and outcomes. Child Abuse & Neglect. 2018 Sep 1;83:10-20.

Reason for exclusion: Ineligible outcomes.

4. Ashby B, Ranadive N, Alaniz V, St. John-Larkin C, Scott S. Implications of comprehensive mental health services embedded in an adolescent obstetric medical home. Maternal and Child Health Journal. 2016 Jun;20:1258-65.

Reason for exclusion: Ineligible participant group – perinatal.

5. Atif N, Lovell K, Husain N, Sikander S, Patel V, Rahman A. Barefoot therapists: barriers and facilitators to delivering maternal mental health care through peer volunteers in Pakistan: a qualitative study. International Journal of Mental Health Systems. 2016 Dec;10:1-2.

Reason for exclusion: Ineligible participant group – perinatal.

6. Avilla RM, Surjan J, de Fátima Ratto Padin M, Canfield M, Laranjeira RR, Mitsuhiro S. Factors associated with attrition rate in a supportive care service for substance using pregnant women in Brazil. The American Journal on Addictions. 2017 Oct;26(7):676-9.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors.

7. Bacchus LJ, Bullock L, Sharps P, Burnett C, Schminkey D, Buller AM, Campbell J. 'Opening the door': a qualitative interpretive study of women's experiences of being asked about intimate

partner violence and receiving an intervention during perinatal home visits in rural and urban settings in the USA. Journal of Research in Nursing. 2016 Sep;21(5-6):345-64.

Reason for exclusion: Ineligible study design.

8. Baldisserotto ML, Miranda Theme M, Gomez LY, Dos Reis TB. Barriers to seeking and accepting treatment for perinatal depression: a qualitative study in Rio de Janeiro, Brazil. Community mental health journal. 2020 Jan;56(1):99-106.

Reason for exclusion: Ineligible participant group – perinatal.

9. Barrera AZ, Nichols AD. Depression help-seeking attitudes and behaviors among an Internet-based sample of Spanish-speaking perinatal women. Revista panamericana de salud publica. 2015;37:148-53.

Reason for exclusion: Ineligible participant group – perinatal.

10. Baron E, Field S, Kafaar Z, Honikman S. Patterns of use of a maternal mental health service in a low-resource antenatal setting in S outh A frica. Health & social care in the community. 2015 Sep;23(5):502-12.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors.

11. Beasley LO, Ridings LE, Smith TJ, Shields JD, Silovsky JF, Beasley W, Bard D. A qualitative evaluation of engagement and attrition in a nurse home visiting program: From the participant and provider perspective. Prevention Science. 2018 May;19:528-37.

Reason for exclusion: Ineligible participant group – perinatal.

12. Breunis LJ, de Kroon ML, Laureij LT, de Jong-Potjer L, Steegers EA, Been JV. Smoke and Alcohol Free with EHealth and Rewards (SAFER) pregnancy study: a before− after study protocol. NPJ primary care respiratory medicine. 2020 Nov 18;30(1):51.

Reason for exclusion: Ineligbile participant group.

13. Brown S, MacNaughton G, Sprague C. A right-to-health Lens on perinatal mental health care in South Africa. Health and Human Rights. 2020 Dec;22(2):125.

Reason for exclusion: Ineligible participant group – perinatal.

14. Buston K, MacLachlan A, Henderson M. How do pregnant women with additional health or social care needs experience parenting groups: evidence from delivery of Enhanced Triple P for Baby and Mellow Bumps as part of the Trial of Healthy Relationships Initiatives in the Very Early Years (THRIVE). Child Care in Practice. 2022 Oct 2;28(4):721-38.

Reason for exclusion: Ineligible outcomes.

15. Byatt N, Cox L, Moore Simas TA, Kini N, Biebel K, Sankaran P, Swartz HA, Weinreb L. How obstetric settings can help address gaps in psychiatric care for pregnant and postpartum women with bipolar disorder. Archives of women's mental health. 2018 Oct;21:543-51.

Reason for exclusion: Ineligible participant group – perinatal.

16. Cantwell R. Mental disorder in pregnancy and the early postpartum. Anaesthesia. 2021 Apr;76:76-83.

Reason for exclusion: Ineligible study design.

17. Corrarino JE, Williams C, Campbell III WS, Amrhein E, Kalachik D, LoPiano L. Linking substance-abusing pregnant women to drug treatment services: a pilot program. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2000 Jul 1;29(4):369-76.

Reason for exclusion: Ineligible study design.

18. Chablani A, Spinney ER. Engaging high-risk young mothers into effective programming: the importance of relationships and relentlessness. Journal of Family Social Work. 2011 Jul 1;14(4):369-83.

Reason for exclusion: Ineligible participant group – perinatal.

19. Chang JJ, Tabet M, Elder K, Kiel DW, Flick LH. Racial/ethnic differences in the correlates of mental health services use among pregnant women with depressive symptoms. Maternal and child health journal. 2016 Sep;20:1911-22.

Reason for exclusion: Ineligible outcomes – predictors.

20. Chase E, Maxwell C, Knight A, Aggleton P. Pregnancy and parenthood among young people in and leaving care: what are the influencing factors, and what makes a difference in providing support?. Journal of adolescence. 2006 Jun 1;29(3):437-51.

Reason for exclusion: Ineligble participant group – perinatal.

21. Chen X, Burgdorf K, Dowell K, Roberts T, Porowski A, Herrell JM. Factors associated with retention of drug abusing women in long-term residential treatment. Evaluation and Program Planning. 2004 May 1;27(2):205-12.

Reason for exclusion: Ineligible participant group - perinatal.

22. Clark KA, Dee DL, Bale PL, Martin SL. Treatment compliance among prenatal care patients with substance abuse problems. The American journal of drug and alcohol abuse. 2001 Jan 1;27(1):121-36.

Reason for exclusion: Ineligible outcomes – predictors.

23. Creech S, Davis K, Howard M, Pearlstein T, Zlotnick C. Psychological/verbal abuse and utilization of mental health care in perinatal women seeking treatment for depression. Archives of women's mental health. 2012 Oct;15:361-5.

Reason for exclusion: Ineligible participant group - perinatal

24. Cruz CC. Stigma-Free Pregnancy: A recruitment and retention strategy for healthcare systems to engage pregnant women with Substance Use Disorder in collaborative care (Doctoral dissertation, University of Southern California).

Reason for exclusion: Ineligible study design.

25. Da Costa D, Zelkowitz P, Nguyen TV, Deville-Stoetzel JB. Mental health help-seeking patterns and perceived barriers for care among nulliparous pregnant women. Archives of Women's Mental Health. 2018 Dec;21:757-64.

Reason for exclusion: Ineligible participant group.

26. Dadi AF, Miller ER, Azale T, Mwanri L. “We do not know how to screen and provide treatment”: a qualitative study of barriers and enablers of implementing perinatal depression health services in Ethiopia. International journal of mental health systems. 2021 May 5;15(1):41.

Reason for exclusion: Ineligible participant group - perinatal

27. David DH, McMahon TJ, Luthar SL, Suchman NE. Sensation Seeking, Coping With Stress, and Readiness to Engage in Therapy: Does Ego Development Influence the Psychosocial Functioning of Substance-Abusing Mothers?. American journal of orthopsychiatry. 2012 Apr;82(2):231-40.

Reason for exclusion: Ineligible participant group.

28. Day E, Porter L, Clarke A, Allen D, Moselhy H, Copello A. Drug misuse in pregnancy: the impact of a specialist treatment service. Psychiatric Bulletin. 2003 Mar;27(3):99-101.

Reason for exclusion: Ineligible outcomes.

29. Dennis CL, Vigod S. Expanding midwifery’s role to improve perinatal mental healthcare access. Evidence-Based Nursing. 2019 May 28.

Reason for exclusion: Ineligible participant group – perinatal.

30. Derkas E. " Don't let your pregnancy get in the way of your drug addiction": CRACK and the ideological construction of addicted women. Social Justice. 2011 Jan 1;38(3 (125):125-44.

Reason for exclusion: Ineligible study design.

31. Dolman C, Howard L, Jones I. Women with Lived Experience in the Perinatal Period: What do they want from Their Doctors?. European Psychiatry. 2022 Jun;65(S1):S50-.

Reason for exclusion: Ineligible participant group - perinatal

32. Duff P, Shoveller J, Chettiar J, Feng C, Nicoletti R, Shannon K. Sex work and motherhood: Social and structural barriers to health and social services for pregnant and parenting street and off-street sex workers. Health care for women international. 2015 Sep 2;36(9):1039-55.

Reason for exclusion: Ineligible participant group - perinatal

33. Eddy T, Kilburn E, Chang C, Bullock L, Sharps P. Facilitators and barriers for implementing home visit interventions to address intimate partner violence: Town and gown partnerships. Nursing Clinics of North America. 2008 Sep 1;43(3):419-35.

Reason for exclusion: Ineligible participant group.

34. Edge D. Perinatal depression: its absence among Black Caribbean women. British Journal of Midwifery. 2006 Nov;14(11):646-52.

Reason for exclusion: Ineligible participant group – perinatal.

35. Edge D, MacKian SC. Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK. Ethnicity & health. 2010 Feb 1;15(1):93-111.

Reason for exclusion: Ineligible participant group – perinatal.

36. Falletta L, Hamilton K, Fischbein R, Aultman J, Kinney B, Kenne D. Perceptions of child protective services among pregnant or recently pregnant, opioid-using women in substance abuse treatment. Child Abuse & Neglect. 2018 May 1;79:125-35.

Reason for exclusion: Ineligible outcomes.

37. Flynn L, Budd M, Modelski J. Enhancing resource utilization among pregnant adolescents. Public Health Nursing. 2008 Mar;25(2):140-8.

Reason for exclusion: Ineligible outcomes.

38. Fonseca A, Canavarro MC. Towards a model of professional help-seeking for women's perinatal mood and anxiety disorders: The application of the information-processing model of help-seeking decisions. Journal of Affective Disorders. 2021;282:686-8.

Reason for exclusion: Ineligible study design.

39. Field S, Honikman S, Abrahams Z. Adolescent mothers: A qualitative study on barriers and facilitators to mental health in a low-resource setting in Cape Town, South Africa. African Journal of Primary Health Care and Family Medicine. 2020 Jan 1;12(1):1-9.

Reason for exclusion: Ineligible participant group – perinatal.

40. Fiocchi FF, Kingree JB. Treatment retention and birth outcomes of crack users enrolled in a substance abuse treatment program for pregnant women. Journal of substance abuse treatment. 2001 Mar 1;20(2):137-42.

Reason for exclusion: Ineligible outcomes – predictors.

41. Ford E, Roomi H, Hugh H, van Marwijk H. Understanding barriers to women seeking and receiving help for perinatal mental health problems in UK general practice: development of a questionnaire. Primary health care research & development. 2019 Jan;20:e156.

Reason for exclusion: Ineligible participant group – perinatal.

42. Frederiksen MS, Schmied V, Overgaard C. Supportive maternity care services: A Danish study exploring parents' experiences with perinatal mental health issues. European Journal of Public Health. 2020 Sep;30(Supplement_5):ckaa165-127.

Reason for exclusion: Ineligible participant group – perinatal.

43. Galvin SL, Ramage M, Leiner C, Sullivan MH, Fagan EB. A cohort comparison of differences between regional and buncombe county patients of a comprehensive perinatal substance use disorders program in western North Carolina. North Carolina Medical Journal. 2020 May 1;81(3):157-65.

Reason for exclusion: Ineligible outcomes – predictors.

44. Gartner K, Elliott K, Smith M, Pearson H, Hunt G, Martin RE. "People in regular society don't think you can be a good mother and have a substance use problem": Participatory action research with women with substance use in pregnancy. Canadian Family Physician. 2018 Jul 1;64(7):e309-16.

Reason for exclusion: Ineligible participant group – perinatal.

45. Goodman JH. Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. Birth. 2009 Mar;36(1):60-9.

Reason for exclusion: Ineligible participant group – perinatal

46. Gilchrist G, Cameron J, Nicolson S, Galbally M, Moore P. Reducing depression among perinatal drug users–what is needed? A triangulated study. Advances in Dual Diagnosis. 2012 Nov 16;5(4):164-75.

Reason for exclusion: Ineligible participant group - perinatal.

47. Gonzalez G. Psychosocial factors related to program retention for low-income pregnant and parenting women in outpatient, case management substance abuse treatment. University of California, Santa Barbara; 2001.

Reason for exclusion: Wrong participant group – perinatal; Wrong outcomes – predictors

48. Goyal NK, Folger AT, Hall ES, Teeters A, Van Ginkel JB, Ammerman RT. Multilevel assessment of prenatal engagement in home visiting. J Epidemiol Community Health. 2016 Sep 1;70(9):888-94.

Reason for exclusion: Ineligible outcomes – predictors.

49. Goyal NK, Hall ES, Jones DE, Meinzen-Derr JK, Short JA, Ammerman RT, Van Ginkel JB. Association of maternal and community factors with enrollment in home visiting among at-risk, first-time mothers. American journal of public health. 2014 Feb;104(S1):S144-51.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

50. Gray LA, Price SK. Partnering for mental health promotion: Implementing evidence based mental health services within a maternal and child home health visiting program. Clinical Social Work Journal. 2014 Mar;42:70-80.

Reason for exclusion: Ineligible participant group – perinatal.

51. Grella CE, Joshi V, Hser YI. Program variation in treatment outcomes among women in residential drug treatment. Evaluation review. 2000 Aug;24(4):364-83.

Reason for exclusion: Ineligible study design.

52. Gruß I, Firemark A, Davidson A. Motherhood, substance use and peer support: Benefits of an integrated group program for pregnant and postpartum women. Journal of Substance Abuse Treatment. 2021 Dec 1;131:108450.

Reason for exclusion: Ineligible participant group - perinatal

53. Han M, Stone S. Access to psycho-social services among pregnant and parenting teens: Generating questions using youth reports and GIS mapping techniques. InChild & Youth Care Forum 2007 Dec (Vol. 36, pp. 213-224). Springer US.

Reason for exclusion: Ineligible participant group – perinatal.

54. Hodgkinson S, Beers L, Southammakosane C, Lewin A. Addressing the mental health needs of pregnant and parenting adolescents. Pediatrics. 2014 Jan 1;133(1):114-22.

Reason for exclusion: Ineligible participant group – perinatal.

55. Holland ML, Christensen JJ, Shone LP, Kearney MH, Kitzman HJ. Women's reasons for attrition from a nurse home visiting program. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2014 Jan 1;43(1):61-70.

Reason for exclusion: Ineligible participant group.

56. Horan H, Mobley E, Lavender C, Thompson A, Bryant W, McDaniel J, Robertson E, McIntosh S, Albright DL. “I am busy enough…”: Navigating challenges experienced by Medicaid providers serving pregnant people living with substance use disorders in Alabama. Journal of Nursing Scholarship. 2023 May;55(3):556-65.

Reason for exclusion: Ineligible participant group - perinatal

57. Jacobs L. 'Bad'mothers have alcohol use disorder: Moral panic or brief intervention?. Gender and Behaviour. 2014 Jan 1;12(1):5971-9.

Reason for exclusion: Ineligible participant group.

58. Jankovic J, Parsons J, Jovanović N, Berrisford G, Copello A, Fazil Q, Priebe S. Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study. BMC medicine. 2020 Dec;18:1-2.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

59. Johnson SM, Trejo G, Beck KL, Worsley C, Tranberg H, Plax KL, Linton JM. Building community support using a modified World Café method for pregnant and parenting teenagers in

Forsyth County, North Carolina. Journal of pediatric and adolescent gynecology. 2018 Dec 1;31(6):614-9.

Reason for exclusion: Ineligible participant group – perinatal.

60. Jones HE, Svikis D, Rosado J, Tuten M, Kulstad JL. What if they do not want treatment?: Lessons learned from intervention studies of non-treatment-seeking, drug-using pregnant women. American Journal on Addictions. 2004 Jan 1;13(4):342-57.

Reason for exclusion: Ineligible outcomes.

61. Josten LV, Savik K, Anderson MR, Benedetto LL, Chabot CR, Gifford MJ, McEiver J, Schorn MA, Frederickson B. Dropping out of maternal and child home visits. Public Health Nursing. 2002 Jan;19(1):3-10.

Reason for exclusion: Ineligible participant group.

62. Keefe RH, Brownstein-Evans C, Rouland Polmanteer RS. Addressing access barriers to services for mothers at risk for perinatal mood disorders: A social work perspective. Social work in health care. 2016 Jan 2;55(1):1-1.

Reason for exclusion: Ineligible study design.

63. Kelly PJ, Blacksin B, Mason E. Factors affecting substance abuse treatment completion for women. Issues in Mental Health Nursing. 2001 Jan 1;22(3):287-304.

Reason for exclusion: Ineligible participant group.

64. Kelsey CM, Thompson MJ, Dallaire DH. Community-based service requests and utilization among pregnant women incarcerated in jail. Psychological Services. 2020 Nov;17(4):393.

Reason for exclusion: Ineligible outcomes.

65. Knight DK, Logan SM, Simpson DD. Predictors of program completion for women in residential substance abuse treatment. The American journal of drug and alcohol abuse. 2001 Jan 1;27(1):1-8.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

66. Kola L, Abiona D, Adefolarin AO, Ben-Zeev D. Mobile phone use and acceptability for the delivery of mental health information among perinatal adolescents in Nigeria: survey study. JMIR Mental Health. 2021 Jan 26;8(1):e20314.

Reason for exclusion: Ineligible participant group - perinatal

67. Kornfield SL, Kang-Yi CD, Mandell DS, Epperson CN. Predictors and patterns of psychiatric treatment dropout during pregnancy among low-income women. Maternal and child health journal. 2018 Feb;22:226-36.

Reason for exclusion: Ineligible outcomes – predictors.

68. Le TL, Kenaszchuk C, Milligan K, Urbanoski K. Levels and predictors of participation in integrated treatment programs for pregnant and parenting women with problematic substance use. BMC Public Health. 2019 Dec;19:1-1.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

69. Leis JA, Mendelson T, Perry DF, Tandon SD. Perceptions of mental health services among low-income, perinatal African-American women. Women's Health Issues. 2011 Jul 1;21(4):314-9.

Reason for exclusion: Ineligible participant group – perinatal.

70. Lindsay B, Albrecht J, Terplan M. Against professional advice: treatment attrition among pregnant methamphetamine users. Substance abuse and rehabilitation. 2011 Oct 31:189-95.

Reason for exclusion: Ineligible outcomes – predictors.

71. Little F, Galloway A. Early years outreach clinic defeating barriers to perinatal mental health care in rural Australia. Australian Nursing and Midwifery Journal. 2014 Mar;21(8):51.

Reason for exclusion: Ineligible participant group - perinatal

72. Liu CH, Liu H. Concerns and structural barriers associated with WIC participation among WIC-eligible women. Public Health Nursing. 2016 Sep;33(5):395-402.

Reason for exclusion: Ineligible participant group – perinatal.

73. Mattocks KM, Clark R, Weinreb L. Initiation and engagement with methadone treatment among pregnant and postpartum women. Women's Health Issues. 2017 Nov 1;27(6):646-51.

Reason for exclusion: Ineligible participant group - perinatal

74. McGrory J, Breckenridge J, Mowll J. Women who use alcohol and other drugs during pregnancy: exploring the complexity of client engagement and their compliance with human service expectations. Journal of Social Work Practice. 2020 Jan 2;34(1):81-94.

Reason for exclusion: Ineligible study design.

75. Miller EB, Canfield CF, Morris PA, Shaw DS, Cates CB, Mendelsohn AL. Sociodemographic and psychosocial predictors of VIP attendance in smart beginnings through 6 months: Effectively targeting at-risk mothers in early visits. Prevention Science. 2020 Jan;21:120-30.

Reason for exclusion: Ineligible participant group.

76. Millett L, Taylor BL, Howard LM, Bick D, Stanley N, Johnson S. Experiences of improving access to psychological therapy services for perinatal mental health difficulties: a qualitative study of women's and therapists' views. Behavioural and cognitive psychotherapy. 2018 Jul;46(4):421-36.

Reason for exclusion: Ineligible participant group – perinatal.

77. Morelli PT, Fong R. The role of Hawaiian elders in substance abuse treatment among Asian/Pacific Islander women. InSubstance abuse issues among families in diverse populations 2013 Dec 16 (pp. 33-44). Routledge.

Reason for exclusion: Ineligible participant group - perinatal.

78. Morelli PT, Fong R, Oliveira J. Culturally competent substance abuse treatment for Asian/Pacific Islander women. Journal of Human Behavior in the Social Environment. 2000 Sep 1;3(3-4):263-80.

Reason for exclusion: Ineligible participant group – perinatal.

79. Myors KA, Johnson M, Cleary M, Schmied V. Engaging women at risk for poor perinatal mental health outcomes: A mixed-methods study. International journal of mental health nursing. 2015 Jun;24(3):241-52.

Reason for exclusion: Ineligible participant group – perinatal.

80. Nagle U, Farrelly M. Women's views and experiences of having their mental health needs considered in the perinatal period. Midwifery. 2018 Nov 1;66:79-87.

Reason for exclusion: Ineligible participant group – perinatal.

81. Nakku JE, Okello ES, Kizza D, Honikman S, Ssebunnya J, Ndyanabangi S, Hanlon C, Kigozi F. Perinatal mental health care in a rural African district, Uganda: a qualitative study of barriers, facilitators and needs. BMC health services research. 2016 Dec;16:1-2.

Reason for exclusion: Ineligible participant group – perinatal.

82. Navaie-Waliser M, Martin SL, Campbell MK, Tessaro I, Kotelchuck M, Cross AW. Factors predicting completion of a home visitation program by high-risk pregnant women: the North Carolina Maternal Outreach Worker Program. American Journal of Public Health. 2000 Jan;90(1):121.

Reason for exclusion: Ineligible outcomes – predictors.

83. Nicholson WK, Brickhouse B, Powe NR, Bronner Y. Prenatal Patients' Views of Prenatal Care Services. Ethnicity & Disease. 2004 Jan 1;14(1):13-20.

Reason for exclusion: Ineligible outcomes – predictors.

84. O'Connor A, Harris E, Hamilton D, Fisher C, Sachmann M. The experiences of pregnant women attending a specialist service and using methamphetamine. Women and Birth. 2021 Mar 1;34(2):170-9.

Reason for exclusion: Ineligible outcomes.

85. Osok J, Kigamwa P, Huang KY, Grote N, Kumar M. Adversities and mental health needs of pregnant adolescents in Kenya: identifying interpersonal, practical, and cultural barriers to care. BMC women's health. 2018 Dec;18(1):1-8.

Reason for exclusion: Ineligible outcomes.

86. Palmer Molina A, Palinkas LA, Monro W, Mennen FE. Barriers to implementing a group treatment for maternal depression in Head Start: Comparing staff perspectives. Administration and Policy in Mental Health and Mental Health Services Research. 2020 Jul;47:545-54.

Reason for exclusion: Ineligible participant group.

87. Paris R, Herriott AL, Maru M, Hacking SE, Sommer AR. Secrecy versus disclosure: Women with substance use disorders share experiences in help seeking during pregnancy. Maternal and Child Health Journal. 2020 Nov;24:1396-403.

Reason for exclusion: Ineligible outcomes.

88. Peacock-Chambers E, Paterno MT, Kiely D, Fioroni T, Byatt N, Friedmann PD. Engagement in perinatal outpatient services among women in recovery from opioid use disorders. Substance abuse. 2021 Oct;42(4):1022-9.

Reason for exclusion: Ineligible participant group - perinatal.

89. Price SK, Proctor EK. A rural perspective on perinatal depression: Prevalence, correlates, and implications for help-seeking among low-income women. The Journal of Rural Health. 2009 Mar;25(2):158-66.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

90. Rathod SD, Honikman S, Hanlon C, Shidhaye R. Characteristics of perinatal depression in rural central, India: a cross-sectional study. International Journal of Mental Health Systems. 2018 Dec;12:1-8.

Reason for exclusion: Ineligible participant group – perinatal; Ineligible outcomes – predictors

91. Recto P, Champion JD. "We Don't Want to be Judged": Perceptions about Professional Help and Attitudes Towards Help-Seeking among Pregnant and Postpartum Mexican-American Adolescents. Journal of pediatric nursing. 2018 Sep 1;42:111-7.

Reason for exclusion: Ineligible participant group – perinatal.

92. River LM, Narayan AJ, Galvan T, Rivera LM, Harris WW, Lieberman AF. On the verge of motherhood and mental illness: Prenatal mental health service utilization among women at highest risk. Zero to Three. 2019 May 1;39(5).

Reason for exclusion: Ineligible outcomes.

93. Sadicario JS, Parlier-Ahmad AB, Brechbiel JK, Islam LZ, Martin CE. Caring for women with substance use disorders through pregnancy and postpartum during the COVID-19 pandemic: Lessons learned from psychology trainees in an integrated OBGYN/substance use disorder outpatient treatment program. Journal of substance abuse treatment. 2021 Mar 1;122:108200.

Reason for exclusion: Ineligible participant group - perinatal.

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Reason for exclusion: Ineligible participant group - perinatal

Appendix C. Findings and Illustrations of Qualitative Studies (Study 3)

Abrahams et al. 2023	
Finding 1	Concerns about confidentiality (U)
Illustration	"… especially in a community where everyone knows everyone, I do not trust them [nurses]."(p.6)
Finding 2	Concerns about consequences from violent partners (U)
Illustration	"… so we have to think twice before you do something that you are going to regret."(p.6)
Finding 3	High workload (healthcare workers) (C)
Illustration	"if she's not gonna ask you or tell you about her problem then you oversee that—you overlook that, because she looks happy, she's not looking stressful."(p.6)
Finding 4	Discomfort with mental health issues (healthcare workers) (U)
Illustration	"I can talk and everything but there's a point where right, I'm not trained for this … I don't want to take in so much because it also takes so much out from you."(p.6) "if you probe and you ask those three questions [the screening tool], what do you do if the answer is yes?"(p.6)
Finding 5	Stigma (healthcare workers) (U)
Illustration	"One ANC nurse explained that mental health issues were stigmatised in the community and that patients were concerned that they would be branded as "…mad if you go for counselling.""(p.6) "A lay healthcare worker explained that the community was very small, and that patients were concerned that "… they {neighbours] look at others and they point fingers.""p.6)
Finding 6	Normalization of domestic violence (C)
Illustration	"Healthcare workers thought that women who were abused believed that the abuse was "… how he is showing his love" (Breastfeeding Counsellor), or that he "did not mean to hurt them" (ANC Nurse), or that the women "deserve it" (Breastfeeding Counsellor)."(p.6)
Finding 7	Belief that counselling can't help (U)
Illustration	"Many pregnant women who were abused felt that a referral for mental health counselling would not help them as it would not be able to change their dependence on their abusive partners. One pregnant woman

	explained that she had accepted her abusive relationship by saying: "Everyone mos [anyway] has their own problems …", while another pregnant woman explained that counselling could not change her situation as "I am not working. He is the breadwinner.""[p.7]
Chan & Moriarty 2010	
Finding 1	Pregnancy as a facilitator (clinicians) (U)
Illustration	"During pregnancy women tend to have a heightened sense of responsibility."[p.64]
Finding 2	Concern of harm to the baby as a facilitator (clinicians) (U)
Illustration	"Even though they are having withdrawals they don't want to increase... Their concern is that they want their baby to be born as healthy as possible with as little opioid dependence as possible."[p.64]
Finding 3	Unsupportive family (clinicians) (U)
Illustration	"They're (the client's family) usually too angry to be receptive in those cases. …eventually they come around when they see the benefits."[p.64]
Finding 4	Fear of child removal by CPS (clinicians) (U)
Illustration	"We would want to refer them as quickly as possible and get them engaged with High Risk clinic. And sometimes that's quite difficult, especially if they've had children taken off them before because they're very reluctant. They don't want us to inform anybody that they're pregnant."[p.64]
Finding 5	Stigma and judgement (clinicians) (U)
Illustration	"There is a stigma about it. They've been judged. They've been looked down upon."[p.65]
Finding 6	Staff shortages and staff turnover (clinicians) (C)
Illustration	"...pressures of staff shortages and staff turnover were also mentioned as barriers to integrated care across services and within services, with recognition that these staffing factors also hampered the development of, and continuing rapport with, individual women."[p.65]
Finding 7	Self-judgement and low self-worth (U)
Illustration	"It's just me who does this to myself. I choose to use and so I always feel like I deserve to be looked down upon by these doctors and nurses."[p.65]
Finding 8	Guilt (U)

Illustration	"This overwhelming feeling that I had of guilt… I was just torn two ways by this really strong desire to just stick a… needle in my arm and the feeling of what is that doing to my baby."(p.65)
Finding 9	Apprehension about methadone being addictive (U)
Illustration	"I was really anti-methadone. Amongst the junkie community who aren't on methadone they say 'Don't get on methadone, you'll be on it for life.'"(p.65)
Finding 10	Stigma from healthcare providers (U)
Illustration	"I never ever went to the chemist without my partner when I was pregnant 'cause I couldn't cope with the snide comments."(p.66) "The way I'm treated by people is intolerable. It's here (the clinic), it's the chemists, the doctors, society, (the) job, going for jobs. Going back to my previous career is just about impossible."(p.66)
Finding 11	Not feeling heard/understood (U)
Illustration	"Obviously they see so many women… that they're just kinda immune to it…You can't have any kinda talk… it's all very medical."(p.66)
Curran 2022	
Finding 1	Uncertainty/fear about opioid replacement medication and its effects (U)
Illustration	"My experience was one that – I thought I can't really explain it because I was nervous. I was scared that I didn't know what the outcome would be if I'm going to be [able to] hold the baby or not, because I just thought that I didn't know what it would be like. I don't know if my baby's going to be OK. I was taking so many medications and listening to what doctors' advice was like. I was nervous."(p.104)
Finding 2	Shame and responsibility (U)
Illustration	"I felt like I was responsible just because of something I could have controlled."(p.105)
Finding 3	Stigma and discrimination (U)
Illustration	"my use of opioids and also my color. Because she said that I was careless because using of opioids during pregnancy isn't safe. And yeah… I'm a black person, and these people, some of them was racist. They didn't care about how you are doing; they didn't even want to help."(p.109) "there was racism, yeah…. I think because I am African American."(p.109)

	"Just the stigma against medication assisted treatment and how we're like the redheaded stepchild of treatment, and like it's not real treatment."(p.109)
Finding 4	Warm and welcoming approach (U)
Illustration	"At first, I was shy, I didn't really want, you know. I know [they were] friendly to me, and this really got me interested in going, making sure, because the encouragement I get from them every day then when I was pregnant. They're very friendly to me. So, I haven't gotten any negative behavior from them."(p.110)
Finding 5	Establishing trust with providers (U)
Illustration	"They give you accurate information because I felt like I didn't come out of that place with doubt. Because if you maybe go somewhere and you want to acquire information about a given product and they're able to explain this given product properly, then you decide, OK, I like to read, first, the information and I like to try this even further. So for me the information, they were very informative and they were very gentle while explaining everything, and taking me through each step, and for me that was what also made me decide to pick that given place."(p.111)
Finding 6	Providers creating a sense of safety (U)
Illustration	"I have a very personal relationship and close relationship with my doctors, and I feel I'm safe with them."(p.112)
Finding 7	Fear of consequences of disclosure (U)
Illustration	"And it was just - yeah, it was like a breakdown moment, but it needed to happen. How would I've hid it any longer like that? It wasn't healthy to do so, but I remember I just didn't want to - ashamed, just feeling shame. And like, oh my god, they're going to think I'm such a loser because I was and not doing anything and just using all the time."(p.105)
Finding 8	Mental health problems (U)
Illustration	"I go to find out I was pregnant, and the world around me just changed. Initially when I found out I went the day after I was told that I'm pregnant – "Wow, pregnant. Am I going to bring forth a child? Oh my god." So I had to … I said yes, I could use a talk for advice on what to do. So after much badness, and everything, I was made to understand the effects on myself and my child. So, I went on medication with an antidote, with a

	gradual process in stopping the injecting of opioids, because I couldn't stop immediately. It was difficult. It was so difficult that sometimes I wouldn't move"[p.106]
Finding 9	Cost of treatment (U)
Illustration	"Ten participants (42%) cited the cost of treatment as a major challenge, and prevented some from continuing with treatment after delivery. Especially when medication was not covered by insurance and the cost incurred out-of-pocket expenses, participants reported the financial strain of daily treatment to be very stressful. About half of the participants who reported financial strain relied on spouses, family members, or friends to help them cover the cost of medication."[p.108]
Finding 10	Transportation issues (U)
Illustration	"Nine participants reported that the challenges related to transportation and travel to and from a provider caused significant stress. Most were travelling 30-45 minutes each way; some were driving hours per day to receive methadone treatment, some used public transportation or buses, and others relied on partners or family members for reliable transportation. One participant who was not able to drive lived within walking distance of the treatment program, but said that it became extremely difficult to walk toward the end of her pregnancy."[p.108]
Finding 11	Covid related health concerns (U)
Illustration	"I was in pain, I was stressed, worried about treatment during Covid"[p.109]
Finding 12	Social support and peer support (U)
Illustration	"Yeah, it was quite helpful, because I wasn't the only one, like, who used opioids during pregnancy, and before. And, like, later on. Yeah. When you meet different people telling their stories, their different stories about opioids, it really encourages you and you see like, they want to stop, and they're struggling, so, that's giving you hope when they say they used to use 10 and then they completely stopped, they don't use them anymore… When you hear such stories, they give you hope."[p.112]
Finding 13	Covid related changes (U)
Illustration	"It's actually gotten easier for people because there's online apps devoted just to like buprenorphine treatment now."[p.113]

Haselle et al. 2020	
Finding 1	Depression and anxiety (U)
Illustration	"After I went through all of that, with me I just didn't care a lot about doing other stuff. Anything that was outside, especially after it happened, I was sad so I sat in the house and didn't do anything, 'cause I was like "this sucks, I do not want to do this right now."(p.294)
Finding 2	Low agency and low self-worth (C)
Illustration	"Some women are so traumatized by what they've been through, so it does help build walls and others probably overcompensate . . . they're not, you know, they do not have a healthy sense of self-esteem right now."(p.294)
Finding 3	Pregnancy and other physical health concerns (U)
Illustration	"When I was big enough you like cannot do anything, you cannot."(p.294) "Depending on what kind of pregnancy you have, you might be sick all of the time."(p.294)
Finding 4	Perceived betrayal of partners (U)
Illustration	"So now you're in this situation and you're holding on to what they used to be and you're holding on to the potential of what they can be and not really living in the present and realizing what they actually are. And that's when the guilt comes in with maybe I should wait, maybe he can change."(p.294)
Finding 5	Controlling partners (U)
Illustration	"If they tell their boyfriend or husband that they're going to do this program and he says that basically they cannot or she cannot do it, you know, she cannot do it. It's messed up how some of these ladies, I'm not saying all but some I have seen before have let men take so much control of their life and what you can and cannot do . . . By any means if you want to do a program [while pregnant] you know, if it's benefiting you and your unborn child, then why not do it. But, you got to think of reality because if you're with an abuser and he's controlling your life, then you're going to be in a messed-up situation because there's no help, you know."(p.294)
Finding 6	Fear of repercussion from partners (U)

Illustration	"It's definitely, that is the first priority, to save her and her baby's life 'cause all it takes is one push, one hit, a car accident, him losing his temper and he hits her stomach, out of a rage, just throwing his arms. You cannot change that."(p.295)
Finding 7	Lack of time or conflicting scheduling (U)
Illustration	"Yeah, more than one [session option], like having those days but more than one group on those days so that way different hour people could go. So, that way at least they know, "if I can get out on Tuesday I can go to this group or this group.""(p.295)
Finding 8	Transportation (U)
Illustration	"I would have to walk all the way to the front of the building to try and catch a bus just to get a bus a mile down the street then have to wait a whole other hour to get back on the bus . . ."(p.295)
Finding 9	Compensation or incentive (U)
Illustration	"I think [women] would probably come, you know, like, if there was some kind of gift card or something, or food [for them and their family]."(p.295)
Finding 10	Normalization of Intimate Partner Violence (U)
Illustration	"Some girls do not know because they're used to the same thing they have seen [growing up] and they think it's okay, but it's not okay. I grew up with my mom being like that and some probably think that's what you're supposed to do. Or yeah, you know, some parent I had actually told me that they had someone tell them if you do not do nothing wrong then he will not hit you so stop doing stuff."(p.295)
Finding 11	Parental responsibilities (U)
Illustration	"It's too much for my infant child, so I'm not going to be dragging her here and here and here . . ."(p.295)
Finding 12	Social stigma (C)
Illustration	"Some people belittle it or they think you're lying. You do not want to tell anyone because you do not want to be judged, you do not want them to judge whether it's true or not. That might not be their opinion of your significant other but they do not know that person behind closed doors like that. So, to them, they could never do that. "Oh you're lying, you're lying." So, stuff like that, people not wanting to find out like if your

	family wanted to know where you were and you had to tell them and them not wanted to find out that you're going through this at all."[(p.295)]
Finding 13	Fear of helping systems (U)
Illustration	"So, I think it's scary because my husband didn't really do anything to my kids it was always to me and that's where of course I didn't want to get involved with things because I was afraid that my children would be took from me because of some of the things that would happen privately. So, that's where I think a lot of fear and that's the reason a lot of women do not participate in things that could be a lot more beneficial to them."[(p.296)]
Finding 14	Mistrust of services (C)
Illustration	"Me personally, I cannot just talk to any counselor. I have to . . . talk to someone that's real, that understands . . . [people] that have been through the situation [of experiencing IPV while pregnant] . . ."[(p.296)]
Finding 15	Perceived lack of available resources (C)
Illustration	"One of the reasons that I wanted to come to this is because I had wished there was something like this when I was in my twenties with the abusive men. Like I had to leave all on my own and I was so scared, there was no information, no literature, no groups [or interventions for] what I was going through."[(p.296)]
Jackson & Shannon 2012	
Finding 1	Affordability (NS)
Illustration	"Money, good insurance"[(p.1765)]
Finding 2	Availability (NS)
Illustration	"Wouldn't accept pregnant women"[(p.1765)]
Finding 3	Acceptability (NS)
Illustration	"Being judged, shamed"[(p.1765)]
Finding 4	Accessibility (NS)
Illustration	"My family needs a lot of help, needs me to be home"[(p.1765)]
Jessup et al. 2003[46]	
Finding 1	Fear of child custody loss and criminal prosecution (U)
Illustration	"... with a dirty tox screen, it could have been a lot more severe. I could have... been taken to court. I could have been arrested if they wanted to."[(p.291)]

	“If you have another [drug exposed] child within a three-year period, even if you're staying clean and sober, your child will be taken from you, and can be automatically be placed for adoption... [it is a] state policy... I wanted to come here [to the treatment program] and there wasn't an opening... I didn't go to my doctor at that time [in pregnancy] because of my name being on that list... I was really scared of that... that's what kept me from going to prenatal care."(p.292)
Finding 2	Perceptions of (un)helpfulness of treatment (C)
Illustration	“Unlike their attitudes about the necessity of prenatal care, participants viewed substance abuse treatment as a remote and unknown source of help and it was not identified as an immediate need during pregnancy. Treatment was seen primarily as a requirement in order to retain or regain custody of their children or for transitioning out of jail to a supportive environment. Although 24 of the participants had substance abuse treatment histories, treatment programs were not viewed as places that would have been of major assistance to them during pregnancy. In some cases, women construed 'treatment' to be a two- or three-day physical detoxification, wherein no other services were provided.”(p.293)
Finding 3	Domestic violence and partner substance use (C)
Illustration	“Domestic violence and partners' substance abuse made disengagement threatening for the women due to physical and financial dominance by male partners and the women's responsibility for their children.”(p.295)
Finding 4	Program requirements that excluded pregnant women and parenting women (C)
Illustration	“Program-based barriers, cited by participants, included limits on the number and ages of children who could accompany their mothers to treatment and other burdensome pre-admission requirements. While some women were able to place children with a family caregiver, placement of children in foster care in order to enter treatment was commonly experienced. Participants' status as opiate-dependent pregnant women created barriers that disrupted and delayed residential treatment entry. Opiate dependent women, enrolled in narcotic treatment programs (NTP) (methadone maintenance), described being viewed by residential treatment programs

	as 'too complex', and program admissions were therefore delayed or refused. Pregnancy itself was a barrier to drug treatment, as it conferred stigma and resulted in additional health care needs. Participants described treatment programs that excluded pregnant women by their claim of inappropriate service and milieu and other programs, purported to serve pregnant women, that had difficulty accepting and keeping a women on medically indicated bedrest, providing transportation to prenatal care and serving nutritious meals."(p.295)
Finding 5	Poverty, homelessness and incarceration (C)
Illustration	Participants also experienced poverty, homelessness, and incarceration, additional barriers embedded in their care-seeking experiences. Participants who were in jail during their pregnancies (n = 11) were incarcerated for an average of 10.5 weeks, with a range of four to twenty-four weeks. These conditions required women to be primarily occupied with daily survival for themselves and their children.(p.295)
Kemet et al. 2022	
Finding 1	Inaccessibility of services (U)
Illustration	"With MediCal (California government insurance) you have to do all the research yourself, and you're already stressed out, and it's like, it's too many loops... And they wonder why we don't access these services."(p.781) "…if I come in here talking to you with some common sense of attitude, calmly, respectfully, and ask 'can you help me?' you're just going to send me packing. But if I come in here and just yell and scream and I'm just jumping off the walls acting like I might hurt myself, or somebody else, you're going to get me some help. I don't think that's the way it has to be."(p.781)
Finding 2	Insurance related inaccessibility (U)
Illustration	"I was seeing a lady, but I had issues with my insurance… my therapist wasn't getting paid for our sessions, so I had to stop seeing her. And I didn't know what to do in terms of finding a therapist that my insurance covered... A lot of back-and-forth, you know, calling this person saying to call that person."(p.781)
Finding 3	Social determinants of health (C)

Illustration	“Homelessness, food insecurity, and lack of adequate social support made it incredibly difficult for participants to receive mental health care. Two other women also commented on the challenges of seeking mental health care as a pregnant woman while also battling structural and social determinants of health such as lack of transportation, money, or social support.”(p.782)
Finding 4	Provider distrust – financial motivations for prescribing medication (U)
Illustration	"And they rush to just throw you medicine. It's like, I could not even need medicine. I might just need somebody to talk to for like an hour, and it's like ... I might just need that good 45 minutes, to just let go. Oh no, no, no, no, no. We going to send you out of here with two prescriptions. But I don't really think I need all of this. I think I might just need someone to talk about things that I build on up in my head. And I really think their paycheck is based on how many medicines they give out."(p.783)
Finding 5	Provider distrust – racism and White supremacy (U)
Illustration	"There are a lot of Black mental health professionals out there. There's a lot more than you think, but they so go into this white supremacy realm that they even stop caring about our Black mental health. I just don't feel like Black, um, mental health is a concern in a white supremacy pyramid."(p.783)
Finding 6	Racial concordance and/or anti-racist care (U)
Illustration	"...because he was so cool…he knew about the homeless prenatal shelter, he knew about all the stuff going on, he cared, he was like, do you know about this? Do you know about that? He made sure I knew every resource that was out there…he made sure to tell me about them."(p.783) "When it comes to dealing with a Black person, you definitely need somebody with that state of mind, or that has been there, or knowing what's actually going on and not just reading the papers and like ‘I learned this in medical school, or I learned about this in my classes’…"(p.783) "You're so lucky, I was in the hospital like, I don't want no more White people coming in here. Pilipino. Mexican. Anything but White. Put a sign on the front door."(p.783)
Finding 7	Black advocacy in mental health care (U)

Illustration	"But you need more Black advocacy in that field [mental health], which means that some people [Black providers and patients] are going to have to get up, and stand up, and rise up."(p.784) …I would say that looking and listening and being a part of your own struggle. I would say you need strong Black advocators…"(p.784)
Kopelman et al. 2008	
Finding 1	Insurance and cost (U)
Illustration	"If you have insurance or can afford it - oh, you're their favourite patient... if you're very limited, they give you the least amount [of help] they can give you."(p.429)
Finding 2	Transport issues (C)
Illustration	"Women in focus groups noted that transportation problems were often caused by problems with finances, but they added that distance to care also had an impact on transportation as a barrier."(p.429)
Finding 3	Limited knowledge about local mental health care (C)
Illustration	"Women in the focus groups identified as important barriers a lack of knowledge about where to go for treatment, as well their providers' and their own lack of knowledge about depression during pregnancy itself."(p.429)
Finding 4	Lack of trust in providers regarding prescribing of medication (U)
Illustration	"They [medical providers] say it [medication] is safe - take this three times or four times [a day], whenever you need it - but then you read that it's really dangerous... so I lose my trust."(p.429)
Finding 5	Fear of child removal (C)
Illustration	"Focus group participants worried about other potential negative consequences of seeking mental health care, specifically mentioning fears of having one's children taken away."(p.429)
Finding 6	Stigma (U)
Illustration	"You get that look like, 'You shouldn't be having children if you need this kind of help'."(p.429)
Kruk & Banga, 2011	
Finding 1	Being able to approach CPS without the threat of child apprehension (U)
Illustration	"Eight of the 10 women highlighted the primary importance of being able to approach CPS for help during pregnancy without the threat of child

	apprehension. Six women identified the need for CPS intervention during early pregnancy, indicating that they would have readily engaged CPS if they felt supported rather than threatened."(p.83) "You hide your drug use because you're scared they're going to apprehend your baby when, you know, you hide it and go back to it and just keep stuffing it [using drugs], and you've got all that shame and guilt and you don't want to talk to anybody…"(p.83)
Finding 2	Collaboration, inclusion in treatment goals (U)
Illustration	"Women stressed the importance of CPS workers' asking them about their current needs and exploring how these could be best met. Women felt valued and empowered when recovery goals were jointly negotiated, and women's stated needs kept front and centre, rather than being told what they needed to do."(p.84) "People always told me that I had to get clean … saying you can't be doing this to this baby, you have to get clean, and I said, I know, I know, and another barrier I think was, people telling me that I have to get clean … and my total attitude was—I don't have to do fucking shit."(p.84)
Finding 3	Accountability without judgement (U)
Illustration	"Betty's social worker helped her to make a list of what she needed to do in order to achieve her goals. For example, having to provide regular hair samples made it difficult "to sneak, to do drugs." Linda had to call her social worker every morning, and provide a random urine sample when requested. These women did not feel judged, but built a supportive relationship with their worker, who kept them accountable. As Betty stated, "It's keeping me straight, right?""(p.84)
Finding 4	Recognition of strengths and efforts (U)
Illustration	"I needed the social worker to make me feel competent—like anything is possible … someone who is going to say that there's a way … there is hope and they can point you in the right direction and give you options."(p.84)
Finding 5	Consistency and continuity (U)
Illustration	"You get different workers and you just get to know a worker and then next thing that worker is off on a leave, and then you get another worker and it is happening again.… We just got to know him, he's now leaving

	so it's like, wow … we're going to have to meet all these other needs of another worker but we already done half of what we've been asked to do—it's just discouraging."[p.85] "When I cleaned up toward the end of my pregnancy, my social worker promised me if I was clean when I gave birth to my baby he wouldn't be apprehended.… Yes, I was clean for 60 days, and he still apprehended my baby."[p.85]
Finding 6	Children, and treatment that accommodated children (U)
Illustration	"There is a reason for everything … and there was a reason why I was a drug addict.… There's a reason why I had a baby … and I believe in my heart the reason I had a baby is to get me out of my drugs."[p.85] "My child has motivated me because she's one of the ones I'm getting better for … because if I'm not good—she ain't coming home."[p.85] ...five women identified the need for a recovery process that allowed their children to accompany them in treatment, indicating that actively parenting their children was a powerful asset in their recovery. The majority of the women felt that recovery that does not permit children is a barrier, and some indicated they would have not entered a recovery program that did not allow them to bring their children.[p.86]
Finding 7	Support with instrumental needs (U)
Illustration	"When women did not have the necessities for healthy living, their lives became more stressful and complicated with their pregnancy. Angie recalls, "We were homeless … we were living on the streets.… [My partner] he'd go for days without eating to make sure I ate—made sure the baby got enough." Linda indicated that "for the first half of my pregnancy, I was basically living in a crack house." Having a supportive living environment helped these women to make the changes they wanted to initiate when they became pregnant. Safe housing was identified as women's primary instrumental need."[p.87] "I was very sick all the time [during pregnancy]. You know she actually came and picked me up, right at my door."[p.87]
Finding 8	Support with mental health needs (U)
Illustration	"These people [CPS] are making my life miserable because they weren't giving me the help that I needed. They weren't giving me the treatment

	that I needed and I needed to go into treatment … and deal with my crack issues … and deal with grief and loss issues … and all these freaking issues that I had going on … and I was left out in the cold to deal with all this shit by myself."(p.87)
Finding 9	Gender specific and peer recovery programs (c)
Illustration	"The women made it clear that they were seeking gender-specific recovery programs that utilized mutual aid and peer support as core components. The importance of fostering the development of sustaining relationships with women facing similar life circumstances was identified as critical. In addition, women emphasized that a "one-size-fits-all" formula of recovery would not work; offering a menu of choices and multiple paths to recovery, including both abstinence- and harm reduction-based approaches, are particularly important to women who have felt disempowered throughout their lives."(p.88)
Lefebvre, 2010	
Finding 1	Lack of negative judgement by staff (U)
Illustration	"I liked her a lot because she wasn't judging"(p.50)
Finding 2	Lack of stigma by staff (U)
Illustration	"I don't use [any] more except for the methadone. I go to the hospital and the doctor, who doesn't know me, just like that [says] ''You're a heroin addict.'' They treated me like garbage, but when I see my doctor here, it's different. Very different. I can see it in how my doctor looks at me. Somewhere else they don't look at you at all . . . here, they understand you . . . you're somebody"(p.50)
Finding 3	Respectful and knowledgeable communication (U)
Illustration	''I was really scared, and going through TCUP relieved a lot of those scared feelings. I was reassured that I could have a healthy baby, which was a big help.''(p.50) ''I got the information I needed and it helped me get to where I am today, which is 8 months clean.''(p.50)
Finding 4	Communication between the care team (U)
Illustration	''If someone didn't have the answer, they made sure they got the answer for me from someone else. Which again, reinforces the team.''(p.50)
Finding 5	Peer support groups (U)

Illustration	‘‘I think it would be more comfortable because you’re around people who are sharing the same experience . . . you’re at ease to express your issues because people are going through the exact same thing as you."[(p.51)]
Finding 6	Self-responsibility (U)
Illustration	"My other two daughters got taken away because I did marijuana. I asked the public health nurse, when I was pregnant . . . if she could help me so I wouldn’t have to go through it again. And with him, I volunteered to do it just in case they asked so that I could show . . . that I was clean."[(p.51)]
Oni et al. 2022	
Finding 1	Fear of losing child custody (U)
Illustration	“…you don’t want to sit there and say I’m a drug addict, I’m about to have a baby please take it off me. You know, that’s your fear. So, I didn’t access anything (antenatal and treatment) at all. I didn’t seek any medical assistance until the seventh month, out of fear….”[(p.578)]
Finding 2	Negative impact of CPS involvement on management or treatment (U)
Illustration	“Yeah um, if they want something you gotta jump through hoops but if you want something, they won’t do shit for you. They [child protection services] are nasty and they don’t know what they’re doing. They think they do, they take kids from the wrong parents. They make life harder for mothers. I don’t think they quite understand what a mother goes through when she loses her child. Even though sometimes it is her [mother’s] fault, but having your children removed from you damages everything.”[(p.578)]
Finding 3	Societal stigma and self-guilt (U)
Illustration	“…I was secretive, … I did use a few times, to tell you the truth, but I was like really secretive of it… I didn’t tell anyone because of the stigma and the guilt. I never appeared off my head or anything, so I never got tested so that they just thought I was off it.”[(p.579)]
Finding 4	Healthcare provider related stigma (U)
Illustration	“…there where some doctors who stuck their nose up at me…pretty much calling me a bad parent because I was using [using drug] … I stopped, I stopped seeing them.”[(p.579)]
Finding 5	Difficulty in everyday life and meeting daily needs (U)

Illustration	"…. if you've got drug issues you've got other problems as well that normal women wouldn't have such as sleeping rough and not knowing where you're going to end up when you have your baby…"(p.579) "I've lost my kids four times, due to domestic violence and drug addiction. Though the domestic violence isn't fair, but it should be a part of it, it's not anything I could have stopped."(p.579) "Being a single mum trying to figure everything out on your own is tough. Then the depression kicks in and that's when things go downhill [using more substances]. You'll be very lucky to be able to pick yourself from there..."(p.579)
Finding 5	Perceived limited treatment options and their side effects (U)
Illustration	"…I didn't want to go on MMT [methadone]. You know, I was begging not to go on that [MMT] but there's no other option… I had no other choice but methadone."(p.579) "… for me, I basically go cold turkey because if you have the suboxone during pregnancy, it may affect the baby… also the nurses don't know what suboxone could actually do to my baby."(p.579)
Finding 6	Inadequate support from service facilities (U)
Illustration	"[Interviewer: What would help?] I suppose a bit more support, like support me. Don't just take my kids away and then kind of leave me on my own. I suppose peer support group and more support services with no judgement will help"(p.580)
Sacks et al. 2015	
Finding 1	Internal sense of need (U)
Illustration	"I just thought it was a good idea, I guess…My job stresses me out a lot; my boyfriend stresses me out sometimes, and just like money and everything is stressing me out right now with the baby coming, and so that would probably be why [I'd seek treatment.]"(p.488)
Finding 2	Encouragement by family, friends, and partners (U)
Illustration	'It was my family encouraging me to go get help. My family knows me pretty well.''(p.488)
Finding 3	Encouragement by professionals (U)
Illustration	'If my OB would tell me to go, then I would do it.''(p.488)
Finding 4	Time and childcare (U)

Illustration	‘‘I was seriously busy with work and school, and I didn’t really have time for it even if I wanted to go.’’(p.488) ‘‘I have three kids and a million things going on so…I just didn’t have any time.’’(p.488)
Finding 5	Unavailability and inaccessibility of mental health appointments (U)
Illustration	‘‘No one was accepting OHP [Medicaid] patients.’’ Then, once they did find a provider, there were often long waits to get an appointment, ‘‘Once I did find the right office, at first they said the wait would be up to 6 weeks.’’(p.489)
Finding 6	Transportation issues (U)
Illustration	‘‘I don’t have a car so it’s really hard for me to get everywhere.’’(p.489)
Finding 7	Not thinking treatment is needed or warranted (U)
Illustration	‘‘Maybe not thinking that I needed it…I decided to handle [my depression] on my own.’’(p.489) ‘‘I wasn’t sure if any of those feelings I had were going to last for very long….I’ve struggled with depression. I also know that I’m a slow processor, and so I was hoping that it was just anxieties and fears that would pass.’’(p.489)
Finding 8	Previous negative experiences with mental healthcare providers (U)
Illustration	‘‘I get really annoyed with it. When I was a teenager I did lots of counselling, and I would see like four different people in the same day, and it just drove me nuts.’’ Another participant had seen the counsellors her son saw and noted: "I think she was more crazy than the people she was seeing. So yeah, I guess it depends on the counsellor because some counsellors are really stupendous and great and stuff like that, and other ones it’s just, yeah."(p.489)
Finding 9	Wanting to avoid psychiatric medication (U)
Illustration	"Everyone I’ve been to says I need to take pills, and I wasn’t taking medication like that when I was pregnant….If somebody would have said ‘Okay, we can do counselling and then maybe after you’re done breastfeeding or whatever then we could do, could get you back on your medication’ that would have been good, but I couldn’t find it."(p.489)
Finding 10	Ineffectiveness of incentives (U)

Illustration	‘‘[It was] just a little extra motivation. I probably was going to go anyway; it was just a little bonus.’’ Others explained that they were not going to be convinced to seek mental health care by a small incentive: ‘‘Really there was nothing that was going to motivate me to go, because every time I called somebody they wanted to give me pills and I wasn't going to take them."(p.489)
Finding 11	Physical and mental ill-health (U)
Illustration	‘‘I was sick every day of my pregnancy. I threw up every day… but they just took so long to find someone who could counsel me, and I was just too sick to even follow through with it.’’(p.489) "My anxiety would kick in, and I would not want to go do anything, and at first I was worried about having no medical, and it made me really depressed to think about stating [counselling] and having to quit and not actually wanting to quit."(p.489)
Williams et al. 2023	
Finding 1	Stigma and judgement from service providers (U)
Illustration	"Yes. How do I say it – it is not good to judge and shame people in public; “Look how you look.” “You’re smelling.” That will not work. Or if the child is underweight; “You did not breastfeed them properly”(p.04) "So you have to interrogate the hell out of them. Because normally what they tell you is not what it seems. They will not tell you that they drank last night but you can smell it so I’m like no but you did drink… I do not let up. I’m relentless. Many other people will just like leave it. I’m relentless. I will ask you. If you go into labour now and that water broke and it smells like alcohol do you know your baby can die”(p.04)
Finding 2	Relationships with partners (U)
Illustration	"And also you talk about the gender-based violence to them because others they are abused at home that is why maybe they are not going to the clinic, or else they are depending to the alcohol. Things like that."(p.04)
Finding 3	Ineffective screening and referral processes (U)
Illustration	"They said they cannot tell me not to drink, but I should know my limits. I told them that it’s only 2 to 3 beers a day."(p.04) "There was no counselling, nothing!… Yet on my maternity book it states that I needed counselling yet I did not get it."(p.04)

Appendix D. Video and Script Stimuli (Study 5.1 & 5.2)

Figure D.1

Screenshot of Video Stimulus Shown to Participants in Study 5.1

Script Used in the Video Stimulus in Study 5.1 and Provided to Participants in Study 5.2

Social Worker

Ms Smith, as you know, we're here to talk about how your living situation has been affecting your children (parent interjects)

Parent

My children are fine

Social Worker

Well, we have reports that show that your living situation is unstable - (Parent interjects)

Parent

Our living situation's fine now. Where are you getting this information from?

Social Worker

Please listen to what we have to say without interjecting and then you will get your turn to speak

Parent

I am listening.

Social Worker

So on our last visit we established that there was considerable risk to your children due to you living in a tent

Parent

I already told you that was temporary. I was supposed to move in with a friend of mine, but she changed her mind at the last minute and told me I couldn't stay there anymore (Social Worker interjects)

Social Worker

Ms Smith…

Social Worker

We referred you to homelessness support services with the request that you find a suitable dwelling. Have you engaged with these services?

Parent

Yes I did try to engage with the services but none of them would give me a stable home and the others said that for me to come in I had to have no dependent children.

Social Worker

You need to provide a stable home for your children

Parent

I am! We've just gone back home now

Social Worker

What home are you referring to?

Parent

To my house, where do you think I'd be referring to?

Social Worker

Ok, but you told us that you left because of family violence?

Parent

It was just a fight! I didn't say violence!

Social Worker

Well, our understanding is that it did involve violence

Parent

And who said that?

Social Worker

We have police attendance records that show visits to your residence based on neighbour reports of loud yelling and shouting

Parent

But there was no violence! No arrests! My husband had just lost his job and we were tight on money. I had contacted different services for money and had not heard back from anybody. My kids are safe when they're with me.

Social Worker

You are not telling us the full story. We have these reports from the police, so we have to establish your children are going to be safe.

Parent

The police only came around came around that one time coz my partner was having a fight with his brother in the backyard. The neighbours are always trying to stick their nose in our business, they don't know what's going on. If you want to see kids in trouble, I know some families you can go visit.

Social Worker

Well if you want to make a report about that you are more than welcome but today we are here to discuss your situation. So you haven't successfully engaged with any services, but you are no longer living in a tent and have returned to your home, correct?

Parent

Yeah

Social Worker

How do we know that your situation is now stable and your children will be safe?

Parent

Because there's nothing wrong. You and the school are causing problems where there aren't any. I have tried contacting services lots of times for support and I never hear back from them.

Social Worker

We hold legitimate concerns for your children's safety Ms Smith.

Parent

But I just needed space for a few nights with my kids. I contacted a friend to stay at her house, which I told you didn't work out. Me and my partner fight but there's no violence, it's just normal stuff. My kids are safe with me, ask them

Social Worker

We have asked them Ms Smith.

Parent

Yeah good, they would have told you there's nothing wrong I feed them and take them to school, I make sure they're clean. I'm a good mum

Social Worker

Ok, Ms Smith. Is there anything else you'd like to tell us about your current situation?

Parent

No, you already know everything so you should know that there's no issues. My kids are safest at home with me and not with whatever foster carer or whoever you put them with. This whole process is out to get me.

(scene ends)