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Review Article

At the Edge of Care: A Systematic Review and Thematic Synthesis of Parent and Practitioner Views and Experiences of Support for Parents with Mental Health Needs and Children's Social Service Involvement

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

1. Introduction

Many people who have contact with mental health services are primary caregivers, with recent estimates reporting that up to 38% of those attending inpatient psychiatric services, and 51% attending outpatient services, are parents to children under the age of 18 [1]. Having a child is a time of significant transition and change; estimates suggest that one in four women experience anxiety or depression during or after pregnancy [2], while approximately 35% of women with a preexisting diagnosis of psychosis or bipolar disorder experience an escalation postnatally [3]. Whilst research predominantly focuses on maternal mental health, nearly a third of fathers also experience psychological distress during the early parenting period [4]. Mental health difficulties can have wide-reaching impacts on parents and their families, especially as young children are heavily dependent on caregivers for their welfare. Whilst the majority of parents with mental health difficulties do not maltreat their children, parental mental health problems have been associated with increased risks for child maltreatment [5].

Children's social services can provide a range of support for families with vulnerable children and may instigate child protection procedures where a child is deemed at risk of harm. In the US, national data show that parents with mental health diagnoses are eight times more likely to have children's social services involvement and 25 times more likely to lose custody of their children compared to the general population [6]. Research using administrative health and child protection records illustrates high levels of preexisting mental health needs among mothers with child protection involvement in the UK [7, 8]. Despite this, parental mental health received limited attention in the UK government's recent plan for children's social care reform [9].

Mothers with mental health diagnoses and child protection involvement have often experienced social services intervention as children, suggestive of an intergenerational cycle of trauma [10]. They are also more likely to be socially deprived, unemployed, and to experience domestic violence [11, 12], indicating a complex interplay of risk factors, needs, and wider inequity. Recent UK population data found that a combination of parental mental health difficulties and financial hardship was associated with poorer physical, mental, and behavioural outcomes for children [13]. The impact of financial hardship on social services involvement is supported by a recent review of UK local authorities finding that children in the most deprived neighbourhoods were 13 times more likely to be on a Child Protection Plan and 11 times more likely to be looked-after children than those living in the least deprived neighbourhoods [14].

Parents whose children have been removed by social services report feelings of shame [15], loss of hope [16], escalating adversity, and social isolation [17]. Some mothers go on to have further pregnancies in quick succession, with a high likelihood of repeated child protection interventions and custody loss [18]. Negative outcomes for children can be exacerbated in the looked-after system, through multiple placements, bullying, and abuse [19]. Despite this, the number of looked-after children in the UK is increasing and predicted to rise to 95,000 by 2025 [20].

There is a need for services to help support families with mental health needs and children's social services involvement, preventing both the maltreatment of children and, where possible, the traumatic separation of children from their birth parents. What constitutes a "child protection intervention" varies globally [21]. Countries such as the US and UK take a "child protection orientation," focusing on risk to children and the primary involvement of child protection services but often overlooking the wider system, including parents' mental health and financial stability [22]. Contrasting this is the "family service orientation" adopted by European countries such as Sweden and Germany, where the psychological and socioeconomic problems of parents are considered central aspects of child protection [21]. The structure of services also impacts the nature of the support offered. For example, evidence has shown that the involvement of separate health and social care services creates collaboration difficulties, leading to fragmented delivery of support [23, 24]. In recent years, there have been an increasing number of initiatives to integrate services and provide specialised care to parents across a range of settings [25].

Reviews of interventions for parents with mental health diagnoses show that psychological therapy [26], practical support [27], and whole-family interventions [28] can have a positive impact on family wellbeing and reduce risks of child maltreatment. However, effect sizes are small and research uses a broad range of outcomes to measure effectiveness, making comparisons difficult [29]. Furthermore, there are a range of psychological, practical, and cultural barriers to engaging parents of at risk children [30], and social workers cited parental nonengagement as a major contributing factor in social services decisions to issue care proceedings [31].

Qualitative evidence of parents' and practitioners' views offers additional insights into how engagement, implementation, and outcomes for parents might be improved. As well as struggling with the demands of parenting, parents with mental health needs report their parenting role as a source of strength, resilience, and hope [32, 33]. Many parents fear custody loss and consequently are resistant to social services intervention [34]. Concerns have been raised over the heavy use of diagnostic labels such as "personality disorder" in this population, resulting in negative assumptions and service exclusion [35]. Given the possibilities of intergenerational trauma, it has also been argued that a lack of trauma-informed care may make support difficult for parents to engage with [36]. Overall, parents value flexible and holistic care, for example, 24-hour crisis services and family case management [37]. Recent research has suggested a "recovery approach" to child protection may be more able to incorporate service users' personal goals for parenting and mental wellbeing [38].

Research examining practitioners' views of service models has emphasized the need for greater collaboration between mental health and social work practitioners [39, 40]. High staff turnover among both mental health and social work professionals is common [41], as well as a lack of appropriate resources, supervision, and high caseloads [42, 43]. There is a need to understand the impact of these system constraints on both professionals and the families they support.

Whilst existing research offers insight into different aspects of support, synthesizing the evidence systematically allows us to gain a more comprehensive understanding of experiences and views of support for parents with mental health needs and children's social services involvement. Despite methodological challenges involved in synthesizing qualitive research [44], there is growing recognition of its value in health services research to inform recommendations for policy and practice [45]. Furthermore, existing literature outlines steps authors can take to ensure qualitative evidence is synthesized with sufficient rigour, whilst maintaining the context and meaning present in individual studies [46]. Whilst existing reviews focus on parents with mental health needs [47] or those with child protection concerns [29], families with both mental health and children's social services involvement have a distinct set of needs which single-focus interventions often neglect [48]. The nature, structure, and names of these services differ between contexts, but for the purpose of this review, we will use "children's social services" to mean services designed to support and protect vulnerable children.

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

1.1. What Is Known about This Topic?

(i) The effects of child abuse and child protection involvement are profound and enduring for both parent and child.

(ii) A range of services and professionals are involved in supporting parents with mental health needs and children's social services involvement.

(iii) These parents have diverse and complex needs and find it difficult to access and engage with support.

1.2. What This Paper Adds?

(i) Children's social services involvement places parents under pressure, creating stress, and sparking a cascade of stressful professional involvement over which parents feel they lack control.

(ii) Trauma-informed, transparent, and collaborative support is crucial to parental engagement with services.

(iii) Organisational factors including resources, timing of care, service structures, and high caseloads limit the quality of support professionals can offer.

2. Methods

2.1. Search Strategy. We followed PRISMA reporting guidelines throughout [49] and prospectively registered the study protocol on PROSPERO (CRD42022310600). The protocol was developed collaboratively by our multidisciplinary review team which included survivor, clinical and social science researchers, and clinicians working in this field. We identified eligible studies for the review by searching eight electronic databases: PsycINFO, CINAHL, HMIC, MEDLINE, Embase, Social Policy and Practice, Social Services Abstracts, and Social Science Citation Index. We searched grey literature on OpenGrey, Social Care Online, and ProQuest. We completed forward citation searching of included studies in Google Scholar. Studies were also identified through expert recommendations from the review team and their networks.

Our search strategy included MeSH headings and free-text terms based on the following key concepts centred around the SPICE framework [50]: child protection/child abuse (setting), parents and health and social care professionals (perspective), support/interventions (phenomenon of interest), mental health (context), and qualitative/experiences (evaluation). We limited searches to studies published since the year 2000 to balance the breadth of studies returned with relevance to current service provision. Our search strategy can be found in the supplementary material (S1).

2.2. Screening and Selection Criteria. We imported all studies returned by searches into EPPI-reviewer and removed duplicates. The eligibility criteria found in Table 1 were used to screen the titles and abstracts of papers as well as for subsequent full-text screening. Two reviewers independently completed double-screening of 10% of studies from both the title and abstract and full-text pools. One study [51], including the experiences of fathers whose partners had mental health diagnoses, was taken to the wider review team for further discussion before being excluded from the final pool. Lastly, forward citation searching was completed for included papers, and any identified studies were double-screened.

2.3. Quality Appraisal. We used the Critical Appraisal Skills Programme (CASP) qualitative checklist (2018) to assess the quality of included papers, as recommended by Long et al. [52]. Discussion with the review team identified the importance of additional areas of assessment relevant to the review as follows: positionality, service user involvement,

Table 1: Eligibility criteria for included papers.

Search concept	Inclusion criteria	Exclusion criteria
Condition/domain being studied	(i) Studies with a focus on the views/experiences of support for parents	(i) Studies without a primary focus on the views/experiences of support or interventions (ii) Studies where it is not possible to disentangle the views/experiences of different stakeholders
Perspective	(i) Parents meeting formal diagnostic criteria for mental health difficulties, receiving high scores on screening tools, or self-reporting mental health difficulties AND with current or past children's social services involvement (ii) Practitioners or professionals who support these parents	(i) Studies not including the views/experiences of eligible parents or practitioners (ii) Studies that do not allow the differentiation of eligible parents/practitioner views from those of noneligible participants
Phenomenon of interest	(i) Studies with an explicit focus on experiences of support or interventions for parents, where "support" is taken as any professional support including mental health, social work, parenting, or practical support	(i) Support or interventions not aimed at parents, e.g., aimed at children or wider family members
Type of study	(i) Studies using a qualitative research design (ii) Studies using a mixed methods design if qualitative data are reported separately (iii) Studies published in peer-reviewed journals or published articles or reports	(i) Studies not including analysis of data, e.g., reflective/commentary pieces (ii) Studies using a quantitative design (iii) Alternative formats such as book chapters, conference papers, editorials, letters, blogs, websites, theses, general comment studies (iv) Studies not published or available in English

and intersectionality, which were added as key questions 11–13. A full version of the adapted CASP and further information about scoring used in this review can be found in S2. We rated included studies "Yes" "No" or "Can't tell" for each CASP criteria, with 10% of studies doubly rated and discrepancies resolved through further discussion. In cases of uncertainty or insufficient information required for scoring, we allocated studies "Can't tell" for that criterion. The quality assessment of two studies [32, 53] required the acquisition of additional details of the study methodologies. We chose not to exclude studies from the review based on quality as we recognised that low-quality studies may still offer useful perspectives important to the review. Instead, we aimed to gain insight into the strength of evidence and methods used.

2.4. Lived Experience Involvement. We sought input from a Lived Experience Advisory Group (LEAG) consisting of four mothers from diverse cultural and socioeconomic backgrounds with lived experience relevant to our topic. During the data synthesis stage, we held two data workshops with the group who used their experience of mental health difficulties and children's social services involvement to help us make sense of the findings and their implications. Data workshops were informed by Shimmin et al. [54] principles for trauma-informed intersectional patient and public involvement in research. Given the sensitive nature of this review, one-to-one debrief meetings were offered to each LEAG member after meetings.

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

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

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

3. Results

3.1. Description of Included Papers. We managed database searching and screening in EPPI-reviewer. A full description of the screening process can be found in Figure 1.

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

In terms of settings, most participants were recruited from community mental health and social care services or local authorities. Two studies were set in services supporting the homeless [56, 57]. Studies were carried out in the UK ($n = 13$), US ($n = 10$), Australia ($n = 10$), Canada ($n = 3$), Sweden ($n = 2$), New Zealand ($n = 2$), and Japan ($n = 1$).

3.2. Quality Assessment. There was wide variation in study quality, as seen in Table 3. All studies but one reported clear and relevant research goals investigated with an appropriate design and methodology. Studies tended to score well on recruitment and data collection methods, but many lacked exploration of researcher reflexivity and adequate consideration of ethical issues, despite conducting interviews with a vulnerable participant group. Whilst several studies referenced a valid method of qualitative analysis, others did not provide sufficient detail required by the CASP criteria such as how analytical themes were derived from the data and were subsequently scored as "Can't tell". Most studies stated their findings and their implications clearly. Discussions of intersectionality, user involvement, and positionality were

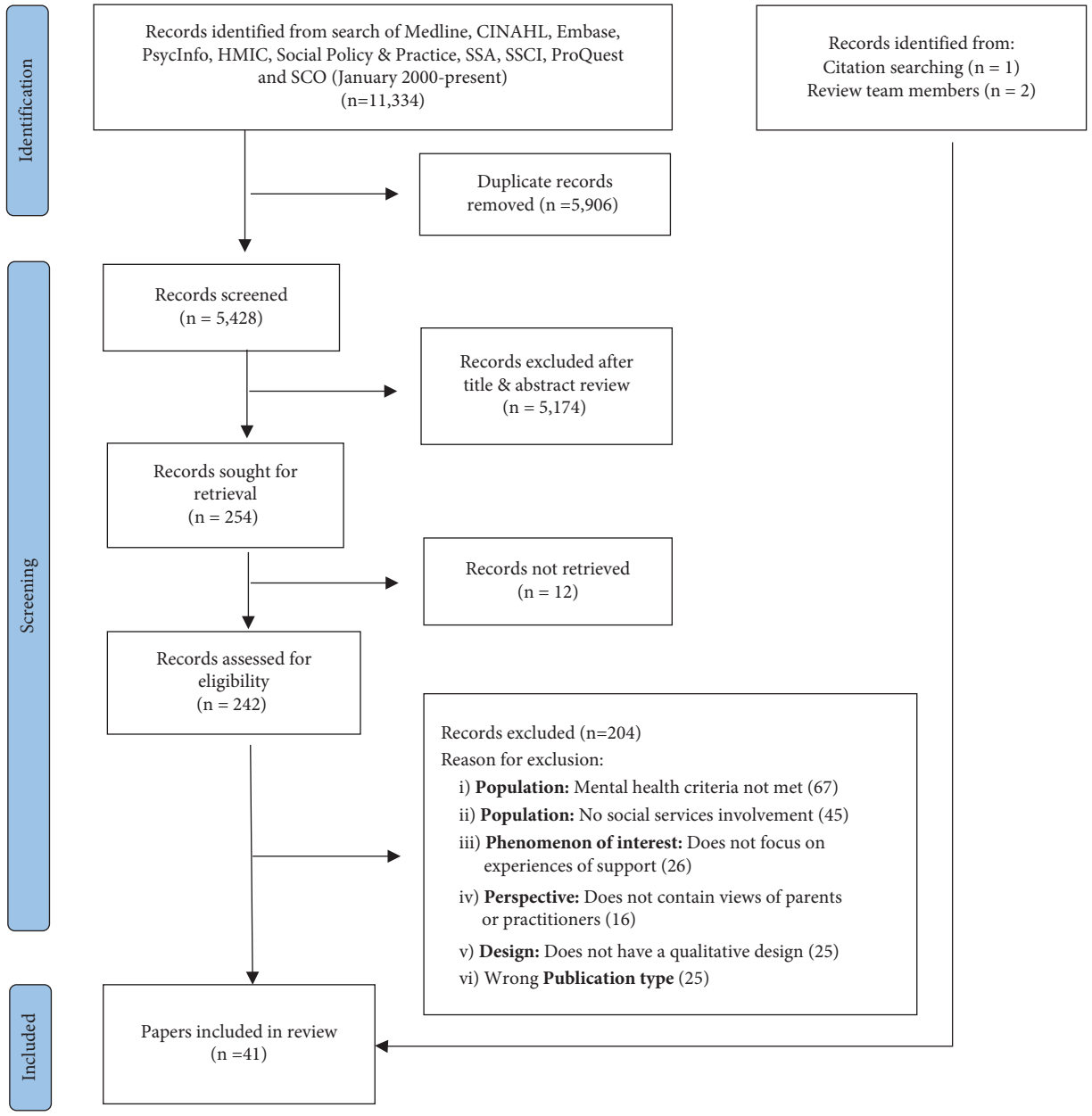

Figure 1: PRISMA flow diagram showing search strategy.

rare, meaning most studies scored low on the additional quality assessment criteria. 26 studies did not report basic demographic information about participants, limiting our understanding of how participant sociodemographics and/or researcher identity impacted findings and conclusions.

3.3. Thematic Synthesis. We developed four overarching themes encompassing both parents' and practitioners' experiences of support as follows: (1) a downward spiral of service intervention; (2) working with parents, not against them; (3) support wanted versus support provided; and (4) constrained by service rigidity. We use "parents" throughout to acknowledge the mixed participant pools, but most perspectives in the literature were those of mothers. An overview of themes, subthemes, and quotations is reported in Table 4.

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

Table 2: Characteristics of included studies.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(1) Ackerson [34] Coping with the dual demands of severe mental illness and parenting: the parents' perspective	Parents	$N = 13$ (i) Diagnosis: not specified (ii) Gender: 12 female (92%) (iii) Ethnicity: not reported (iv) Age: not reported	Community Mental Health Centres Illinois, USA	Semistructured interviews grounded theory	(1) Problems with diagnosis and treatment (2) Stigma and discrimination (3) Chaotic interpersonal relationships (4) Strain of single parenthood (5) Custody issues (6) Relationship with children (7) Social support
(2) Afzelius et al. [42] Children of parents with serious mental illness: the perspective of social workers	Practitioners	$N = 13$ (i) Profession: social service professionals (11 social workers, 1 trainee social worker, 1 treatment assistant) (ii) Gender: 12 female (92%) (iii) Age: $M = 44$ (29–57)	Children's Social Care Services Sweden	Focus groups and semistructured interviews ontent analysis	(1) Identifying with the situation of the child (2) Handling parental severe mental illness
(3) Barbour et al. [55] Assessing risk: professional perspectives on work involving mental health and child care services	Practitioners	$N = 30$–33 (not specified) (i) Profession: mixed (mental health (MH) and social services staff) (ii) Gender: not reported (iii) Age: not reported	Setting not reported UK	Focus groups thematic analysis	(1) The legacy of specialisation (2) Differing thresholds and codes (3) Assessing risk (4) Balancing risk and families' rights
(4) Barrow et al. [56] Context and opportunity: multiple perspectives on parenting by women with a severe mental illness	Both	Practitioners ($n = 7$) (i) Profession: housing shelters (ii) Gender: 4 female (57%) (iii) Age: not reported parents ($n = 7$) (iv) Diagnosis: not reported (v) Gender: 100% female (vi) Ethnicity: 3 African American, 3 Latina, 1 other (vii) Age: $M = 36.7$ (28–43)	Transitional Homeless Shelter New York, USA	Focus groups grounded theory	(1) Mother's perspectives: "I want to always keep that good relationship" (2) Service provider perspectives: "It may be the client's priority but not ours"

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(5) Caplan et al. [57] Indigenous and nonindigenous parents separated from their children and experiencing homelessness and mental illness in Canada	Parents	$N = 36$ (i) Diagnosis: not reported (ii) Gender: 12 female (33%) (iii) Ethnicity: 21 indigenous Canadian, 15 nonindigenous Canadian (white Canadian or white European) (iv) Age: $M = 40$	Homelessness Project (At Home Chez Soi, AHCS) Canada	Semistructured narrative interviews thematic analysis and intersectional analysis	(1) Children as central in mothers narratives vs. peripheral in fathers (2) Cultural disconnection and reclamation of indigenous parents (3) Gender and ancestry of parent
(6) Coates and Howe [58] Working with families who experience parental mental health and/or drug and alcohol problems in the context of child protection concerns: recommendations for service improvement	Both	Practitioners ($n = 10$): (i) Profession: 7 MH clinicians, 1 family support worker, 1 KTS-WFT site team leader, 1 psychiatrist (ii) Gender: not reported (iii) Age: not reported Parents ($n = 20$): (iv) Diagnosis: not specified (v) Gender: 17 female (85%) (vi) Ethnicity: not reported (vii) Age: not reported	Keep Them Safe Whole Family Team (KTS-WFT) Project - Central Coast Local Health District Outreach Service New South Wales, Australia	Semistructured interviews thematic analysis	(1) Service model improvement recommendations from the perspective of clinical staff (2) The KTS-WFT site from the perspective of discharged clients
(7) Coates [39] Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: inter-agency collaboration	Practitioners	$N = 10$ (i) Profession: 8 MH clinicians, 1 psychiatrist, 1 KTS-WFT Site team leader (ii) Gender: not reported (iii) Age: not reported	Northern Sydney Local Health District (NSLHD) Sydney, Australia	Open interviews grounded theory analysis	(1) Working collaboratively with child protection services
(8) Darlington et al. [23] Complexity, conflict and uncertainty: issues in collaboration between child protection and mental health services	Practitioners	$N = 232$ (i) Profession: 156 statutory child protection, 69 adult MH services, 50 child and youth MH services, 13 integrated MH services, 12 Other (ii) Gender: 73% female (iii) Age: $M = 37.7$ (21–65)	Department of Families and Queensland Health Australia	Self-administered cross-sectional survey analytical method not reported	(1) The nature of child protection needs and parental mental health (2) The extent of collaboration (3) The impact of uncertainty on collaboration (4) Positive experiences and difficulties with collaboration

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(9) Darlington et al. [24] Practice challenges at the intersection of child protection and mental health	Practitioners	$N = 36$ (i) Profession: 17 child protection workers, 15 adult MH workers, 4 child and youth MH workers (ii) Gender: 31 female (86%) (iii) Age: $M = 36.3$ (25–56)	Department of Families and Queensland Health Australia	Case-based interviews thematic analysis	(1) Factors associated with effective collaboration between child protection and adult mental health: communication, knowledge, role clarity, and resource factors (2) Challenges to collaborative work: mental illness characteristics, balancing conflicting needs
(10) Darlington and Feeney [59] Collaboration between mental health and child protection services: professionals' perceptions of best practice	Practitioners	(See: [23])	Department of Families and Queensland Health Australia	Self-administered, cross-sectional survey	Suggestions for improving interagency collaboration: (1) Improving communication (2) Enhancing the knowledge base of professionals in both sectors (3) Providing adequate resources and appropriate service models
(11) Darlington and Feeney [60] Clients' and professionals' experiences of traversing mental health and child protection systems: implications for practice	Both	Practitioners ($n = 4$): (i) Profession: child protection caseworkers (1 family support worker, 2 child protection workers, 1 MH social worker) (ii) Gender: 100% female (iii) Age: $M = 36.5$ (26–50) Parents ($n = 4$): (iv) Diagnosis: 2 X psychosis, 1 X PTSD, 1 X depression (v) Gender: 100% female (vi) Ethnicity: not reported (vii) Age: $M = 31$ (19–36)	Department of Families and Queensland Health Australia	Semistructured interviews around 4 client-caseworker dyads thematic analysis	(1) Assessment and case planning issues (2) Service coordination and collaboration issues
(12) Davidson et al. [61] Championing the interface between mental health and child protection: evaluation of a service initiative to improve joint working in Northern Ireland	Practitioners	$N = 109$ (i) Profession: 12 "champions" in MH, 59 MH team members, 12 "champions" in childcare, 26 children"s social workers (ii) Gender: 84% female (iii) Age: not reported	Northern Health and Social Care Trust (NHSCT), Northern Ireland, UK	Questionnaires analytical method not reported	Service evaluation, themes not reported

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(13) Diaz-Caneja and Johnson [16] The views and experiences of severely mentally ill mothers--a qualitative study	Parents	$N = 22$ (i) Diagnosis: 8 X schizophrenia delusional, 4 X bipolar disorder, 4 X severe depression with psychotic symptoms (ii) Gender: 100% female (iii) Ethnicity: 13 White British, 3 White other, 1 Black British, 1 Black Caribbean, 1 Black African, 2 Asian, 1 mixed (iv) Age: >20	Camden and Islington Community Mental Health Team London, UK	Semistructured interviews thematic analysis	(1) Positive aspects of motherhood (2) Difficulties associated with motherhood (3) Stigma (4) Effect of mental illness on children (5) Views about services
(14) Ghaffar et al. [62] Exploring the experiences of parents and carers whose children have been subject to child protection plans	Parents	$N = 47$ (i) Diagnosis: not reported (ii) Gender: 39 female (83%) (iii) Ethnicity: 36 White British, 5 X British Asian 6 X not specified (iv) Age: <20 ($n = 2$), 20–29 ($n = 20$), 30–29 ($n = 12$), 40–49 ($n = 7$), >50 ($n = 1$)	Local authorities in Northern England, UK	Semistructured interviews thematic analysis	(1) Power differentials between service users and professionals (2) Opportunities for building effective relationships (3) family involvement in decision-making
(15) Hanley and Long [63] A study of Welsh mothers' experiences of postnatal depression	Parents	$N = 10$ Diagnosis: postnatal depression Gender: 100% female Ethnicity: not reported Age: 17–33	Wales, UK	Semistructured interviews content analysis	(1) Previous knowledge of postnatal depression (2) Early traumatic life events (3) Self-awareness of health status (4) Attachment strengths and weaknesses (5) Intimate relationships (6) Social relationships (7) Support systems (8) Valued experiences (9) Prevention strategies and lifestyles
(16) Hetherington and Baistow [64] Supporting families with a mentally ill parent: European perspectives on interagency cooperation	Practitioners	$N =$ not reported (i) Profession: adult MH workers and child welfare workers (ii) Gender: not reported (iii) Age: not reported	The Icarus Project Brunel University, UK	Focus groups analytical method not reported	Reported cross-country differences in structures, resources, expectations, and attitudes and how these affect professional responses and the experiences of families

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(17) Hinden et al. [37] The invisible children's project: key ingredients of an intervention for parents with mental illness	Both	Practitioners ($n = 9$) (i) Profession: 3 case managers, 6 child welfare workers (ii) Gender: not reported (iii) Age: not reported Parents ($n = 9$) (iv) Diagnosis: 5X Major Depressive disorder, 1X schizoaffective, 1X substance abuse, 1X adjustment disorder, 1X bipolar disorder (v) Gender: not reported (vi) Ethnicity: 6 Caucasian, 3 African American (vii) Age: 26–40	Invisible Children's Project Department of Social Services New York, USA	Semistructured interview general inductive approach	(1) Identification of essential services for parents with mental illness (2) Mediators of successful outcomes
(18) Hollingsworth et al. [65] The role of positive and negative social interactions in child custody outcomes: voices of US women with serious mental illness	Parents	$N = 3$ (i) Diagnoses: 2 X bipolar disorder with psychosis, 1 X schizoaffective disorder (ii) Gender: 100% female (iii) Ethnicity: African American (iv) Age: 28–38	National Institute of Mental Health—longitudinal study of the meaning of motherhood University of Michegan, USA	Semi-structured interviews thematic Analysis	(1) The relationship between a mother's social interactions and the presentation of threats to her child (ren)'s safety (2) The relationship between a mother's positive and negative interactions and losing or relinquishing custody of her child (ren) (3) The relationship between a mother's social interactions and her efforts to regain custody (reunification) or to adjust to permanent placement
(19) Honey et al. [66] Living with mental illness and child removal	Parents	$N = 8$ (i) Diagnoses: 3X depression, 3X bipolar, 3X psychotic disorder, 2X anxiety disorder, 1X post-traumatic stress disorder (ii) Gender: 100% female (iii) Ethnicity: not reported (iv) Age: not reported	Setting not reported University of Sydney, Australia	Semistructured interviews interpretive phenomenological approach	(1) Chaotic lives preremoval (2) Pain and loss (3) Protecting myself (4) Constrained mothering

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(20) Humphreys et al. [67] Beyond co-occurrence: addressing the intersections of domestic violence, mental health and substance misuse	Practitioners	$N = 28$ (i) Profession: senior practitioners working in child protection, family support, specialist domestic violence, MH and substance misuse (ii) Gender: not reported (iii) Age: not reported	STACY Project – Domestic Violence Services Australia	Semistructured interviews, ethnographic notes, transcripts thematic synthesis	(1) Partnering with nonoffending parent (2) Addressing the intersection of domestic violence with mental health (3) Pivot to the perpetrator (4) Differing frameworks across services
(21) Kageyama and Yokoyama [68] Social workers' support skills for parents with mental disorders: a qualitative descriptive study in child-welfare social workers	Practitioners	$N = 8$ (i) Profession: child welfare social workers (ii) Gender: 6 female (75%) (iii) Age: $M = 50.8$ (42–60)	Research for child welfare department Japan	Semistructured interviews qualitative descriptive analysis	(1) Identification of goals social workers supported parents in (2) Support skills used by social workers
(22) Keddell [69] Constructing parental problems: the function of mental illness discourses in a child welfare Context	Both	Practitioners ($n = 22$): (i) Profession: social workers (ii) Gender: 19 female (86%) (iii) Age: not reported Parents ($n = 8$) (iv) Diagnosis: not specified (majority depression) (v) Gender: 7 female (88%) (vi) Ethnicity: not reported (vii) Age: not reported	Child-welfare NGO Aoteatora, New Zealand	Semistructured case-based interviews secondary discourse analysis of paired social worker and service user narratives	(1) Dominance of a family maintenance discourse that framed decision-making (2) Defining children's best interests as relational needs and rights (3) The use of mental illness and lack of support to construct nonculpable causes of original family problems (4) "Safety" in addition to risk (5) Strong commitment to "respect for persons"
(23) Lever Taylor et al. [70] Experiences of social work intervention among mothers with perinatal mental health needs	Parents	$N = 18$ (i) Gender: 100% female (ii) Diagnosis: 4 X depression, 1 X anxiety, 9 X personality disorder, 4 X bipolar disorder/psychosis/ schizophrenia (iii) Ethnicity: 12 White British, 1 White other, 4 Black Caribbean, 1 Black African (vi) Age: $M = 28.7$	NHS Mental Healthcare Services, UK	Semistructured interviews thematic analysis	(1) Labelled as "bad mothers" (2) Set up to fail (3) Turning points

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(24) Marziali et al. [71] Supportive group therapy for parents who chronically neglect their children	Parents	$N = 6$ (i) Diagnosis: complex emotional needs (ii) Gender: not reported (iii) Ethnicity: not reported (vi) Age: not reported	Personality Disorder Group Therapy Service Evaluation Canada	Observed and transcribed group sessions analytical process not reported	(1) The search for boundaries (2) Attack and despair (3) Mourning and repair (4) Integration of self-control
(25) Mason et al. [72] Experiences of child protection workers in collaborating with adult mental health providers: An exploratory study from Ontario, Canada	Practitioners	$N = 339$ (i) Profession: family service workers (31.2%), children's service workers (13.3%), intake workers (10.0%), investigation workers (9.1%), other (36.4%) (ii) Gender: not reported (iii) Age: 52.1% between the ages of 25 to 44 years	Children's Aid Societies, Ontario, Canada	Survey data (open-ended questions) thematic qualitative analytic procedures [73]	(1) Collaborative strategies (2) Barriers and facilitators to collaboration (3) Ideas to improve collaboration between child welfare and adult mental health services
(26) McPherson et al. [48] Evaluating integrative services in edge-of-care work	Practitioners	$N = 24$ (i) Profession: MH practitioners, enhanced therapists, PIMHAP lead, trainee clinical psychologists, children's services managers, children's services social workers, children's centre managers, midwives, allied project consultants, and administrators (ii) Gender: not reported (iii) Age: not reported	Norfolk Parent Infant Mental Health Attachment Project (PIMHAP) Service Evaluation	Focus groups	(1) A safe place to leave professional defences behind (2) Working within financial and professional constraints (3) Creating solutions to long-standing dilemmas (4) Holding really tough stuff without switching off

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(27) Mind [74] A right to know, a right to be involved: a survey of the views of people with mental health problems who were parents experiencing local authority statutory children's services	Both	Practitioners ($n = 9$) (i) Profession: child and family social workers, independent Reviewing Officer, family resilience workers, community MH workers, solicitors (ii) Gender: not reported (iii) Age: not reported Parents ($n = 14$) (iv) Diagnosis: not reported (v) Gender: not reported (vi) Age: not reported (vii) Ethnicity: not reported	Mind's Parenting Advocacy Service, Croydon, UK	Survey data (open questions) and 1 : 1 telephone interviews not reported	Service evaluation, themes not reported
(28) Ostler [75] Dysregulation of the caregiving system in the context of maternal depression: the role of mistrust in the development and causation of abusive parenting behaviour	Parents	$N = 8$ (i) Diagnosis: depression (ii) Gender: 100% female (iii) Ethnicity: 4x African American, 3x Caucasian, 1X Hispanic backgrounds (iv) Age: 21–44	State Child Protective Services, Illinois, USA	Parent interviews, record reviews, observational and standardized measures deductive thematic analysis	(1) Mistrust as an extreme defense (2) Reported childhood experiences (3) Abusive and role-reversed parenting behaviours (4) Attachment-relevant triggers of abusive parenting (5) Context of depression
(29) Pause [76] How can maternal mental health services best support women who have experienced the removal of children from their care?	Both	Practitioners ($n = 9$) (i) Profession: MH Clinicians (ii) Gender: not reported (iii) Age: not reported Parents ($n = 32$) (iv) Diagnosis: not reported (v) Gender: 100% female (vi) Age: not reported (vii) Ethnicity: not reported	Maternal Mental Health Service Cheshire and Merseyside, UK	Virtual focus group, individual conversations, and an online survey analysis not reported	(1) Women who have experienced the removal of children are currently not routinely offered maternal mental health services (2) Women will be feeling overwhelmed and may be fearful of services (3) Maternal mental health services should offer support early, build trusting relationships, work collaboratively with other services, and be open and honest with women (4) Services should understand the impact of trauma, ask and listen to women's preferences

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(30) Perera et al. [32] There is a lot to it: being a mother and living with a mental illness	Both	Practitioners ($n = 11$) (i) Profession: 6 social workers, 2 psychiatric nurses, 2 medical offers, 1 parent peer leader (ii) Gender: 9 female (81%) (iii) Age: not reported Parents ($n = 8$) (iv) Diagnosis: 5 X schizophrenia, 2 X psychotic depression, 1 X bipolar disorder (v) Gender: 100% female (vi) Ethnicity: not reported (vii) Age: $M = 36$ (26–44)	Adult public mental health service Melbourne, Australia	Semistructured interviews constructivist grounded theory	(1) Positive aspects of motherhood for women living with mental illness (2) Challenging aspects of motherhood
(31) Powell et al. [77] Perceived community-based needs of low-income parents with psychiatric disabilities who experienced legal challenges to their parenting rights	Parents	$N = 12$ (i) Gender: 10 female (83%), 2 men (17%) (ii) Diagnosis: mixed (anxiety, bipolar disorder, depression, post-traumatic stress disorder (PTSD), and schizophrenia) (iii) Ethnicity: 7 White, 1 Black/African American, 1 Asian, 3 multiracial (iv) Age: not reported	Setting not reported USA	Semistructured telephone interviews content analysis	(1) Types of supports parents reported as useful for their well-being (2) Chronic economic hardships and material deprivation

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(32) Rouf et al. [78] Making decisions about parental mental health: an exploratory study of community mental health team staff	Practitioners	$N = 13$ (i) Profession: 3 community psychiatric nurses (CPNs), 3 psychologists, 3 social workers and 4 psychiatrists, 5 named nurses for child protection (ii) Gender: 100% female (iii) Age: not reported	Community Mental Health Team, Oxford and Buckinhamshire Mental health Trust UK	Semistructured interviews (all staff) diaries (named nurses) interpretative phenomenological analysis (IPA)	(1) The tensions of working across systems (2) Trying to balance the perceptions and feelings involved in sense-making (3) The role that interpersonal dynamics play in the understanding and management of risk
(33) Scott et al. [79] What does "recovery" from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress	Both	Practitioners ($n = 11$) (i) Profession: child protection workers (ii) Gender: not reported (iii) Ethnicity: not reported (iv) Age: not reported Parents ($n = 13$) (v) Ethnicity: 11 New Zealand Europeans, 1 Māori, 1 Asian (vi) Gender: 9 (69%) female (vii) Diagnosis: mixed (viii) Age: 20+	Child Custody Research Project (CCRP) Aotearoa, New Zealand	Semistructured interviews, primary thematic analysis, and secondary discourse analysis	(1) Child protection worker perspectives on symptom management and recovery (2) Parents on their experiences of recovery and on the views of child protection workers
(34) Siverns and Morgan [15] "If only I could have said, if only somebody was listening": mothers' experiences of placing their child into care	Parents	$N = 3$ (i) Diagnosis: not specified; receiving service support for trauma (ii) Gender: 100% female (iii) Ethnicity: 2 White British, 1 Asian British (iv) Age: 21–50	Mental Health Services (NHS and private healthcare providers) UK	Semistructured interviews interpretive phenomenological analysis (IPA)	(1) Fractured sense of motherhood (2) Feelings of failure, shame, and regret (3) Dehumanisation and disempowerment

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(35) Stanley et al. [40] Working on the interface: identifying professional responses to families with mental health and child-care needs	Both	Practitioners ($n = 500$) (i) Profession: 104 children's social workers, 67 health visitors, 58 adult psychiatry staff, 56 community psychiatrist nurses, 54 MH social workers, 22 child care voluntary agency staff, 19 child and adolescent psychiatry staff, 19, GP's, 18 family centre workers, other (occupational therapists, guardians, police, paediatricians, MH volunteers, residential care workers) (ii) Gender: not reported (iii) Age: not reported parents ($n = 11$) (iv) Diagnosis: not reported (v) Gender: 100% female (vi) Ethnicity: not reported (vii) Age: not reported	2 local authority areas in the northeast of England UK	Semistructured postal survey (practitioners) semistructured interviews (parents) thematic analysis	(1) Professional roles and remits (2) Focusing on users' needs (3) Interprofessional coordination (4) Identifying a lead service (5) The mothers' perspectives
(36) Staudt and Massengale [80] Parents involved with child welfare: their perceptions of mental health services	Parents	$N = 20$ (i) Diagnosis: not reported (ii) Gender: 100% female (iii) Ethnicity: 3 African American, 17 European American (iv) Age: not reported	Public child welfare agencies Tennesee, USA	Semistructured interviews grounded theory	(1) Relationships with therapists (2) Perceived treatment benefits (3) Availability and accessibility of services and therapists (4) Treatment expectations

Table 2: Continued.

First Author and Title	Participants	Population characteristics (number, gender, ethnicity, profession, diagnosis)	Setting	Data collection and analysis	Key themes
(37) Stephens [53] Recognizing complex trauma in child welfare-affected mothers of colour	Parents	$N = 20$ (i) Diagnosis: not specified—all had experience traumatic event (ii) Gender: 100% female (iii) Ethnicity: 8 Black or African American, 7 Latina or Hispani, 5 mixed race (iv) Age: $M = 43$	CW-affiliated community-based organizations (e.g., social service providers, mental health centres) New York, USA	Semistructured interviews Interpretive phenomenological analysis and directed content analysis	(1) Chronic and compound exposure to potentially traumatic events (PTEs) (2) Interpersonal violations of trust (3) Pervasive mistrust of others (4) Revictimization (5) The absence of appropriate MH treatment (6) Grown while living with complex trauma
(38) Tchernegovski et al. [81] How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study	Practitioners	$N = 11$ (i) Profession: MH clinicians (ii) Gender: 8 female (73%) (iii) Age: $M = 39.3$	Clinical adult mental health sector-public services Victoria, Australia	Semistructured telephone interviews interpretive phenomenological analysis	(1) Managing sensitive parenting conversations (2) Making decisions about child safety in unclear or unpredictable situations (3) Working with child protection services
(39) Björkhagen Turesson [82] Conceptions, norms, and values in the work of child protective services with families at risk: an analysis of social workers' diaries	Practitioners	$N = 3$ (i) Profession: Social workers (ii) Gender: not reported (iii) Age: not reported	Child protective Services Sweden	Social workers' diary entries thematic analysis	(1) The Janus face of child protective services (2) Clienthood and its conditions (3) Child protective services and good and bad parenting (4) The fathers
(40) Yoo et al. [83] Psychotherapy for child welfare cases: clinicians' and parents' perspectives	Both	Practitioners (see [84]) Parents ($N = 7$): (i) Diagnosis: not reported (ii) Gender: 100% female (iii) Ethnicity: 4 White American, 3 African American (iv) Age: $M = 29.4$ (19–39)	Child welfare agencies Illinois, USA	Semistructured interviews thematic analysis	(1) Psychotherapy as a place for safety and empathy (2) Psychotherapy as a place for challenge (3) Psychotherapy as a place for problem resolution
(41) Yoo et al. [84] They're not bad parents. They've just made bad choices: "Mental health clinicians" perspectives of parents involved with child protective services	Practitioners	$N = 10$ (i) Profession: 3 family therapists, 3 counsellors, 3 social workers, 1 clinical psychologist (ii) Gender: 9 female (90%) (iii) Age: $M = 43.5$	Child welfare agencies Illionois, USA	Semistructured interviews thematic analysis	(1) Parents strengths: potential and capacity for care (2) Parents challenges: reasons behind maltreatment

Table 3: Quality assessment of included papers.

First Author	Aims	Appropriateness	Design	Recruitment	Data collection	Research relationships	Ethics	Data analysis	Findings	Value	Intersectionality	Service user involvement	Positionality
Ackerson (2003)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No
Azfelius (2017)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No
Barbour (2002)	Can't tell	Can't tell	Can't tell	Yes	Yes	No	No	No	Yes	Yes	No	No	No
Barrow (2014)	Yes	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	No	Yes	Yes
Caplan (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	No	Yes
Coates (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No
Coates (2017)	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	No	No	No
Darlington (2004)	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No	No
Darlington (2005)	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No	No
Darlington (2008)	Yes	Yes	Can't tell	Yes	Yes	No	Can't tell	No	Yes	Yes	No	No	No
Darlington (2009)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes	No	No	No
Davidson (2010)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Yes	Yes	No	No	No
Diaz-Caneja (2004)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes	Yes	No	No
Ghaffar (2011)	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	No	No
Hanley (2006)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	No
Hetherington (2001)	Yes	Yes	Yes	Can't tell	Can't tell	No	No	No	Yes	Yes	No	No	No
Hinden (2005)	Yes	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Can't tell	Yes	Yes	No	No	No
Hollingsworth (2013)	Yes	Yes	Yes	Yes	Can't tell	No	No	Yes	Yes	Yes	No	No	No
Honey (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No
Humphreys (2021)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes	No	No	No
Kageyama (2018)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes	Yes	No	No
Keddell (2016)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No
Lever Taylor (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Marziali (2006)	Yes	Yes	Can't tell	Yes	Yes	No	No	Yes	Yes	No	No	No	No
Mason (2018)	Yes	Yes	Yes	No	Yes	No	No	No	Yes	Yes	No	Yes	No
McPherson (2018)	Yes	Yes	Yes	Yes	No	No	No	Can't tell	Yes	Yes	No	No	No
Mind (2005)	Yes	Yes	Can't tell	Yes	Yes	No	No	No	Yes	Yes	No	Can't tell	No
Ostler (2015)	Yes	Yes	Can't tell	Can't tell	Yes	No	Can't tell	Yes	Yes	Yes	No	No	No
Pause (2021)	Yes	Yes	Can't tell	Yes	Can't tell	No	Can't tell	Can't tell	Yes	Yes	No	Can't tell	No
Perera (2014)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Yes	Yes	No	No	No
Powell (2020)	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes	No	Yes	No
Rouf (2012)	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	No	No	Yes
Scott (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No
Siverns (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Stanley (2003)	Yes	Yes	Can't tell	Yes	Yes	No	?	No	Yes	No	No	No	No
Staudt (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	No
Stephens (2019)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	No	Can't tell
Tchernegovski (2018)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes
Turesson (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	No	Yes	No	No
Yoo (2020)	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes	Yes	Yes	No	Yes
Yoo (2022)	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes	Yes	No	No	Yes

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

> "Social services still say to this day if I end up in hospital. . .I'd lose the kids. So, that hangs over your head–it makes you stay quiet rather than say anything at all.. . .It's been said I don't give social services enough information on a regular basis–I've been put down as uncooperative" (mother) [40].

When parents did seek support, they reported that professionals, especially social workers, started from the assumption that "women with severe mental illness are unlikely to be adequate mothers" [16]. One study analysing social workers' diary entries found evidence of derogatory language used to describe parents, their homes, and lifestyles [82] arguably confirming parents' fears of negative judgement.

(2) Social Services Involvement Exacerbating Mental Health Difficulties. The involvement of children's social services was described as triggering "a clock ticking" [55], leading to

Table 4: Table of quotations.

Theme/subtheme	Illustrative quotations
Theme 1: A downward spiral of service intervention	
Needing support but fearing the consequences	"All mothers discussed feeling "scared" or "frightened" or having a fear of losing care of their child once CPS became involved. As a result this caused some mothers to be reluctant in seeking mental health services for the fear that their child may be taken away" [32] "Every mother's fear is that her children will be taken into care. . .if I did anything that made them think I was going crazy then they'd take my daughter away." (mother) [16] "The first social worker used to look at me like I was an alien. . .I don't know if they have a full understanding. . . that even if someone's got a mental illness, they can still be a good parent." (mother) [70] "When I asked for help from services, they just wrote down, "mum can't cope, mum is saying this, mum is doing this." And they use it against you." (mother) [76]
Social services involvement exacerbating mental health difficulties	"My daughter got taken away. . .that was probably the worst time for me. Cause she had been with me for seven years. . . she had always been in my care. . . and then she was gone and I couldn't talk to her. I felt really bad. I just wanted to die, you know. It was really bad." (mother) [57] "It's like you're at the worst time of your life and they want you to be at your best, to show them that you are the, you know, and put these runs on the board. . .you're at your absolute worst, and they're expecting you to be the best you've ever been." (mother) [66] "Because there is a stigma when you are not looking after your children. People are looking at you and because you are washed and dressed and presentable and they can't see a reason why you can't look after your child, other than you must be a drug addict, you must be a dreg of society. So I feel stigmatised." (mother) [16]
Mental health treatment making parenting difficult	"Some mothers and staff members spoke about mothers refraining from taking their medication to take adequate care and meet the needs of their children. Staff members reported that this was often due to the side effects of medication (e.g., drowsiness) which greatly added to the challenges of parenting." [32] "Symptom management and engagement with mental health professionals and services are not in themselves indicative of recovery. Indeed, for many parents, having to engage with services was seen to be an indication of a setback, a lack of personal resources to cope, or a challenge to their recovery, rather than a support of it." [79]
Theme 2: Working with parents, not against them	
Engaging parents through relationship building	"In the end social services will take (the children), because they'll have no choice, quite honestly. I won't work with them, I won't engage, I won't do absolutely anything that they tell me to and. . . I will get what I want in the end (referring to the children being removed) because it was the only way I saw out of it." (mother) [15] One mother described how she and social workers learnt to know and understand each other better. She attributed this to shifts in communication styles on both sides that resulted in social workers seeing her as a mother in need of support, rather than a risk: "I didn't feel like anybody was listening to me. . .when they finally did listen everybody just kind of clicked. . ." (mother) [70] "There's nothing they could have done differently to engage me more, so in some ways, perhaps chasing me was a waste of time really" (father) [58]

Table 4: Continued.

Theme/subtheme	Illustrative quotations
Working with trauma	There were repeated failures in caregiver and CWS responsiveness to the needs that mothers presented with. Sixteen of the 20 mothers stated that they had not even been asked about their histories or their trauma when interfacing with CWS workers. One mother stated, "no one wanted to hear about me. What I had been through did not matter to them." [53] "We take those individuals who already carry the shame and guilt of their own childhood. And then, they're parents, and they're wanting something different (for their children). I don't believe that parents go into parenting wanting to mess up, wanting to ineffectively parent and harm their children." (mental health clinician) [84] "It's still following me. It's like they see these things of who I used to be and they're not talking to who I am now. They're not looking at what I'm doing now. Like I changed my life when I had children, I'm a completely different person." (father) [79]
Strengths-focused vs. deficit-focused	"One mother, who had a negative experience of professionals, previously, spoke eloquently about how social workers" belief in her ability to change motivated her to seek help and focus on the needs of her children: "they told me. I've got the potential to do it. I've just got to get my mind in the right place." [62] "How many sacrifices that those moms make to come to therapy is amazing. Some of them could leave hours before coming to therapy because they have to get a bus (and) wait for the next bus. The whole thing may take four hours just to come to therapy, but they did it every week. I've had people come in (when) there're horrible rainstorms, waiting outside for the bus or having to walk to get to therapy, because they want to get their child back." (mental health clinician) [84] Statements such as "We're not going to change the borderline personality disorder and were not going to change the bipolar' (Mary: OT social worker) construct the problem as intractable and undercut any faith in clients' ability to recover and eventually regain care of their children." [79]
The importance of transparency	"Some felt decisions were made before meetings started. One couple felt they could not contribute to decisions being made. They said "from her coming home. . . we were kept in the dark". Another mother said: "They always asked us, but our view. They said "we still want to know your views", but it never made a difference". [62] "I never in my wildest imagination dreamed that my children would be took for the period of time that they were took. I thought it was temporary – maybe a week or two until I got back up on my feet, got us another house, moved out of the area, moved away from the person that was causing us direct danger – and then my kids would be back. They told me to give up custody and you would get your kids back; so I am like – how long? He was like, maybe a month or two. But (that) turned into almost two years." (mother) [65] "It's important that we, together with (child protection), are open to families about the concerns. They need to be told, and we need to be told, so it's clear to everyone and we're all on the same page. It's our job to help parents understand the decisions child protection makes, but we can't do that unless we understand them as well. It's very important that families don't receive conficting information, but unless we work closely, this happens and families get confused. They need to know clearly what's expected of them." (child protection worker) [39]
Theme 3: Support wanted vs. support provided	
Parenting support	"Five of the women did describe feeling able to talk about their experiences and difficulties as mothers to their keyworkers. Each of these had a consistent keyworker with whom she had felt able to establish a trusting relationship. This was seen as a substantial support in parenting." [16] "They value that we recognise that it's (parenting) an important part of their lives . . .sometimes in the mental health system it's very much about your diagnosis and medication. That sort of holistic picture of a person can get missed out . . .. It improves my relationship with them, talking about parenting." (mental health clinician) [81]

Table 4: Continued.

Theme/subtheme	Illustrative quotations
Financial support	"As far as the neglect and leaving (children) alone, many say "I had no other options. I have no help." I had one (mother) who would leave her children locked in her apartment because she had to go work midnights because she had no options, no childcare" (mental health clinician) [84]
	"The fact that I was unemployed at that time. I was very proud. I did not want to go to social services to get assistance, and when I finally went, they gave me such a hard time. They even went so far as to say I could sell my furniture and my car to take care of (my son)." (mother) [65]
	"My kids aren't in school and I'm supposed to have them for a few days. But because I'm broke until the end of the week and I don't really have food or anything, he's not going to help. So, I just don't get to see my kids." (mother) [77]
Mental health treatment	"Several participants recognized that medication and mental health treatment and support are helpful in managing symptoms. However, they also stressed that medication and attending appointments can interfere with parenting and the level of interaction mothers have with their children." [32]
	"It was also clear that for the majority of these parents their acute symptoms abated with proper diagnosis and treatment. However, they continued to struggle with the handicap of being labelled mentally ill." [34]
	"(It) is just the temptation to pathologise the victim's experience of domestic violence and put a diagnosis on it and focus specifically from a mental health point of view: diagnose, medicate, discharge - which doesn't hold the perpetrator accountable whatsoever?" (mental health clinician) [67]
	"I've been diagnosed everything. . . . one said I was a paranoid schizophrenic and the other one said no I wasn't. . . . you know, when you get a different doctor, they see what they think they see, and do the best they can, you know . . . and some of them want to medicate you to death, and, you know, not deal with your problems and not talk to you." (Parent) [34]
Working with wider support networks	"They (family) did step in and help me out, but sometimes their good intentions were the worse thing for me. Sometimes they tended to take over and they had the children a lot . . . also they got on me a lot . . . (and told me to) snap out of it." (mother) [34]
	"The dad is a real asset, but he has not been allowed to participate. . . I have personally decided that the fathers should now be included, but I have really had to work on myself. We are not in complete agreement within the treatment group." (Social worker) [83]
	"Women told us how important it is to include their partners and/or the children's fathers in any services offered, noting that it is "not just women. I know that there are men going through traumatic times". [76]
Theme 4: Constrained by service rigidity	
Fragmented services	"Making contact (with mental health professionals) is a poor experience the majority of the time. I cannot recall any mental health provider who initiates and who is responsible for collaborative communication" (child protection worker) [72]
	"They (social services) are only here for (the baby), you know. . .If you want (my baby) to do well, we need to be well as well. Well, I need to be well." (mother) [70]
	"I try to understand where child protection are coming from in their decision-making. But I'm not sure that they fully appreciate the impact of depression or anxiety on someone. I think they are extremely child focussed and that's their job but there isn't much room for an understanding of what's actually driving the distress in the family." (mental health clinician) [39]
	"I can only do the mental health stuff—I cannot do the child care and I am finding more and more social workers who can only do one or the other" (social worker) [55]

Table 4: Continued.

Theme/subtheme	Illustrative quotations
A heavy focus on risk	"You worry that you're (pause) reacting too strongly to a situation. You are misjudging it. You know, you think you are seeing something that you are not. I suppose the other fear is that you're missing something, and you'll get blamed for it. That sort of thing." (Psychiatrist) [78] "A salient example of risk eclipsing other considerations is the experience McKayla recounts of being reduced to her mental illness and its attributed risks. "Nobody was taking any of that into consideration, they were just, this is who she is, these things what she is doing is who she is and she's a risk. I was at risk, yes." (parent)." [79] "Clinicians explain that both individual and group supervision is critical in terms of enhancing objectivity and assisting them to tolerate the uncertainty and complexity of the work." [58]
Service inaccessibility	"I kind of feel betrayed by (child protection services) because I had already asked them for help prior to (the removal). They didn't care. I'd asked a mental health worker to help and she didn't care." (mother) [66] "All the women who cared for their children identified difficulties in attending appointments or using day care services as there were no crèche facilities and mental health service premises were not appropriate environments for children." [16] "The majority of clinicians comment that families should be referred "much earlier, not when it's at the pointy end" (Alex). Clinicians argue that working with families earlier, before they have reached such high levels of risk, will impact positively on client outcomes as well as staff wellbeing." [58] "I'm trying to think about mental health, but they really feel quite distant and not—I really very rarely consider them, I guess. . .. it just seems that they have really, really strict, hard boundaries and that they're very clear about that, and so I just don't find them approachable." (children's social worker) [60] "Mental health can only cover so much because of government funding now, so if you're not in that category or criteria, you've got to go to general practitioners who are not trained on mental health issues, and they'll quickly write you out a script, and you're not getting the help you need. And there's a really big failing in the mental health system at the moment. . . I feel you've got to fall before they'll listen, and that's that." (social worker) [60]

pressure on parents, custody disputes, and intrusive home visits. In one paper, a mother described her experience of attending a custody case conference as "being thrown to the wolves" [62]. Interactions with child protection workers were experienced as "daunting," "intimidating," and "traumatic," contributing to a worsening of mental health symptoms, reduced confidence, and strained relationships with parents' wider support networks.

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

> "I'm stuffing myself with pills to help with anxiety. . .if I was feeling suicidal at the beginning, you know, when I left the hospital, now I feel four times more suicidal because of what (social services) are doing." (mother) [70].

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

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

> "What comes first? Me sleeping or me being available for my child?" (mother) [32].

However, even if treatment was not perceived as helpful, parents felt they had to prove their engagement with services and comply with treatment plans to maintain or regain custody of their children.

3.3.2. Working with Parents, Not against Them. Many studies discussed how professionals from a range of services worked with and engaged parents and correspondingly, how parents viewed professionals and the services they worked for. Professionals discussed various engagement techniques and examples of "good practice." These often aligned with what parents wanted from professionals but not with the support they said they received.

(1) Engaging Parents through Relationship Building. From both parent and practitioner perspectives, relationships between parents and professionals were fraught. High levels of trauma in parents' backgrounds, coupled with previous negative experiences with social services in some cases, led to parents beginning interactions with professionals from a place of mistrust, viewing social services intervention as "synonymous with the risk of their baby being taken into care" [63]. In some cases, parents felt negative judgement and child removal was inevitable so they "shut down" and disengaged to protect themselves [15]. Many parents felt professionals weren't interested in their own needs or background:

> "No one wanted to hear about me. What I had been through did not matter to them." (mother) [53].

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

> "I can have all these great interventions, but if I do not have a good rapport or relationship with the parent, it's not going to do anything." (mental health clinician) [83].

Despite these efforts, both professionals and parents identified that some parents are not ready to engage with services and that "chasing" them was neither a good use of resources nor therapeutically beneficial [58].

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

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

However, very few studies mentioned how acknowledging trauma influenced professional practice with only one study explicitly mentioning the use of trauma-informed care in child protection practices [79]. At the same time, adopting a "trauma-informed" label did not necessarily indicate that parents' difficulties were grounded empathically within an understanding of their past experiences and wider circumstances. For example, the title of a study focused on trauma-informed care reads "they're not bad parents, they've just made bad choices" [84], arguably suggesting these parents have "chosen" to be in their difficult situations, rather than these choices themselves being understood also as rooted in a wider context of adversity and inequity.

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

(3) Strengths-Focused versus Deficit-Focused. Parents felt that children's social workers focused heavily on "failures" of parenting and risk assessments leading to parents losing confidence in their own abilities to care for their children. This aligned with some social workers' views of mental health difficulties as chronically impacting their ability to parent. The concept of mental health 'recovery' was discussed in different ways by parents and professionals, with parents emphasising their parenting role, cultural identity, and connection to others, whilst professionals across services focused on symptom management [79].

Despite this, there were examples of strengths-focused practice leading to positive outcomes, with practitioners recognising parents' devotion to their children, resilience, and determination. One mother described how social workers' "belief in her ability to change motivated her to seek help and focus on the needs of her children" [62]. Some innovative parenting interventions such as the invisible children's project [37] deliberately incorporated a "strengths-based model" which led to improved parental engagement.

(4) The Importance of Transparency. Parents described child protection services as "ultimately powerful but unpredictable" [66]. They recognised that these professionals had power over their lives but felt "kept in the dark" with regards to decision-making [62]. Parents reported frustration that they were not told what was expected of them by services and what consequences might follow. A lack of transparency contributed to parents' mistrust of services with one mother commenting "If they're not being straight with you, how can you be straight with them?" [40]. When parents were given information, they often struggled to understand the professional jargon, and therefore could not "compete on equal terms" during child custody disputes [62].

Forming a collaborative partnership facilitated parental engagement. Examples of this included involving the whole family in decision-making processes, regular communication with parents, and transparency surrounding expectations for parenting. Even when difficult decisions were made, e.g., child removal, seeking the involvement, and agreement of parents first resulted in better outcomes for both parties.

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

(1) Parenting Support. Parenting (particularly mothering) identity was central to parents' strength, resilience, and mental health recovery. Support with parenting was appreciated when delivered in a nonjudgemental way by a trusted professional.

Parents reported that mental health interventions often neglected their parenting role and its impact on wellbeing, with one mother stating that her mental health team was unaware she had a child despite being greatly affected by losing custody of her daughter [16]. Ten studies mentioned parents making efforts to maintain contact or regain custody following child removal and parents appreciated support with this. However, parenting support was often withdrawn following child removal and parents received little support for managing the emotional and practical fallout of custody loss.

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

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

> "They wanted to put me on medication. But I was depressed because I was homeless and I got five kids. I don't take pills so I terminated that service. They never said nothing about helping me with housing" (mother) [78].

Services offering financial support described this as "essential" and "critically related to achieving and sustaining desired outcomes" such as retaining custody of children [37].

(3) Mental Health Support. Parents found the focus on mental health diagnosis confusing, often receiving inaccurate or conflicting diagnoses from different professionals. Certain diagnoses, such as "personality disorder," typically led to social work professionals viewing these parents as "high risk" and resistant to change. Conversely, those with postnatal depression more commonly felt that their difficulties had been sanctioned by a diagnosis [63]. Whilst some professionals found diagnostic labels useful (e.g., to externalise blame), others saw pitfalls to this practice: "we don't see the person, we often just see the diagnosis" (mental health nurse) [55]. At times, an overreliance on diagnoses led to the pathologisation of parenting

difficulties and even experiences of domestic violence - with a tendency to "diagnose, medicate, and discharge" (mental health clinician) [67].

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

(4) Working with Wider Support Networks. Thirteen studies discussed the importance of family and friends as sources of support and stability for parents and their children. Despite familial relationship difficulties, extended family members often took on child-care responsibilities when parents could not manage on their own.

> "Those parents who had a strong social support network, whether it was family, friends, or church were able to cope with crises better than those who were more socially isolated". [34].

Professionals recognised the importance of parents' support networks but also the tendency for family and couple relationships to become strained and "create stress" for parents [84]. Professionals across a variety of services primarily engaged with parents and rarely mentioned working with wider support networks. The peripheral role of fathers is reflected by participant demographics within the literature: 16 out of 25 parent cohorts were made up solely of mothers and mothers also comprised the great majority of participants in studies with mixed cohorts. Where discussion of fathers was included, fathers reported their parenting role as a central aspect of their lives, but services tended to place pressure solely on mothers to care for children. There were mixed views on this among professionals, yet a sense that attitudes were changing:

> "The dad is a real asset, but he has not been allowed to participate. . . . I have personally decided that the fathers should now be included, but I have really had to work on myself. We are not in complete agreement within the treatment group." (social worker) [82].

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

(1) Fragmented Services. The involvement of professionals from separate services meant no one could take a holistic view of a parent's situation, family, and intersecting needs. Children's social workers typically lacked understanding of parental mental health and were anxious about complex cases involving mental health needs. Some viewed parents' and children's needs as separate and conflicting, concluding that "it may not be possible to work on behalf of children while attending to their parents who have a serious mental illness" [42]. Others understood that parents' and children's perspectives were interdependent but felt they were not trained to juggle both. Mental health clinicians felt parenting capacity assessments were beyond their role and were in turn described by social workers as "having little concern" for children [72].

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

> "I felt a lot of the time that (mental health professionals) weren't helping us. . .we came from two very different angles. They were very mum-focused, client-focused and we were very client-focused but on the child really, so I found they weren't giving us a lot of the best information" (child protection worker) [24].

Some studies evaluated service efforts to improve collaboration, ranging from whole-family teams [39, 48] to the specialised training of individuals responsible for service integration [61]. In general, these services reported better outcomes such as reduced incidents of child removal.

The extent of separation between services differed between countries. A comparative study showed that professionals working in England reported less collaboration and knowledge outside of their field than those in other European countries [64].

(2) A Heavy Focus on Risk. Child protection workers consistently discussed risk evaluation and found decisions surrounding parents with mental health difficulties "stressful, uncertain, and complex" [78]. They felt they lacked sufficient information about a parent's mental health and subsequently relied on their intuition rather than concrete evidence in decision-making. They reported imagining the "worst case scenario", exacerbated by media reporting of cases where social services failed to protect a child. Some reported a shift from the traditional "family maintenance" discourse to reduced risk tolerance among professionals:

> "I would say that there is no risk-taking now. It's about what will happen—what will the headlines say if I don't remove this child?" (social work manager) [55].

Parents reported that a sole focus on risk overshadowed hope for recovery and recognition of their strengths, feeling instead "reduced to a mental illness and its attributed risks" [79]. Risk to parents was mentioned much less frequently than risk to children, and mental health clinicians believed child protection services neglected risk to parents in their decision-making.

Professionals across services reported high caseloads and felt worried about their work outside of hours. There were several examples of how providing further support for professionals improved their practice. A range of professionals viewed opportunities to reflect on practice and engage in supervision as vital for making collaborative and good decisions. Service models designed to facilitate interagency cooperation allowed social services professionals to "work therapeutically whilst holding high levels of risk" [48].

(3) Service Inaccessibility. Professionals and parents viewed mental health support as crisis-driven rather than preventative, contributing to parents feeling betrayed when services were unable to provide support. Once services were involved, the situation was likely to have reached "crisis point," meaning actions to control risk were "inevitable" [58]. Professional frustration and powerlessness over limited service resources mirrored that of parents, with one social worker recognising "you've got to fall before they'll listen, and that's that" [60]. Working with constant crises also contributed to poor staff wellbeing, high staff turnover, and burnout. Focus on crisis care over early intervention was shared by all European countries but was "most marked" in England [64].

Another aspect of accessibility is understanding and meeting cultural needs. Culturally informed support was only discussed in one study [57] where indigenous Canadian parents were reliant on culturally informed interventions to support their mental health and reconnect with their children following custody loss.

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

> "The whole thing may take four hours just to come to therapy, but (mothers) did it every week." (mental health clinician) [84].

Social workers viewed mental health services as inaccessible due to their "strict and hard boundaries" in terms of who is eligible for support [60].

4. Discussion

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

Overall, parents were fearful of the consequences of service involvement and mistrustful of professionals. These findings align with previous research on parents at risk of custody loss, which suggests that mistrust of professionals, or low "epistemic trust," leads to service disengagement and the commencement of child removal processes [36]. The authors suggested that mistrust of professionals stems from adverse childhood experiences and intergenerational trauma, concluding that "acts of resistance or rejection of professional help can be seen as adaptive—given women's childhoods and relationship histories" . In our review, many parents reported a history of trauma, including child abuse and domestic violence. This suggests that adopting trauma-informed approaches, where professionals and their wider services work collaboratively and openly with parents to resist retraumatisation, is crucial to services becoming more trustworthy. Whilst child protection services in various countries incorporate trauma-informed care for young people [85], this review argues for the extension of these practices to parental support.

A recent report from Child Protection England recognised that "multi-agency arrangements for protecting children are more fractured and fragmented than they should be" [86] and our findings suggest this issue is also common in other countries. Our review found that multiagency collaboration is heavily impacted by the separation of mental health and social care, and of child and adult care within these services. However, we found examples of local initiatives designed to facilitate collaboration between services, ranging from the creation of whole-family teams, e.g., Coates [39] to the specialised training of individuals responsible for service integration, e.g., Davidson et al. [61]. Insights from these initiatives shed light on the mediators and positive impact of effective collaboration. A further barrier to interagency working is information-sharing, with child protection workers reporting frustration at mental health services refusing to share information about parents, and vice versa. This review provides supporting evidence for efforts to improve collaboration across services. For example, following the Independent Review of Children's Social Care [87], the UK government has announced plans to create "a decisive multiagency child protection system" including social workers, family support workers, and specialist workers, e.g., mental health professionals to

address barriers to interagency working and collaboration [9]. Whilst this is a positive response with the potential to improve outcomes for families, our lived experience advisors raised concerns about information being shared "behind parents' backs" making it difficult for them to feel able to disclose concerns to anyone safely. Therefore, a move to more cooperative working must be mindful of respecting parents' rights to confidentiality, particularly in mental health services.

Mental health and parenting difficulties should not be viewed in isolation, yet discussions of social and cultural factors were largely absent in the studies included in this review. Quantitative research reports a complex interaction between financial deprivation, ethnicity, and child protection interventions, which requires accurate reporting to explore fully [88]. Nevertheless, the present review finds that current qualitative evidence on child welfare and/or child protection does not explicitly adopt an intersectional framework to expose potential inequities in child welfare processes and outcomes. This made it difficult for us to understand the impact of structural factors such as class, ethnicity, and financial hardship. Our review also raises concerns about potential widespread lack of understanding of these factors among professionals, with some parents reporting that child protection workers judged them based on aspects of their identity, including mental health diagnosis, single parenthood, and socioeconomic status. This was also emphasised by our lived experience advisors who felt families were treated differently by professionals based on their ethnicity and class, with families experiencing financial hardship and from ethnic minority backgrounds facing deep discrimination. Considering the person as a whole, their identities and complexities, enables researchers to understand how the combination of these social identities affect show they are viewed and treated by professionals and the institutions they work in. For example, wider research has argued that racial patterns of deprivation best explain ethnic minority group overrepresentation in child protection [88]. This suggests the intersection of ethnicity and financial hardship is crucial to incorporate into any approaches designed to address racial inequalities, yet interventions currently overlook this. For example, the UK government's recent plan to address racial disparities in children's social care fails to mention the role of financial deprivation [9].

The present review suggests that approaches to mental health treatment focusing on diagnostic pathways and medication offer only a partial response to parents' difficulties. This was reflected by the disparity between the kinds of support parents wanted (financial and practical) and the support professionals typically described offering (medication and psychological therapy). Past research has identified complex links between financial hardship and both mental health [89] and child neglect [90], but studies rarely mentioned financial support for parents, explained in part by the narrow, risk-focused, and medicalised approaches mental health and children's services tend to adopt as well as a general lack of resources.

In line with previous literature [91, 92], both social and mental health care professionals reported limited resources, high caseloads and burnout, difficulties also echoed in discussions with lived experience advisors and the wider review team. The effects of under-resourced services permeated across all aspects of professional practice, including relationship building, collaboration, and risk management. A heavy focus on minimising risk and uncertainty also resulted in mechanisms and procedures that affected practitioners' ability to provide therapeutic support and diverted attention from the complex relational, political, and moral contexts in which social work practice operates. Professionals, particularly those working in children's social services, were often aware of the negative impacts their actions may have on parents and children but felt powerless to do things differently in the face of these organisational constraints. This represents a high risk of "moral injury", which occurs when staff are forced to comply with practices that they consider to be immoral and harmful [93]. This may explain the high number of staff choosing to leave social care roles, reflected by recent findings of a 50% increase in the number of vacant adult social care positions in England over the past year [94]. The reported detrimental impacts of public sector cuts and increased privatisation of social care as a way to reform children's services [95] suggests a need to urgently target structural factors to protect staff from moral injury, reduce staff turnover and enable professionals to provide more effective support to parents and families.

As well as providing support to professionals, this review suggests ways in which current systems could be replanned to improve support for parents with mental health needs and children's social services involvement. First, systemic changes to services enabling trauma-informed care would allow parents to engage parents earlier and more effectively in the child protection process, preventing an escalation of risk. Second, mental health and social care is crisis driven, making costly outcomes such as child removal more likely. A focus on early prevention could reduce the likelihood of these outcomes, freeing up professional time and money and ensuring better outcomes for families [96]. Finally, research literature demonstrates that investing in staff provides a range of benefits. For example, providing adequate training, supervision, and reflection time reduces burnout and improves professional collaboration [58]. Findings from this review suggest a target of training should be broadening practitioners' approach to consider the interdependent needs of parents with mental health difficulties and their children. Crucially, improving professional practice in these ways is only possible in adequately funded services, where staff have a manageable workload. Therefore, this review suggests that individual factors such as professional practice should not be targeted independently of organisational constraints.

4.1. Strengths and Limitations. This review synthesized findings from a wide range of studies including a variety of participants, methodologies, and service types. The involvement of a multidisciplinary review team and lived

experience advisors ensured data interpretations were firmly grounded in a range of experiences, including those of service-users. Whilst we were able to present a broad overview of the existing research, synthesizing a large evidence base inevitably leads to some loss of depth and nuance from the literature, and readers are advised also to interrogate the individual studies reviewed.

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

Whilst the number of studies focusing on parents' and professionals' views of support was similar, the number of professionals' perspectives included in this review was far greater than parents' perspectives, meaning this review may represent a somewhat unbalanced view of support for parents. Furthermore, research into staff wellbeing in this context remains scarce and future work should unpack the impact of employee burnout on professional practice. As outlined, the majority of parents' perspectives in this review are those of mothers, and exploring fathers' perspectives remains an important priority for future research. Future research should also consider how the paternal role interacts with mental health and children's social services support and outcomes, rather than viewing mothers as the sole target of these interventions. This is especially important in light of findings that domestic violence, usually perpetrated by men against women, leads to maternal mental health difficulties and child protection involvement [97].

5. Conclusion

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

Data Availability

The qualitative data used to support the findings of this study are included within the article in Table 4. Full qualitative data in the form of NVivo files used to support the findings of this study are available from the corresponding author upon request. Search terms and the adapted Critical Appraisal Skills Programme (CASP) are included within the supplementary information file.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Supplementary Materials

S1: search Strategy for electronic databases. A full list of search terms used to search the electronic databases including free-text and MeSH terms. S2: adapted Critical Appraisal Skills Programme. An adapted version of the Critical Appraisal Skills Programme (2018) was used to evaluate the study quality in this review. This method includes three additional areas of evaluation: intersectionality, service user involvement, and positionality. (*Supplementary Materials*)

References

[1] D. Maybery and A. E. Reupert, "The number of parents who are patients attending adult psychiatric services," *Current Opinion in Psychiatry*, vol. 31, no. 4, pp. 358–362, 2018.

[2] Y. Parfitt and S. Ayers, "Transition to parenthood and mental health in first-time parents," *Infant Mental Health Journal*, vol. 35, no. 3, pp. 263–273, 2014.

[3] R. Wesseloo, A. M. Kamperman, T. Munk-Olsen, V. J. M. Pop, S. A. Kushner, and V. Bergink, "Risk of postpartum relapse in bipolar disorder and postpartum psychosis: a systematic review and meta-analysis," *American Journal of Psychiatry*, vol. 173, no. 2, pp. 117–127, 2016.

[4] R. Giallo, F. D'Esposito, D. Christensen et al., "Father mental health during the early parenting period: results of an Australian population based longitudinal study," *Social Psychiatry and Psychiatric Epidemiology*, vol. 47, no. 12, pp. 1907–1916, 2012.

[5] S. Ayers, R. Bond, R. Webb, P. Miller, and K. Bateson, "Perinatal mental health and risk of child maltreatment: a systematic review and meta-analysis," *Child Abuse and Neglect*, vol. 98, Article ID 104172, 2019.

[6] K. Kaplan, E. Brusilovskiy, A. M. O'Shea, and M. S. Salzer, "Child protective service disparities and serious mental illnesses: results from a national survey," *Psychiatric Services*, vol. 70, no. 3, pp. 202–208, 2019.

[7] L. J. Griffiths, R. D. Johnson, K. Broadhurst et al., *Born into Care: One Thousand Mothers in Care Proceedings in Wales*, Nuffield Foundation, London, UK, 2020, https://www.nuffieldfjo.org.uk/wp%20content/uploads/2021/05/1000_mothers_briefing_paper_english.pdf.

[8] R. J. Pearson, C. Grant, L. Wijlaars et al., "Mental health service use among mothers involved in public family law proceedings: linked data cohort study in South London 2007–2019," *Soc Psychiatry Psychiatr Epidemiol*, vol. 57, no. 10, pp. 2097–2108, 2022.

[9] Department for Education (DfE), "Stable homes, built on love: implementation strategy and consultation: children's social care reform 2023," 2023, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1133537/Children_s_social_care_stable_homes_consultation_February_2023.pdf.

[10] J. M. Armfield, E. S. Gnanamanickam, D. W. Johnston et al., "Intergenerational transmission of child maltreatment in South Australia, 1986-2017: a retrospective cohort study," *The Lancet Public Health*, vol. 6, no. 7, pp. e450–e461, 2021.

[11] T. Ruud, D. Maybery, A. Reupert et al., "Adult mental health outpatients who have minor children: prevalence of parents, referrals of their children, and patient characteristics," *Frontiers in Psychiatry*, vol. 10, p. 163, 2019.

[12] M. Sheppard, "Double jeopardy: the link between child abuse and maternal depression in child and family social work," *Child <html_ent glyph="@amp;" ascii="&"/> Family Social Work*, vol. 2, no. 2, pp. 91–107, 1997.

[13] N. K. Adjei, D. K. Schlüter, V. S. Straatmann et al., "Impact of poverty and family adversity on adolescent health: a multitrajectory analysis using the UK Millennium Cohort Study," *Lancet Reg Health Europe*, vol. 13, Article ID 100279, 2022.

[14] P. Bywaters, G. Brady, L. Bunting et al., "Inequalities in English child protection practice under austerity: a universal challenge?" *Child and Family Social Work*, vol. 23, no. 1, pp. 53–61, 2018.

[15] K. Siverns and G. Morgan, "'If only I could have said, if only somebody was listening': mothers' experiences of placing their child into care," *Adoption Quarterly*, vol. 24, no. 3, pp. 207–228, 2021.

[16] A. Diaz-Caneja and S. Johnson, "The views and experiences of severely mentally ill mothers - a qualitative study," *Social Psychiatry and Psychiatric Epidemiology*, vol. 39, no. 6, pp. 472–482, 2004.

[17] K. Broadhurst and C. Mason, "Child removal as the *gateway* to further adversity: birth mother accounts of the immediate and enduring collateral consequences of child removal," *Qualitative Social Work*, vol. 19, no. 1, pp. 15–37, 2020.

[18] M. Shaw, S. Kershaw, K. Broadhurst, C. Mason, B. Alrouh, and J. Harwin, *Vulnerable Birth Mothers and Recurrent Care Proceedings: Final Main Report*, Nuffield Foundation, London, UK, 2017.

[19] N. Stanley, D. Riordan, and H. Alaszewski, "The mental health of looked after children: matching response to need," *Health and Social Care in the Community*, vol. 13, no. 3, pp. 239–248, 2005.

[20] Newton, "The future of children's social care an optimised model for supporting children in care and on the edges of care: national enablers, local delivery, issue," 2021, https://www.countycouncilsnetwork.org.uk/wp-content/uploads/CCN-Newton-The-Future-of-Childrens-Social-Care-Emerging-Findings.pdf.

[21] N. Gilbert, N. Parton, and M. Skivenes, *Child Protection Systems: International Trends and Orientations*, Oxford University Press, Oxford, UK, 2011, https://books.google.co.uk/books?id=HFRpAgAAQBAJ.

[22] G. Karpetis, "Mental health knowledge gaps in the child protection work with parents: a narrative review of the social work literature," *Journal of Social Work Practice*, vol. 31, no. 3, pp. 353–368, 2017.

[23] Y. Darlington, J. A. Feeney, and K. Rixon, "Complexity, conflict and uncertainty: issues in collaboration between child protection and mental health services," *Children and Youth Services Review*, vol. 26, no. 12, pp. 1175–1192, 2004.

[24] Y. Darlington, J. A. Feeney, and K. Rixon, "Practice challenges at the intersection of child protection and mental health," *Child and Family Social Work*, vol. 10, no. 3, pp. 239–247, 2005.

[25] R. Cassells, N. Cortis, A. Duncan et al., *Keep Them Safe Outcomes Evaluation: Final Report to the NSW Department of Premier and Cabinet*, University of New South Wales, Sydney, Austria, 2014.

[26] M. M. Overbeek, G. Iozzia, A. Maras, and C. Rijnberk, "Interventions for parents with mental illnesses: a scoping review," *Couple and Family Psychology: Research and Practice, No Pagination Specified-No Pagination Specified*, 2022.

[27] P. Wahl, D. Bruland, U. Bauer, O. Okan, and A. Lenz, "What are the family needs when a parent has mental health problems? Evidence from a systematic literature review," *Journal of Child and Adolescent Psychiatric Nursing*, vol. 30, no. 1, pp. 54–66, 2017.

[28] E. Siegenthaler, T. Munder, and M. Egger, "Effect of preventive interventions in mentally ill parents on the mental health of the offspring: systematic review and meta-analysis," *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 51, no. 1, pp. 8–17.e8, 2012.

[29] C. E. Van Der Put, M. Assink, J. Gubbels, and N. F. Boekhout Van Solinge, "Identifying effective components of child maltreatment interventions: a meta-analysis," *Clinical Child and Family Psychology Review*, vol. 21, no. 2, pp. 171–202, 2018.

[30] S. P. Kemp, M. O. Marcenko, K. Hoagwood, and W. Vesneski, "Engaging parents in child welfare services: bridging family needs and child welfare mandates," *Child Welfare*, vol. 88, no. 1, pp. 101–126, 2009, http://www.jstor.org/stable/45390160.

[31] K. Broadhurst, C. Mason, S. Bedston et al., *Vulnerable Birth Mothers and Recurrent Care Proceedings*, University of Lancaster, Lancaster, UK, 2017.

[32] D. N. Perera, L. Short, and S. Fernbacher, "There is a lot to it: being a mother and living with a mental illness," *Advances in Mental Health*, vol. 12, no. 3, pp. 167–181, 2014.

[33] M. Venkataraman and B. J. Ackerson, "Parenting among mothers with bipolar disorder: strengths, challenges, and service needs," *Journal of Family Social Work*, vol. 11, no. 4, pp. 389–408, 2008.

[34] B. J. Ackerson, "Coping with the dual demands of severe mental illness and parenting: the parents' perspective," *Families in Society-the Journal of Contemporary Human Services*, vol. 84, no. 1, pp. 109–118, 2003.

[35] D. R. Bartsch, R. M. Roberts, M. Davies, and M. Proeve, "Understanding the experience of parents with a diagnosis of borderline personality disorder," *Australian Psychologist*, vol. 51, no. 6, pp. 472–480, 2016.

[36] C. Mason, D. Taggart, and K. Broadhurst, "Parental non-engagement within child protection services—how can understandings of complex trauma and epistemic trust help?" *Societies*, vol. 10, no. 4, p. 93, 2020, https://www.mdpi.com/2075-4698/10/4/93.

[37] B. R. Hinden, B. R. Hinden, K. Biebel, J. Nicholson, and L. Mehnert, "The invisible children's project," *The Journal of Behavioral Health Services and Research*, vol. 32, no. 4, pp. 393–408, 2005.

[38] J. Duffy, G. Davidson, and D. Kavanagh, "Applying the recovery approach to the interface between mental health and child protection services," *Child Care in Practice*, vol. 22, no. 1, pp. 35–49, 2016.

[39] D. Coates, "Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: inter-agency collaboration," *Child and Family Social Work*, vol. 22, pp. 1–10, 2017.

[40] N. Stanley, B. Penhale, D. Riordan, R. S. Barbour, and S. Holden, "Working on the interface: identifying professional responses to families with mental health and child-care needs," *Health and Social Care in the Community*, vol. 11, no. 3, pp. 208–218, 2003.

[41] K. Healy, G. Meagher, and J. Cullin, "Retaining novices to become expert child protection practitioners: creating career pathways in direct practice," *British Journal of Social Work*, vol. 39, no. 2, pp. 299–317, 2007.

[42] M. Afzelius, L. Plantin, and M. Östman, "Children of parents with serious mental illness: the perspective of social workers," *Practice*, vol. 29, no. 4, pp. 293–310, 2017.

[43] M. Paris and M. A. Hoge, "Burnout in the mental health workforce: a review," *The Journal of Behavioral Health Services and Research*, vol. 37, no. 4, pp. 519–528, 2010.

[44] J. Popay, A. Rogers, and G. Williams, "Rationale and standards for the systematic review of qualitative literature in health services research," *Qualitative Health Research*, vol. 8, no. 3, pp. 341–351, 1998.

[45] A. Harden, "Applying systematic review methods to studies of people's views: an example from public health research," *Journal of Epidemiology and Community Health*, vol. 58, no. 9, pp. 794–800, 2004.

[46] J. Thomas and A. Harden, "Methods for the thematic synthesis of qualitative research in systematic reviews," *BMC Medical Research Methodology*, vol. 8, no. 1, p. 45, 2008.

[47] J. Radley, N. Sivarajah, B. Moltrecht et al., "A scoping review of interventions designed to support parents with mental illness that would be appropriate for parents with psychosis," *Frontiers in Psychiatry*, vol. 12, Article ID 787166, 2021.

[48] S. McPherson, L. Andrews, D. Taggart et al., "Evaluating integrative services in edge-of-care work," *Journal of Social Welfare and Family Law*, vol. 40, no. 3, pp. 299–320, 2018.

[49] M. J. Page, J. E. McKenzie, P. M. Bossuyt et al., "The PRISMA 2020 statement: an updated guideline for reporting systematic reviews," *BMJ*, vol. 372, p. n71, 2021.

[50] A. Booth, "Clear and present questions: formulating questions for evidence based practice," *Library Hi Tech*, vol. 24, 2006.

[51] A. S. Storhaug and K. Oien, "Fathers' encounters with the child welfare service," *Children and Youth Services Review*, vol. 34, no. 1, pp. 296–303, 2011.

[52] H. A. Long, D. P. French, and J. M. Brooks, "Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis," *Research Methods in Medicine and Health Sciences*, vol. 1, no. 1, pp. 31–42, 2020.

[53] T. N. Stephens, "Recognizing complex trauma in child welfare-affected mothers of colour," *Child and Family Social Work*, vol. 24, no. 1, pp. 42–49, 2019.

[54] C. Shimmin, K. D. M. Wittmeier, J. G. Lavoie, E. D. Wicklund, and K. M. Sibley, "Moving towards a more inclusive patient and public involvement in health research paradigm: the incorporation of a trauma-informed intersectional analysis," *BMC Health Services Research*, vol. 17, no. 1, p. 539, 2017.

[55] R. S. Barbour, N. Stanley, B. Penhale, and S. Holden, "Assessing risk: professional perspectives on work involving mental health and child care services," *Journal of Interprofessional Care*, vol. 16, no. 4, pp. 323–334, 2002.

[56] S. M. Barrow, M. J. Alexander, J. McKinney, T. Lawinski, and C. Pratt, "Context and opportunity: multiple perspectives on parenting by women with a severe mental illness," *Psychiatric Rehabilitation Journal*, vol. 37, no. 3, pp. 176–182, 2014.

[57] R. Caplan, G. Nelson, J. Distasio et al., "Indigenous and non-Indigenous parents separated from their children and experiencing homelessness and mental illness in Canada," *Journal of Community Psychology*, vol. 48, no. 8, pp. 2753–2772, 2020.

[58] D. Coates and D. Howe, "Working with families who experience parental mental health and/or drug and alcohol problems in the context of child protection concerns: recommendations for service improvement," *Australian and New Zealand Journal of Family Therapy*, vol. 36, no. 3, pp. 325–341, 2015.

[59] Y. Darlington and J. A. Feeney, "Collaboration between mental health and child protection services: professionals' perceptions of best practice," *Children and Youth Services Review*, vol. 30, no. 2, pp. 187–198, 2008.

[60] Y. Darlington and J. Feeney, "Clients' and professionals' experiences of traversing mental health and child protection systems: implications for practice," *Families in Society-the Journal of Contemporary Social Services*, vol. 90, no. 4, pp. 382–389, 2009.

[61] G. Davidson, J. Duffy, L. Barry, P. Curry, E. Darragh, and J. Lees, "Championing the interface between mental health and child protection: evaluation of a service initiative to improve joint working in northern Ireland," *Child Abuse Review*, vol. 21, no. 3, pp. 157–172, 2012.

[62] W. Ghaffar, M. Manby, and T. Race, "Exploring the experiences of parents and carers whose children have been subject to child protection plans," *British Journal of Social Work*, vol. 42, no. 5, pp. 887–905, 2011.

[63] J. Hanley and B. Long, "A study of Welsh mothers' experiences of postnatal depression," *Midwifery*, vol. 22, no. 2, pp. 147–157, 2006.

[64] R. Hetherington and K. Baistow, "Supporting families with a mentally ill parent: European perspectives on interagency cooperation," *Child Abuse Review*, vol. 10, no. 5, pp. 351–365, 2001.

[65] L. D. Hollingsworth, D. Swick, and Y. J. Choi, "The role of positive and negative social interactions in child custody outcomes: voices of US women with serious mental illness," *Qualitative Social Work*, vol. 12, no. 2, pp. 153–169, 2013.

[66] A. Honey, M. Miceli, and R. Mayes, "Living with mental illness and child removal," *Advances in Mental Health*, vol. 19, no. 2, pp. 164–175, 2021.

[67] C. Humphreys, S. Heward-Belle, M. Tsantefski, J. Isobe, and L. Healey, "Beyond co-occurrence: addressing the intersections of domestic violence, mental health and substance misuse," *Child and Family Social Work*, vol. 27, no. 2, pp. 299–310, 2022.

[68] M. Kageyama and K. Yokoyama, "Social workers' support skills for parents with mental disorders: a qualitative descriptive study in child-welfare social workers," *The Open Public Health Journal*, vol. 11, no. 1, pp. 309–318, 2018.

[69] E. Keddell, "Constructing parental problems: the function of mental illness discourses in a child welfare context," *British Journal of Social Work*, vol. 46, no. 7, pp. 2088–2103, 2016.

[70] B. Lever Taylor, L. Mosse, and N. Stanley, "Experiences of social work intervention among mothers with perinatal mental health needs," *Health and Social Care in the Community*, vol. 27, no. 6, pp. 1586–1596, 2019.

[71] E. Marziali, T. Damianakis, D. Smith, and N. Trocmé, "Supportive group therapy for parents who chronically neglect their children," *Families in Society*, vol. 87, no. 3, pp. 401–408, 2006.

[72] R. Mason, J. Du Mont, M. Paterson, and I. Hyman, "Experiences of child protection workers in collaborating with adult mental health providers: an exploratory study from Ontario, Canada," *Children and Youth Services Review*, vol. 86, pp. 271–276, 2018.

[73] B. F. Crabtree and W. L. Miller, *Doing Qualitative Research*, Sage, London, UK, 2nd edition, 1999.

[74] Mind, *"A Right to Know, A Right to Be Involved" Mind in Croydon's Parenting Adovacy Survey*, Croydon, UK, 2015.

[75] T. Ostler, "Dysregulation of the caregiving system in the context of maternal depression: the role of mistrust in the development and causation of abusive parenting behavior," *Psychiatry*, vol. 78, no. 1, pp. 42–54, 2015.

[76] Pause, "How can maternal mental health services best support women who have experienced the removal of children from their care?," 2021, https://www.pause.org.uk/wp-content/uploads/2021/05/Maternal-Mental-Health_report-2021-digital-1.pdf.

[77] R. M. Powell, M. Mitra, J. Nicholson, and S. L. Parish, "Perceived community-based needs of low-income parents with psychiatric disabilities who experienced legal challenges to their parenting rights," *Children and Youth Services Review*, vol. 112, Article ID 104902, 2020.

[78] K. Rouf, M. Larkin, and G. Lowe, "Making decisions about parental mental health: an exploratory study of community mental health team staff," *Child Abuse Review*, vol. 21, no. 3, pp. 173–189, 2012.

[79] A. L. Scott, K. Pope, D. Quick, B. Aitken, and A. Parkinson, "What does "recovery" from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress," *Children and Youth Services Review*, vol. 87, pp. 95–102, 2018.

[80] M. Staudt and K. Massengale, "Parents involved with child welfare: their perceptions of mental health services," *Social Work in Mental Health*, vol. 13, no. 4, pp. 336–348, 2015.

[81] P. Tchernegovski, A. E. Reupert, and D. J. Maybery, "How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study," *Child and Family Social Work*, vol. 23, no. 3, pp. 381–389, 2017.

[82] A. Björkhagen Turesson, "Conceptions, norms, and values in the work of child protective services with families at risk: an analysis of social workers' diaries," *Clinical Social Work Journal*, vol. 48, no. 4, pp. 369–379, 2020.

[83] H. Yoo, S. Racorean, and V. Barrows, "Psychotherapy for child welfare cases: clinicians' and parents' perspectives," *Child and Family Social Work*, vol. 25, no. 4, pp. 775–784, 2020.

[84] H. Yoo, S. Racorean, and V. Barrows, "They're not bad parents. They've just made bad choices Mental health clinicians' perspectives of parents involved with child protective services," *Qualitative Social Work*, vol. 21, no. 1, pp. 53–70, 2022.

[85] N. A. Conners-Burrow, T. L. Kramer, B. A. Sigel, K. Helpenstill, C. Sievers, and L. McKelvey, "Trauma-informed care training in a child welfare system: moving it to the front line," *Children and Youth Services Review*, vol. 35, no. 11, pp. 1830–1835, 2013.

[86] Child Safeguarding Practice Review Panel, "Child protection in england: national review into the murders of arthur labinjo-hughes and star hobson," 2022, https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson.

[87] J. MacAlister, *The Independent Review of Children's Social Care*, Department of Health and Social Care, London, UK, 2022.

[88] P. Bywaters, J. Kwhali, G. Brady, T. Sparks, and E. Bos, "Out of sight, out of mind: ethnic inequalities in child protection and out-of-home care intervention rates," *British Journal of Social Work*, vol. 47, no. 7, pp. bcw165–1902, 2016.

[89] K. M. Kiely, L. S. Leach, S. C. Olesen, and P. Butterworth, "How financial hardship is associated with the onset of mental health problems over time," *Social Psychiatry and Psychiatric Epidemiology*, vol. 50, no. 6, pp. 909–918, 2015.

[90] A. Gupta, "Poverty and child neglect – the elephant in the room?" *Families, Relationships and Societies*, vol. 6, no. 1, pp. 21–36, 2017.

[91] P. Antonopoulou, M. Killian, and D. Forrester, "Levels of stress and anxiety in child and family social work: workers' perceptions of organizational structure, professional support and workplace opportunities in Children's Services in the UK," *Children and Youth Services Review*, vol. 76, pp. 42–50, 2017.

[92] K. O'Connor, D. Muller Neff, and S. Pitman, "Burnout in mental health professionals: a systematic review and meta-analysis of prevalence and determinants," *European Psychiatry*, vol. 53, pp. 74–99, 2018.

[93] F. G. Reamer, "Moral injury in social work: responses, prevention, and advocacy," *Families in Society*, vol. 103, no. 3, pp. 257–268, 2021.

[94] Skills for Care, "The state of the adult social care sector and workforce in england. skills for care 2022," 2022, http://www.skillsforcare.org.uk/stateof.
[95] R. Jones, *In Whose interest?The Privatisation of Child protection and Social Work*, Bristol University Press, Bristol, UK, 1 ed edition, 2019.
[96] A. Haynes, C. Cuthbert, R. Gardner, D. Hodson, and P. Telford, *Thriving Communities:a Framework for Preventing and Intervening Early in Child Neglect*, NSPCC, London, UK, 2015.
[97] S. Oram, H. Khalifeh, and L. M. Howard, "Violence against women and mental health," *The Lancet Psychiatry*, vol. 4, no. 2, pp. 159–170, 2017.