Parental health in the context of public family care proceedings: a scoping review of evidence and interventions

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Abstract

Background - Child protective services (CPS), or their equivalent, have statutory power to remove children from birth parents in instances of child abuse, neglect, or concerns around parenting capacity via public family care proceedings. Parents who have children subject to proceedings, 'birth parents', often have complex health and social care needs.

Objective - We aimed to review what is known about the health needs of these birth parents and the interventions implemented to support these health needs.

Methods – We searched PubMed, Scopus, and grey literature using a systematic strategy of key concepts "health", "care proceedings", and "parents". We included all publications in English that reported parental health in the context of care proceedings from the 1st of January 2000 to the 1st of March 2021.

Results - Included studies (n=61) reported on maternal health (57%) or the health of both parents (40%), with only one study reporting on fathers alone. We conceptually categorised parental health need (n=41) into i) mental health, ii) physical health, iii) substance misuse, iv) developmental disorders, and v) reproductive health. Health inequities and poor access to services were described across all categories, with longstanding issues often pre-dating proceedings or the child's birth. All interventions supporting parental health (n= 20) were targeted at mothers, with some supporting fathers (n=8), formally or informally. We grouped similar interventions into three types: alternative family courts, wrap-around services, and specialist advocacy/peer support.

Conclusions - Parents who have children subject to care proceedings have complex health needs that pre-date CPS concerns. The studies included in our review strongly suggest that health issues are exacerbated by child removal, triggering deteriorations in mental health, poor antenatal health for subsequent pregnancies, and avoidable mortality. Findings highlight the need for targeted and timely intervention for parents to improve whole-family outcomes. There are models that have been designed, implemented, and tested using relationship-based, trauma-informed, multidisciplinary, family-focused, and long-term approaches.

1. Background

Underpinned by the United Nation's Convention on the Rights of the Child agreement, governments across the world have a duty to protect children (United Nations, 1989). Child protective services (CPS), or equivalent systems, provide a method for a state to intervene in a child's care when there are significant concerns over their welfare. Such public 'care proceedings' provide statutory power to remove a child from their birth parents when necessary (Gilbert et al., 2011). Most commonly, this is in instances of child maltreatment (abuse, neglect) or concerns around parenting capacity (UK Public General Acts, 1989). States have responsibility to protect at-risk children, yet there are difficulties in balancing the harms and benefits of such intrusive interventions into family life (Munro & Ward, 2008). The decision for a child to be taken into care has enduring consequences for the child and the parent, with Looked After children experiencing poorer health, social and education outcomes compared to that of their peers (Berlin et al., 2011; Courtney et al., 2007). Looked After children are also more than twice as likely than other adolescents to enter parenthood early and to have CPS involvement and intervention with their own children (Coman & Devaney, 2011; Wall-Wieler, Roos, Nickel, et al., 2018).

The biological parents of children subject to care proceedings ('birth parents') often have complex health needs, such as mental health and substance misuse difficulties, which can lead to CPS involvement and intervention with their children (Bedston et al., 2019; Broadhurst et al., 2017; Philip et al., 2021). Many people with complex health needs care adequately for their children, yet some health challenges can directly and indirectly impact on parenting ability (Barlow et al., 2006; Munro & Ward, 2008). For example, studies have reported increased risk of child maltreatment and accidental injury among families with parental substance misuse and mental health difficulties (Nevriana et al., 2020; Pierce et al., 2020). Parents may also experience periods of relapse or acute illness requiring

hospitalisation, affecting their ability to take care of children and family functioning (Källquist & Salzmann-Erikson, 2019).

There is increasing awareness of the interrelated health needs of children and their caregivers (Woodman et al., 2020). Although it is not always possible to prevent children being Looked After, public services have an opportunity to support parental health to interrupt lifelong and intergenerational disadvantage (Bywaters et al., 2016; UK Government, 2022). Given that care proceedings themselves are likely to worsen health issues due to heightened stress and threat to parental identity, there is also an ethical imperative to help these parents (Broadhurst & Mason, 2013; Family Rights Group, 2018). Targeted and effective intervention could result in fewer children being removed from their families, including any potential future pregnancies and subsequent care proceedings (Broadhurst, Alrouh, et al., 2015; Skinner et al., 2021). The first step in policy and practice change to support birth parents is to understand their health needs and the interventions and practice approaches that feasibly and effectively address these needs. We understand many health inequalities are likely downstream effects of entrenched social and economic inequalities; however, this is outside the scope of this review.

1.2. Study objectives

We reviewed the existing literature on the health needs of birth parents before, during and after care proceedings and interventions or practices which had been evaluated in terms of addressing the health needs of birth parents.

2. Methods

We conducted a scoping review using a systematic approach to enhance robustness (Munn et al., 2018). We report our results based on PRISMA-ESR (Tricco, Lillie, Zarin, O'Brien, Colquhoun, Levac, ... & Straus 2018). Our protocol has been published (Grant et al., 2021).

2.1. Eligibility criteria

We included all original research published in English since 2000 that reported on the health of parents whose children were subject to care proceedings. Care proceedings were defined as the involvement of public services in determining child placement for at-risk children under 18. Parental health need was conceptualised as physical and/or mental health needs that could benefit from services, such as health education, disease prevention, diagnosis, treatment, or rehabilitation (Public Health England, 2014). All reviews, opinion pieces or descriptions of health interventions without evaluations were excluded, but reference lists were screened to check for relevant literature (see supplementary material 1).

2.2. Searches

We systematically searched two scientific databases (PubMed and Scopus) and grey literature sources using key concepts ‘health need’, ‘care proceedings’ and ‘parents’. All titles and abstracts returned were screened by two independent reviewers (CG & JR) with a 91% agreement rate. In instances of disagreement, the title/abstract was revisited, and consensus reached. CG conducted all full-text screening (see supplementary material 2)

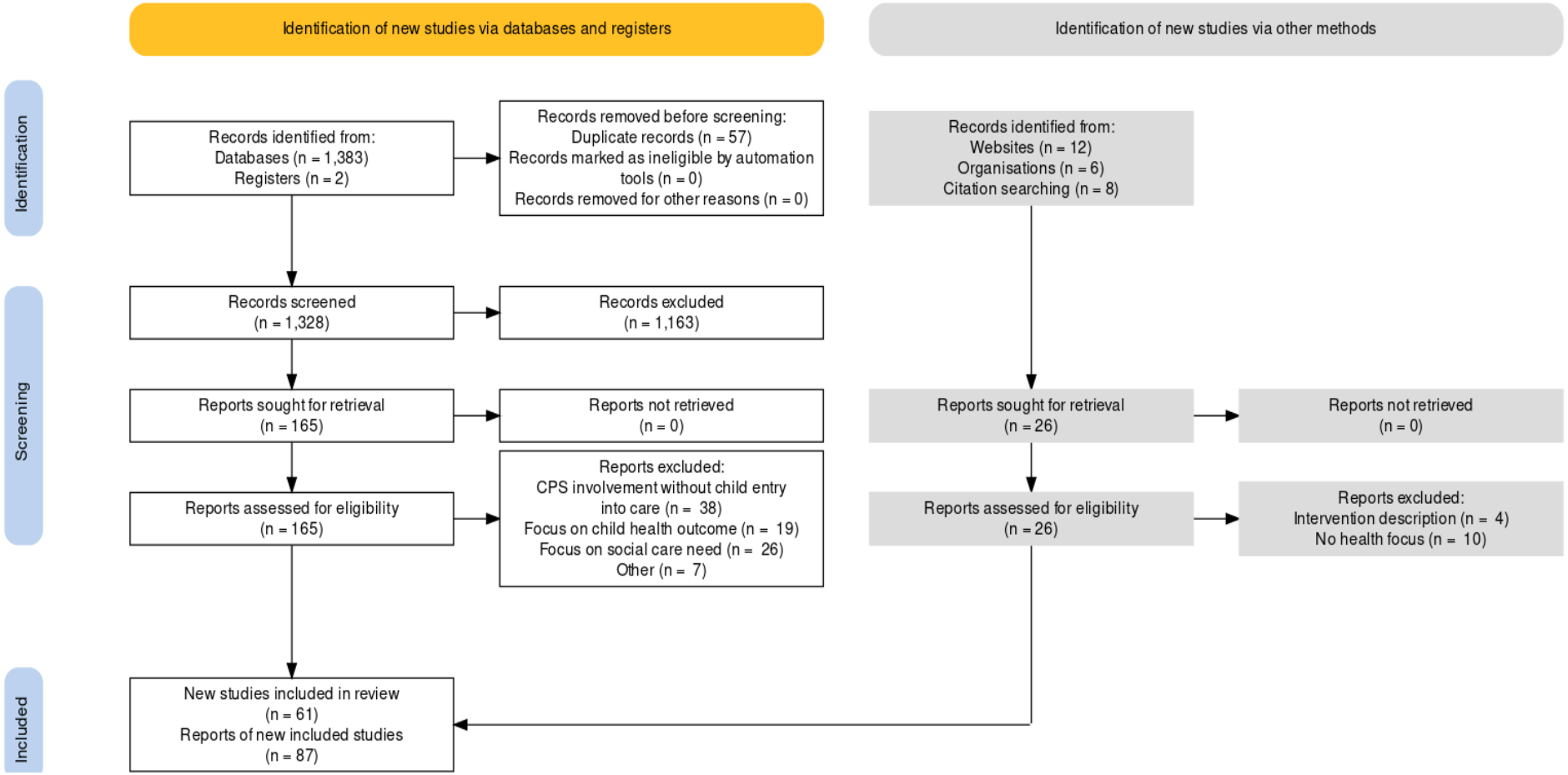
2.3. Data extraction and synthesis

We extracted information on health need, methods, and results for all studies. For included interventions, information on health focus, approach and effectiveness were extracted. We synthsised study findings and included individually reported odds ratios (OR), risk ratios (RR) and hazard ratios (HR) related to parental health outcomes. Statistical results demonstrated the probability that birth parents would experience a particular outcome (OR/RR) or how often particular outcomes happened over time (HR) compared to other groups. We conducted a narrative synthesis of all results with comment and input from a panel of mothers who had lived experience of child removal in England (see supplementary material 3).

3. Results

We included 61 studies reporting on both parental health need (n=41) and supporting interventions (n=20) (see supplementary material 4).

Figure 1 Flow diagram for inclusion as outlined in PRISMA statement



3.1.Study characteristics and populations

Our review captured a huge range of birth parents from across the globe. In the UK, Canada, Australia, and Sweden, administrative health records of over 27,000 birth mothers, 3,690 birth fathers and 1,280 children with parental information recorded were reported. Such approaches allow large populations to be analysed and can ascertain temporality of events yet cannot determine health need that is not known to health services. Further evidence on parental health was captured in analyses of around 1,500 family court case files across the UK, Iceland, Germany, USA, and Australia. Comparison of these data to parents who are not under CPS scrutiny is challenging, as records focus on conditions that impact most heavily on parenting capacity (i.e., complex unmet heath needs). Longitudinal data from Australia, Denmark, and the USA reported on the health needs of over 42,840 families involved in care proceedings, although there are issues with sampling biases. Parental health experiences are explored in qualitative interview data from over 190 birth mothers, 25 birth fathers, and 15 allied professionals in the UK, USA, and Australia. These accounts provide a nuanced insight into parental health need, however, can be limited in reflecting service contact.

3.2 Parental health need (n=41)

Studies reporting on parental health need captured mental health (n=20), physical health (n=7), substance misuse and addictions (n=15), intellectual and developmental disabilities (n=14), and reproductive health (n=5). Most of these studies focused on maternal health (n=22) or both parents (n=18), with only one reporting on fathers exclusively.

3.2.1. Mental health (n=20)

Findings report high rates of mental health need and service use among birth parents, a finding consistent across country, study design and measure. Studies reported high rates of maternal mental health difficulties prior to CPS involvement, including histories of specialist service contact (Griffiths, Johnson, Broadhurst, Bedston, et al., 2020; Griffiths, Johnson,

Broadhurst, Cusworth, et al., 2020; Pearson et al., 2020, 2021; Salzer et al., 2020; Simkiss et al., 2012; Vigod et al., 2018). Compared to women accessing similar services, birth mothers had higher rates of being diagnosed with serious mental illnesses (SMIs), (personality disorders 21% vs 11%, schizophrenia spectrum disorders 19% vs 11%) and being admitted to inpatient stay (27% vs 14) (Pearson et al., 2021). Recording of maternal mental illness in GP data was associated with child removal (OR 2.51, 95% CI 1.55-4.05) (Simkiss et al., 2012) and at a local authority level, maternal adversity (including mental health) accounted for 24% variation in child removal rates (Pearson et al., 2020).

Mothers with SMIs were more likely to have children placed in out-of-home care than other mothers with CPS involvement in the USA (OR 2.8, 95% CI=1.5-5.2) and Canada (OR 6.69, 95% CI=3.89-11.52) (Hollingsworth, 2004; Park et al., 2006; Wall-Wieler, Roos, Brownell, Nickel, Chateau, & Nixon, 2018). Mental health disorders were common professional concerns for parenting capacity in care proceeding files (Broadhurst et al., 2017; Kohl et al., 2011; Kratky & Schröder-Abé, 2018; Sheehan & Levine, 2005), with mothers' poor mental health a greater risk factors for out-of-home child placement (OR 2.33, 95% CI 2.05-2.63) than fathers (OR 1.06, CI 95% 0.94 -1.19) (Whitten et al., 2021). The risk of custody loss was greatest for women with pre-existing mental illness (OR 4.77, 95% CI 4.13–5.50) (Green et al., 2019; Hollingsworth, 2004; Vigod et al., 2018).

Following child removal, parental mental health deteriorated (Wall-Wieler, Roos, Brownell, Nickel, Chateau, & Nixon, 2018). Compared to women who lost a child to death, child removal was associated with higher rates of maternal anxiety (ARR = 2.51; 95% CI, 2.40 to 2.63), depression (ARR 1.90; 95% CI, 1.82 to 1.98), physician contacts for mental health (ARR = 3.01; 95% CI, 2.91 to 3.12) and psychotropic medication use (ARR = 3.01; 95% CI, 2.91 to 3.12) (Wall-Wieler, Roos, Bolton, et al., 2018). Cross-sectional analysis of health records illustrated birth mothers had higher rates of death by suicide compared to their

biological sisters and other mothers in receipt of CPS (RR = 4.46, 95% CI 1.39-14.33 and RR = 3.45, 95% CI 1.61-7.40, respectively) (Wall-Wieler, Roos, Brownell, Nickel, Chateau, & Singal, 2018). Birth mothers were at greatest risk of suicide if they had also been removed from their parents as children (HR = 5.52; 95% CI 2.91–10.46) (Wall-Wieler et al., 2018).

Birth parents qualitative testimonies offered insight into complex histories of trauma and the impact of child removal on mental health (Broadhurst et al., 2017; Broadhurst & Mason, 2020; Honey et al., 2019; Memarnia et al., 2015). Birth mothers and fathers spoke of the abandonment of public services and challenges in advocating for appropriate support (Broadhurst et al., 2017) (Philip et al., 2021). The role of being a parent, even following removal, provided meaning and hope for both mothers and fathers (Philip et al., 2021). Support networks were harnessed to renegotiate parental identity, (Hollingsworth, 2004; Sands et al., 2004), although these were less available for birth fathers (Philip et al., 2021).

3.2.2. Physical health (n=7)

Included studies evidenced poor physical health among birth parents before care proceedings, with outcomes worsening after child removal. Compared to mothers without care proceeding involvement, birth mothers' health records reported higher rates of smoking (60% vs 24%) and unhealthy weight measurements - clinically underweight (6.9% vs 3%) and morbidly obese (5.9% vs 4.6%) (Griffiths, Johnson, Broadhurst, Bedston, et al., 2020; Griffiths, Johnson, Broadhurst, Cusworth, et al., 2020). Mental health records in the UK found birth mothers had a 2.15 greater risk of death compared to other women accessing similar services (Pearson et al., 2021). Interviews with birth fathers raised multiple long-standing physical conditions, such as chronic pain, asthma, epilepsy, and major dental needs (Philip et al., 2021). In court files, physical health concerns were not cited as reasons for removal (Broadhurst et al., 2017), however mothers' non-attendance at their GP appointments increased the risk of child removal (OR 2.42, 95% CI 1.42-4.14) (Simkiss et al., 2012).

Following child removal, birth mothers were more likely to self-report their health as 'poor' (OR 1.50, 95% CI 1.04-2.16) (Kenny et al., 2019). In national mortality data, birth mothers were shown to be at increased risk of dying from amenable (HR 3.04, 95% CI 2.03-4.57) and preventable causes (HR 3.09, 95% CI 2.24-4.26) (Wall-Wieler et al., 2018), including cancer (HR 1.65, 95% CI 0.72-3.81) and cerebrovascular diseases (HR 1.75, 95% CI 0.45 to 6.86). Both parents were at increased risk of dying in transport accidents (HR 2.16, 95% CI 0.26-17.84) and to heart diseases (HR 5.25, 95% CI 1.08 to 25.43).

3.1.3. Substance misuse and addictions (n=16)

Substances described included methamphetamines, marijuana, alcohol, heroin, and opioid-based prescription medications. Professionals cited concerns of parenting capacity due to substance misuse in care proceeding files (Berger et al., 2010; Broadhurst et al., 2017; Henry et al., 2018) and administrative data reported maternal substance misuse as a risk factor for child removal (OR 8.94; 95% CI=5.08-15.71) (Minnes et al., 2008; O'Connor et al., 2020; Sarkola et al., 2007). Mothers accessing specialist drug clinics had high rates of infant entry into care (32-42% of service users) (Eiden et al., 2007; Sarkola et al., 2007; Wobie et al., 2004) and in ecological analyses, increase opioid prescription rates was associated with more (32%) children being removed (Quast, 2018). Birth mothers were most at risk if they were living with another drug user (OR 2.71, 95% CI 1.30-5.56) or had co-morbid mental health challenges (OR 3.9, 95% CI 1.78-8.55) (Gilchrist & Taylor, 2009).

Birth mothers described using substances as a form of self-medication following child removal, reflecting on the lack of professional support after care proceedings and the function of substances to escape the pain. In some instances, this led to the uptake and increased use of opioids, such as heroin (Broadhurst et al., 2017; Broadhurst & Mason, 2020). Birth fathers described using drugs and alcohol as a form of self-medication, including for pain

management, even prior to CPS involvement. It was common for both parents to use drugs, a co-dependency which could produce unhealthy or unsafe environments (Philip et al., 2021).

3.2.4. Intellectual and developmental disabilities (n=14)

Intellectual and developmental disabilities (IDDs) included learning, cognitive and behaviour difficulties, attention deficit hyperactivity disorder (ADHD) and autism spectrum disorders (ASD). Parents with IDDs were overrepresented in care proceedings across all included countries (Booth et al., 2005; Booth & Booth, 2004, 2005; Booth & Booth, 2004; Brown et al., 2018; Mayes & Llewellyn, 2012; Rebbe et al., 2020; Welbourne et al., 2017). IDDs were frequently mentioned in court files as a concern for parenting capacity (Broadhurst et al., 2017), yet there was lack of clarity around their impact on parenting ability or child welfare (Rice et al., 2021; Sigurjónsdóttir & Rice, 2017, 2018; Tøssebro et al., 2017). A diagnosis of an IDD was often used as a proxy for parenting incapacity, with discriminatory evidence used in court [e.g., parental IQ scores] (Callow et al., 2017). In qualitative interviews, legal professionals disclosed feeling ill-informed for how to support these families and felt training was either absent or insufficient (Cox et al., 2015; Kollinsky et al., 2013). Birth mothers expressed confusion throughout care proceedings with unfamiliar settings and jargon. They described ‘mothering differently’ and felt powerless within the family justice system (Mayes & Llewellyn, 2012). Birth fathers with IDDs reported challenges articulating emotions, a factor contributing towards professionals’ concern (Philip et al., 2021).

In Australia, parents with IDDs had higher rates of keeping their children at home compared to an English sample (59% vs 10%) (Booth et al., 2005). In Canada, one in 20 babies born to women with IDDs were discharged into care, a rate 32 times higher than the general population (Brown et al., 2018). Women with comorbid mental illnesses (OR 2.58, 95% CI 1.90–3.50) and inadequate prenatal care (OR 1.76, 95% CI 1.32–2.34) were most at risk of removal (Booth & Booth, 2004; Brown et al., 2018; Tøssebro et al., 2017). Court file reviews

indicated Indigenous women with IDDs experience particular prejudices and had higher rates of out-of-home placement (60% vs 48%) (Collings, Dew, et al., 2018).

3.2.5. Reproductive health (n=5)

Birth mothers with children subject to care proceedings were reported to enter motherhood earlier than other women (Brown et al., 2018; Griffiths, Johnson, Broadhurst, Cusworth, et al., 2020; Wall-Wieler, Roos, Brownell, Nickel, & Chateau, 2018). Among women who had infants subject to care proceedings, one in five did not book an antenatal appointment until after 16 weeks (Griffiths, Johnson, Broadhurst, Bedston, et al., 2020). Health records indicated that late or no antenatal visit was predictive of out-of-home child placement in Canada (OR 1.76, 95% CI 1.32-2.34) and Australia (OR 1.61, 95% CI 1.37–1.90) (Brown et al., 2018; Green et al., 2019).

Findings from UK GP data evidenced maternal use of primary care contraception services was negatively associated with child entry into care (OR 0.64, 95% CI 0.43-0.97) (Simkiss et al., 2012). Interviews with birth mothers in the UK described grief and loss following child removal as complicating factors in decision-making processes, with women often describing subsequent pregnancies as unplanned (Broadhurst et al., 2017). Less is known about birth fathers' reproductive decision-making choices, although interview data illustrated a desire for more children following removal, comparable to maternal literature (Philip et al., 2021). Repeat pregnancies within quick succession were reflected on by birth mothers as a response to fill an emotional gap and reclaim their motherhood status (Broadhurst et al., 2017). Women described fear of pre-birth assessments and CPS involvement throughout subsequent pregnancies (Mason & Wilkinson, 2021) and were more likely to have inadequate prenatal care (OR 4.29, 95% CI 3.68 to 5.01) (Wall-Wieler et al., 2019).

Health need (n=studies)	Countries (n=studies)	Inclusive of fathers (% of sample)	Summary findings for birth parents	
			Qualitative findings	Quantitative findings
Mental health (n=20)	UK (n=7) USA (n=5) Australia (n=4) Canada (n=2) Germany (n=1) Denmark (n=1)	✓ *12% of qualitative* *<1% of quantitative*	• Adverse childhood experiences and trauma common among birth parents and often associated with complex mental health need • Mental health problems raised as professional concern for parenting capacity in care proceedings • Identity of being a 'parent' as an important motivator for recovery and meaning among parents with mental illness • Complex feelings of loss and grief following child removal, including a renegotiation of parental identity, and worsening mental health.	• High rates of diagnosis of serious mental illness (SMIs) (schizophrenia spectrum disorders & personality disorders) among birth mothers • Diagnosis of SMI and histories of inpatient psychiatric care as risk factor for child removal, an effect greater for birth mothers • Child removal associated with deteriorating parental mental health, including increased psychiatric prescriptions, rates of anxiety/depression, and suicide attempts and completions.
Physical health (n=7)	UK (n=5) Canada (n=2)	✓ 100% of qualitative 44% of quantitative	• Birth fathers reported chronic and long-standing physical health conditions • Physical health concerns not frequently captured in court case files.	• Birth parents are dying earlier than comparator groups and from preventable/amenable causes • Maternal non-engagement with GP associated with child removal • Associations between child removal and self-reported poor health among birth mothers.
Substance misuse (n=15)	UK (n=7) USA (n=5) Australia (n=1) Finland (n=1) Canada (n=1)	✓ 25% of qualitative 1% of quantitative	• Substance use perceived as a coping strategy, even before entry to parenthood • Substances used included alcohol, marijuana, methamphetamines, heroin, and opioid-based prescription medication • Substance use raised as professional concern for parenting capacity in care proceedings	• High rates of substance misuse recorded in birth parents' administrative health and court records • Parental drug use as risk factor for child removal, an effect greater for birth mothers • Risk of child removal greatest for mothers using throughout pregnancy, poly drug users and women living with other drug users.

			• Child removal triggering worsening substance misuse, as parents 'self-medicate' acute grief • Co-dependency of both parents using was felt to create unhealthy and destructive environments.	
IDD **(N=14)**	UK (n=7) USA (n=2) Australia (n=2) Canada (n=1) Norway (n=1) Iceland (n=1)	✓ 24% of qualitative 7% of quantitative	• Feelings of powerlessness for women with IDDs 'mothering differently' • Confusion around court processes and legal jargon used throughout proceedings • IDDs used as proxy for parenting incapacity in court records, with discriminatory evidence used in court [e.g., IQ scores] • Professionals feeling ill-informed at how to support families with IDD	• IDDs included learning, cognitive and behaviour difficulties, ASD, and ADHD • Parents with IDDs overrepresented in care proceedings and child removal orders • Rates of early (newborn or infant) child removal far greater among parents with IDDs • Most at risk were mothers with co-morbid mental illnesses, single mothers and women who received poor antenatal care.
Reproductive health **(n=5)**	UK (n=3) Canada (n=2)	*No fathers*		• Birth mothers enter parenthood early • Poor antenatal care associated with increased risk of child removal • Histories of child removal associated with poor antenatal care for subsequent pregnancies • Maternal engagement with primary care contraception services reduced likelihood of child removal.

Table 1 Parental health need summary

3.2. Health interventions for birth parents (n=20)

We grouped health interventions for parents into 3 similar approaches: i) alternative family courts (n=4), ii) wrap-around services (n=10) and iii) specialist advocacy/peer support (n=5). All included interventions were targeted at birth mothers (n=20), with some formally or informally also including birth fathers (n=8). Summary of interventions is in Table 2.

3.2.1. Alternative courts (n=4)

Alternative courts provided different ways of conducting care proceedings, accounting for additional health needs of families before child removal. Most (n=3) addressed parental substance misuse and one evaluated the experiences of parents with IDDs. These courts (e.g., Family Drug and Alcohol Court and Engaging Moms Programme) offered therapeutic approaches to proceedings, with multi-disciplinary teams supporting parents through frequent assessments and interventions (Harwin et al., 2018). Parents had regular drug tests and were seen by the same judge throughout. Findings from effectiveness trials demonstrated a reduction in child removal rates and improvement in parental drug misuse (i.e., access to treatment and cessation) compared to families in regular courts (Green et al., 2007) (Harwin et al., 2018) (Dakof et al., 2010). Changes were sustained at a 5 year follow up with families (Harwin et al., 2016), although mandated drug treatment for mothers was not shown to reduce the likelihood of returns to court (Rittner & Dozier, 2000). The Scottish Tribunal Hearing system was described as an alternative means of conducting care proceedings (McGhee & Hunter, 2011). The process integrated decision making for children who offend and those in need of care and protection. Unlike care proceedings, hearings consisted of citizen volunteers, the child, birth parents and a social worker. In interviews with parents with IDDs, participants reported hearings as less ‘scary’ and felt positively toward the process’s informality. No quantitative evaluation was reported.

3.2.2. Wrap around services (n=10)

Wrap around services provided holistic support for birth parents with care proceeding involvement. These were implemented during high-risk pregnancies (Rutman et al., 2020), as a response to safeguarding concerns (Hanson et al., 2019), and following child removal (Bellew & Peeran, 2017; Cox et al., 2017; McCracken et al., 2020; Roberts et al., 2018). Most services supported mothers (n=5), were delivered via mothers (e.g., in maternity services) and focused on mothers' needs (Andrews et al., 2018). While some supported both parents (n=5), none worked with men in isolation (Roberts et al., 2018). Wrap around services were trauma-informed, relationship-based, and had flexible approaches to outreach and delivery. Services delivered intensive packages of care to support emotional, psychological, and physical needs for between 12-24 months (Rutman et al., 2020). Prenatal interventions mitigated some of the negative effects of maternal drug use on mother and baby health outcomes using harm reduction approaches (Rutman et al., 2020). Specialist support for grief, loss, and trauma related to child loss following child removal was also described (McCracken et al., 2020). Multi-agency working with local partnerships encouraged parental engagement with allied healthcare professionals. In Canada, Indigenous liaison workers ensured services were culturally sensitive, exploring the impact of systemic inequities on health service access (Rutman et al., 2020). In UK based services, women were also encouraged to (re)register with GPs to access primary care support (Cox et al., 2017). In the 'Pause' intervention, long-acting reversible contraception was mandated throughout programme (Bellew & Peeran, 2017; Cox et al., 2017; Roberts et al., 2018).

Mixed-method evaluations evidenced improvement in psychological functioning, wellbeing, and relationship capacity for birth parents (Andrews et al., 2018; Bellew & Peeran, 2017; Cook et al., 2014; Cox et al., 2017; Forrester et al., 2016; Hanson et al., 2019; Lewis-Brooke et al., 2017; Mason & Wilkinson, 2021; McCracken et al., 2020; Roberts et al., 2018; Rutman

et al., 2020). Interviews with birth mothers reported positive life changes, including healthier living. Women described non-judgmental approaches as key for building trust with services (Forrester et al., 2016; Lewis-Brooke et al., 2017). Both mandating LARCs (McCracken et al., 2020) and/or receiving sexual health advice (Cook et al., 2014; Cox et al., 2017; Roberts et al., 2018) reduced rates of rapid repeat pregnancies for mothers. Findings suggest involving birth fathers would improve whole-family health outcomes (Roberts et al., 2018).

3.2.3. Specialist advocacy/peer support (n=5)

These interventions focused on one-to-one support for parents by individuals with specialist knowledge or experience throughout care proceedings. Most included studies described interventions for parents with IDDs (n=4), with one supporting parents with serious mental illnesses (Atkin & Kroese, 2021; Collings, Spencer, et al., 2018; Tarleton, 2008; Walton, 2002). Advocacy was based on principles of empowerment, ensuring parents were aware of their rights and supported to exercise them (Collings, Spencer, et al., 2018). Advocates liaised with CPS, court, hospital, and other professionals with birth parents and attended care proceedings. Advocates were a mix of trained volunteers and practitioners with specialist clinical knowledge (Walton, 2002). Birth parents described better understanding of court proceedings with an advocate, yet the lack of structural support for these roles perpetuated feelings powerlessness for parents (Collings, Spencer, et al., 2018; Tarleton, 2008).

A peer support model was described for parents with IDDs who had experienced domestic violence (Collings et al., 2020), aiming to cultivate emotional and practical support between parents with shared experiences. Narrative interviews with birth mothers involved in peer-support described feelings of comfort and support but highlighted challenges with feasibility, given that all women involved were facing their own challenges (Collings et al., 2020). We did not find any quantitative evaluations of specialist advocacy or peer support interventions.

Intervention type	Country	Name *(if known)*	Health focus	Inclusive of fathers (% of sample)	Evidence base	
					Qualitative	Quantitative
Alternative courts	**UK**	**Family Drug and Alcohol Court**	Substance misuse	✓ (26%)	Interviews with 42 parents, 154 court observations and 89 cases.	Randomised trial comparing 90 families in receipt of FDAC.
	USA	**Family Treatment Court**	Substance misuse	✓ (14%)		Evaluation of over 400 families in receipt of FDAC vs families in usual court, included self-reported outcomes.
	USA	**Mandated treatment**	Substance misuse	✓ (12%)	Retrospective court file analysis of 477 birth parents.	
	USA	**Engaging Moms**	Substance misuse	No		Randomized pilot study of 62 mothers in the programme.
	UK	**Tribunal hearings**	Developmental	✓ (4%)	Interviews with 8 parents, and 7 panel members and legal representatives.	
Wrap-around services	**UK**	**Multi-site,** *Positive Choices, MPower, Family Action, Hummingbirds*	Flexible	✓ (9%)	Interviews with 14 birth parents and 5 practitioners.	Self-reported and clinical data from 82 parents.
	USA	**Rehabilitation and parenting support**	Mental health	✓ (14%)	Retrospective case file abstraction on 104 mothers accessing rehabilitation and support services.	
	UK	**Breaking the Cycle**	Flexible		Interviews with 13 birth mothers and 2 social workers.	Self-assessment questionnaires from 25 mothers.
	Canada	**Breaking the Cycle**	Substance misuse			Referral forms, progress notes and service use records of 166

						women receiving Breaking the Cycle.
	UK	**Reflect**	Flexible	✓ (25%)	Interviews with 4 staff and 16 parents, and analysis of 30 case files.	Self-recorded outcome measures of 9 birth parents.
	UK	**Pause**	Flexible		Interviews with 61 women who received Pause.	Secondary analysis of monitoring data capturing 517 women.
	Canada	**Multi-site** *Breaking the Cycle, Kids First, Mothering Project, Raising Hope, HerWay Home, Sheway, Maxxine Wright Place, H.E.R*	Substance misuse		Interviews with 125 birth mothers, 61 staff and 42 service partners.	Questionnaires and programme outcome data reported on 125 mothers.
	UK	**Hummingbirds**	Flexible		Focus groups and interviews with 20 mothers.	Programme outcome data on 11 women.
	UK	**Option 2**	Substance misuse	✓ (13%)	Interviews with 26 families who received Option 2.	Self-reported outcomes for 31 parents receiving Option 2.
	USA	**Family-based recovery**	Substance misuse	✓ (13%)		Clinical outcome measures on 1408 families receiving FBR.
Specialist advocacy/ peer support	**Australia**	**Specialist advocacy**	Developmental	✓ (30%)	Structured interviews with 10 birth parents.	
	Australia	**Peer-support**	Developmental		Structured interviews with 26 birth mothers.	
	UK	**Specialist advocacy**	Developmental	✓ (Not known)	Structured interviews with 14 birth parents.	
	USA	**Specialist advocacy**	Mental health Developmental		Case study with one practitioner perspective.	
	UK	**Specialist advocacy**	Developmental		Interviews with 4 parents and 4 advocates.	

Table 2 Supporting health interventions and their evidence base

4. Discussion

To our knowledge, this is the first study to review parental health in the context of public family care proceedings. Findings describe the known health needs of birth parents; characterise interventions targeted to support these needs and synthesise their evidence base.

4.1. Findings in context

4.1.1. What are the health needs of birth parents?

The included studies illustrate health inequities across all aspects of birth parents' health compared to parents whose children are not subject to care proceedings. Substance misuse and mental health challenges were commonly recorded and considered risk factors for out-of-home child placement (Honey et al., 2019; Sarkola et al., 2007). As evidenced in the qualitative studies, substance use was often a form of self-medication for birth parents experiencing co-morbid conditions and social disadvantages (Broadhurst et al., 2017; Philip et al., 2021). Support services should consider the function of parental substance use, including pain relief for untreated chronic physical health conditions (Canfield et al., 2017). Previous literature has reported associations between poor physical and mental health (Onyeka et al., 2019), but it was not possible to interpret comorbidity with data included in this review. The lack of insight into parental physical health could be due to these needs being unseen by services, and therefore not captured in data, or outcomes of interest being biased towards parental health issues which are a concern in the context of child protection (I.e., health behaviours which pose a'risk' to a child).

SMI was a consistent risk factor for child removal, particularly for birth mothers (Green et al., 2019; Whitten et al., 2021). In interviews, parents described lifelong health challenges and early childhood adversities (Broadhurst et al., 2017; Memarnia et al., 2015; Philip et al., 2021). There is increasing awareness of the impact early adversity can have on lifelong mental health. Some

SMIs, e.g., personality disorders, might be better treated as trauma-based conditions (Bozzatello et al., 2021). Parents with IDDs were also overrepresented in care proceedings, with high risk of newborn removal (Booth et al., 2005; Brown et al., 2018). People with SMIs and IDDs have the right to become parents (Broadhurst, Shaw, et al., 2015). The prompt and high rate of child removal is a health equity issue and brings into focus mainstream service gaps. Unmet health need must not be a key factor in child removal decisions (Broadhurst, Shaw, et al., 2015).

Child removal triggered health deterioration (Broadhurst & Mason, 2020), including increased rates of anxiety, depression, hospitalisations, and deaths (Wall-Wieler et al., 2018; Wall-Wieler, Roos, Bolton, et al., 2018; Wall-Wieler, Roos, Brownell, Nickel, Chateau, & Singal, 2018). Both parents spoke of feeling abandoned by services, with insufficient or no support following proceedings, impacting on their health (Broadhurst & Mason, 2020) (Broadhurst et al., 2017). This review generates clear justification for intensive, specialist support at this time to address factors that led to CPS involvement, and the compounded impact of child removal (Family Rights Group, 2018). There is a notable dearth of information available on birth fathers. As described in qualitative interviews, parental health need can often be interrelated and services must consider 'whole-family' (Woodman et al., 2020) and 'father-specific' need (Philip et al., 2021). Greater involvement of birth fathers should include better recording of paternal status in health data (Lut et al., 2022).

4.1.2. What are the interventions implemented to support these needs?

Included health interventions were based on principles of being relationship-based, trauma-informed, multidisciplinary, family-focused, and longer-term (i.e., up to 2 years) (Cox et al., 2017). Notably, most interventions described in this review were implemented outside of healthcare services and commissioned by local authorities, charities, or short-term innovation

funding. This results in high variation between what is available to parents living in different areas (a "postcode lottery") (Mason & Wilkinson, 2021; Rutman et al., 2020). A step forward might be adequate and dedicated funding for services to support birth parents, across health, social and legal services boundaries (Family Rights Group, 2018).

Relationship-based practice with birth parents was important for addressing longstanding distrust of services and improving acceptability and effectiveness of interventions (McCracken et al., 2020; Roberts et al., 2018; Rutman et al., 2020). In the short-term, trusted advocacy or peer support throughout care proceedings helped parents navigate complex court systems and uphold their rights (Collings et al., 2020). Yet advocates supporting parents with IDDs or SMIs faced challenges in the lack of formal structural support for their roles, generating feelings of powerlessness for both parent and advocate (Atkin & Kroese, 2021; Collings, Spencer, et al., 2018). Caseworker advocacy roles have been formally implemented to support women who experience intimate partner violence (Rivas et al., 2015), have been trafficked (Westwood et al., 2016), or who are refugees or asylum seekers (Refugee Council, 2022). These examples focus on models of upskilling professionals to respond effectively to specific needs and could be modelled in the context of care proceeding support (Family Rights Group, 2018).

Longer-term wrap-around services provided a way of working with families before, during and after proceedings. These programmes were characterised by offering tailored support via a caseworker who delivered or signposted appropriate services for women and families (Cox et al., 2017; McCracken et al., 2020). The timing of access varied across interventions, with some offering support pre-birth (Rutman et al., 2020; Salford City Council, 2018) and others targeting women following child removal (Cox et al., 2017; McCracken et al., 2020). Services improved birth mothers' emotional wellbeing, relationship capacity and self-esteem (Forrester et al., 2016;

Hanson et al., 2019). The rate of rapid repeat pregnancies decreased for women accessing wrap-around support. This was evident in Pause, where LARCs were a condition to the programme (McCracken et al., 2020) and in other services which offered sexual health education and access (Roberts et al., 2018). As illustrated in a review of parenting interventions for people with SMIs, whole family approaches and family-based work forms crucial components of effective interventions (Radley et al., 2022). The UK 'Supporting Families' is an example of such whole-family caseworker model (UK Gov, 2022).

FDAC evaluations evidenced the benefit of multi-disciplinary support for parents who misuse substances (Harwin et al., 2018). Results demonstrated a reduction in parental substance misuse and improvement in family reunification rates (Harwin et al., 2016). Whilst these findings are promising, there are known challenges with non-linear recovery from drug and alcohol addictions (Laudet et al., 2002). The alternative courts described in this review relied on parental abstinence, rather than harm-reduction approaches implemented in other contexts (Boyd et al., 2022). Harm-reduction approaches to maternity care for drug using pregnant woman in this review illustrated promising health outcomes for both mother and child (Rutman et al., 2020). Providing a safe environment for wrap-around prenatal care mitigated many of the negative effects of maternal drug use and improved service engagement for families (Rutman et al., 2020). The antenatal period offers an opportunity for targeted intervention, yet we know that birth parents may be reluctant to engage with services due to fear of child removal (Broadhurst et al., 2017). More research is needed to understand the role of maternity services in supporting birth parents at risk of child removal (Griffiths, Johnson, Broadhurst, Bedston, et al., 2020).

4.2. Limitations

We were unable to draw strong conclusions on the effectiveness of included interventions and further systematic review methods and meta-analysis is needed. We did not include research on social need, such as experiences of homelessness, poverty, and violence. These findings would undoubtedly be relevant to the health outcomes of birth parents and should be explored further. This review excluded publications not available in English, which might have limited the international significance of findings. As we only included articles describing child placement, results may also underestimate the role of CPS in supporting parental health needs for families who do not undergo care proceedings.

4.3. Implications of findings

Implications for practitioners

- Ask service users about parental status and family planning
- Develop trust with families by working in a relationship- and strengths-based way
- Implement trauma-informed approaches to working with birth parents
- Acknowledge inter-related health need by considering 'whole-family' health
- Be an advocate for the rights of birth parents
- Utilise and strengthen local networks of support

Implications for funders

- Consider commissioning longer-term, holistic support across social care and health
- Blueprinting relationship-based, trauma-informed, long-term support for parents at risk of child removal or who have had a child removed.
- Investment in preventative (pre-birth) intervention for adults with complex needs
- Implement enhanced training programmes for practitioners working with birth parents

Directions for future research

- Greater involvement of birth fathers in research and intervention development
- Understand experiences of health from birth parents' perspective
- Develop more individual-level data-linkages between CPS and parents' healthcare records
- Research into the role of maternity services supporting complex health needs

Table 3 Key implications of scoping review

4.4. Conclusion

Parents who have children subject to care proceedings have complex health needs that often manifest before CPS involvement. The included studies strongly suggest health issues are exacerbated by child removal, including avoidable mortality. There are models that have been designed, implemented, and tested to support birth parents' health using relationship-based, trauma-informed, multidisciplinary, family-focused, and long-term approaches.

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