Supporting the mental health and wellbeing of mothers at risk of recurrent care proceedings: a realist synthesis (protocol)

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Plain English Summary

A large number of children in England and Wales enter local authority care every year. These numbers are increasing across all ages of children, including those removed as babies. Many of the children who are taken into care are born to mothers who have had one or more previous child removed. These mothers have typically experienced difficulties in their childhood including having been in care, are often young when they have their first child and have high levels of need and disadvantage. This includes experiencing mental health problems, substance use and domestic violence. This disadvantage may impact upon their ability to care for their children. Further, the removal of a child causes severe emotional distress and further increases the vulnerability of the mother. Without effective interventions, many of these mothers will go on to repeatedly have children removed from their care with large mental health impact upon the mother and the child as well and financial costs for an already overstretched child welfare system.

New interventions have been introduced which try to support these mothers and reduce the number of children that go into care. However, little is known about whether these interventions work, who they work for, under what circumstance and why. This lack of evidence makes it difficult for local authorities to know what support to provide to mothers in their local areas. This project will draw on different types of evidence to build an idea about how best to support mothers at risk of their children being taken into care. We will do this by working closely with policy colleagues, practitioners and mothers with relevant lived experience and repeatedly test and refine our ideas based upon what we learn. This is called a 'theory-driven approach' and is most suited to interventions such as those provided to mothers at risk of their children being taken into care, as these interventions are likely to have different effects, for different people, who are in different situations. Throughout the project we will:

1. Look for a wide range of different types of evidence of what support might be helpful to mothers and what might not be helpful.
2. Agree what outcomes for mothers we would expect to be produced by 'good' support.
3. Build an idea about what exactly might lead to these outcomes, how and why.
4. Look for further evidence to support or challenge our ideas.
5. Use what we have learnt to describe what 'good' intervention looks like, and how the intervention may need to be adapted for local areas and situations.
6. Produce a map of typical health and social care services which exist nationally for mothers at risk of their children being taken into care and use this map to identify what needs to be changed within care to improve the support that is provided to mothers.
7. Share our findings widely with practice and policy partners to improve care for mothers who are at risk of their children being taken into care.

Scientific summary

Research question: What works to support the mental health and wellbeing of mothers at risk of recurrent care proceedings, and to prevent care entry of their children?

Background: Around one in four mothers who are subject to care proceedings will return for a subsequent set of proceedings. These mothers have often experienced multiple disadvantages, which are compounded by the trauma of child removal. There is an urgent need to understand how to interrupt these cycles of disadvantage, trauma and child removal.

Aims and objectives: The aim of this realist synthesis is to derive explanatory evidence that describes what works to support the mental health and wellbeing of mothers at risk of recurrent care proceedings, and to prevent care entry of their children. Our objectives are to:

1. Establish initial assumptions about how interventions are most likely to work for supporting the mental health and wellbeing of mothers at risk of recurrent care proceedings and to prevent the care entry of their children.

2. Establish patterns of outcomes, in terms of mothers' mental health, wellbeing and subsequent care proceedings or otherwise.

3. Establish the underpinning mechanisms of action that are most likely to explain those patterns of outcomes, taking into account contextual variations.

4. Through the previous three objectives, iteratively develop, confirm or inform the initial assumptions, into working theories that take account of contexts, mechanisms and outcomes of interventions.

5. Empirically test these theories through further literature searches.

6. Building on the working theories, carry out collaborative systems mapping of the care pathway for mothers at risk of recurrent care proceedings to identify where levers in the wider system might be optimised to support interventions.

7. Describe what 'good' intervention looks like, what may be adapted for local contexts and how.

8. Using our extensive practice and policy links, ensure that those findings inform current and future design, development and commissioning of interventions for birth mothers to be implemented within the health and social care system.

Methods: Owing to the complexity of this issue, we will undertake a realist synthesis of the academic and grey literature with stakeholder engagement throughout. The synthesis will be conducted in four iterative stages over an 18-month period. These are to: i) define the scope and generate initial programme theories; ii) retrieve and review the evidence; iii) test and refine programme theories, and iv) develop a narrative. We will produce a programme theory for interventions to support the mental health and wellbeing of mothers at risk of recurrent care proceedings. We will apply a systems lens, working with stakeholders to co-produce actionable policy and practice recommendations including system modifications, promoting contextual relevance and practice implementation which are transferrable to local systems and areas.

Anticipated impact and dissemination: This work will co-produce a system-level theory of change as a conceptual framework for interventions to support the mental health and wellbeing of mothers at risk of recurrent care proceedings, and where, how and why these interventions work (or not). An additional anticipated impact is to inform the development of new interventions and prioritise interventions to be evaluated in future research.

Background and rationale

For the past two decades there has been a year-on-year increase in the number of children being taken into care, resulting in a 'care crisis' (Family Rights Group, 2018); with particular concern regarding the 24% of mothers who are subject to repeat care proceedings and the rising number of babies 'born into care' (Bilson & Bywaters, 2020). The majority of mothers who have been subject to recurrent care proceedings have experienced structural disadvantage in multiple marginalities throughout their lives (Broadhurst & Mason, 2013; Cox, 2012). They are often considerably younger than both the general population of mothers and those mothers that experience a single care proceeding (Broadhurst & Mason, 2017). Many have experienced adversity in their childhoods which led to them becoming looked after themselves and are typically exposed to additional risk factors in their adult life (Broadhurst et al., 2017). The removal of a child is itself traumatic and can compound the mother's difficulties and creating an immediate psychosocial crisis (Broadhurst & Mason, 2020);

whilst also having cumulative and enduring adverse impacts (Broadhurst et al., 2018). The enormity of the recovery challenge following the removal of a child is increasingly recognised (Broadhurst & Mason, 2020), alongside a growing acknowledgement of the moral and economic imperative to support the mental health and wellbeing of mothers who have experienced care proceedings and also to affect change in order to prevent recurrent care proceedings (Broadhurst & Mason, 2013). In response to the 'care crisis', the recent Independent Review of Children's Social Care recommended wide-ranging reforms, amounting to a "radical reset" of a system found to be both inconsistent and "increasingly skewed to crisis intervention, with outcomes for children that continue to be unacceptably poor" (MacAlister, 2022).

Evidence explaining why this research is needed now

There is an urgent need to understand how to interrupt the cycles of trauma and child removal experienced by mothers who are subject to repeat care proceedings (Family Rights Group, 2018). Systematic reviews of randomised controlled trials (RCTs) are considered the 'gold standard' in traditional hierarchies of evidence, and are often relied upon to inform decisions in health and social care practice (Jones & Podolsky, 2015). However, research driven by binary questions of effectiveness have been found to oversimplify the evidence (wherein there is an assumption of straightforward causality between intervention and measurable outcomes) and typically lead to 'successful' interventions which do not transfer to real-world complexity (Skivington et al., 2021). Our proposal for a realist synthesis overcomes this by taking a theory-driven approach to synthesising a broad range of evidence in order to produce a generative causal explanation of a broad range of outcomes by examining both the mechanisms that lead to them and identifying the role of the context in its activation (Pawson, 2006). By engaging with this complexity within the intervention and the context, our proposed synthesis is foundational for understanding how best to design and deliver services to support mothers and including how they may need to be adapted for specific real world contexts. We will apply systems thinking to examine the complexity within the context and identify both key leverage points within the system, as well as considering system changes that may be necessary (Pawson, 2006; Pawson et al., 2005). These findings will inform development of new interventions and will also provide a theory of change against which to conduct future process evaluations of services (HM Treasury, 2020). As such, our approach aligns with the Government's evaluation agenda (Evaluation Task Force, 2022).

The findings of our review will have important and timely implications for key policies and enable the principles of best practice for mothers at risk of recurrent care proceedings to permeate relevant care pathways. For example, the Women's Health Strategy for England 2022 sets out ambitions to respond to the reproductive needs of ALL women. This includes contraception and preconception care, personalised high-quality maternity care and specialist support following pregnancy loss including into subsequent pregnancy. The findings will provide evidence which will enable the fertility, pregnancy, pregnancy loss and postnatal needs of mothers at risk of recurrent care proceedings are appropriately responded to. Under the NHS Long Term Plan (NHS England and NHS Improvement, 2019), there is an ambition for better access specialist community care for women with moderate to severe perinatal mental health difficulties maternal mental health services and specialist community perinatal mental health teams, including support following birth loss. Whilst evidence of what works to prevent care entry and/or reduce duration of care will provide important evidence to inform the planned transformation of children's social care following the major child protection review (MacAlister, 2022) and subsequent government consultation (Department for Education, 2023).

Review of existing evidence. How does the existing literature support this proposal?

Over the past decade there has been a rapid growth in services for mothers at risk of recurrent care proceedings. Innovative approaches to responding to this priority health and social care issue include the Pause intervention, Family Drug and Alcohol Court and a series of locally developed services (Mason & Wilkinson, 2021). More recently, a number of Maternal Mental Health Services have been commissioned to provide mental health support to women with infant removal (Easter et al., 2022). However, there remains a paucity of evidence for interventions to support the mental health of these mothers (Easter et al., 2022) both as a means of supporting the mother in her own right and to prevent future care proceedings (Cox et al., 2020). The small number of studies which have been conducted report positive effects, including a reduction in unplanned pregnancies and/or care entry (Cox et al., 2017; McCracken et al., 2012; McCracken et al., 2017; Roberts et al., 2018). However, these studies have typically employed a naturalist design, with small samples (Grant et al., 2023). Studies have typically sought to control (rather than examine) complexity, for example by excluding pregnant women (McCracken et al., 2012; McCracken et al., 2017). Further, studies do not consider the complexity within the intervention itself; how or why it works (or not). For example, a recent mixed method evaluation combined the outcomes of three separate services which the authors reported shared 'core values' (Cox et al., 2020). However, the properties of the intervention itself; the extent of tailoring to individual need; the range of behaviours or outcomes targeted and the expertise, skills and approach of those delivering the intervention were not considered. Such limitations within the current evidence-base reduces the usefulness of the evidence to decision-makers and falls short of providing the understanding necessary for local authorities to develop adaptable or scalable programmes that work for all mothers.

Aims and objectives

The aim of this realist synthesis is to derive explanatory evidence that describes what works to support the mental health and wellbeing of mothers at risk of recurrent care proceedings, and to prevent care entry of their children. We will synthesise evidence using a realist logic of analysis to:

1. Establish initial assumptions about how interventions are most likely to work for supporting the mental health and wellbeing of mothers at risk of recurrent care proceedings and to prevent the care entry of their children.
2. Establish patterns of outcomes, in terms of mothers' mental health, wellbeing and subsequent care proceedings or otherwise.
3. Establish the underpinning mechanisms of action that are most likely to explain those patterns of outcomes, taking into account contextual variations.
4. Through the previous three objectives, iteratively develop, confirm or inform the initial assumptions, into working theories that take account of contexts, mechanisms and outcomes of interventions.
5. Empirically test these theories through further literature searches.
6. Building on the working theories, carry out collaborative systems mapping of the care pathway for mothers at risk of recurrent care proceedings to identify where levers in the wider system might be optimised to support interventions.
7. Describe what 'good' intervention looks like, what may be adapted for local contexts and how.
8. Using our extensive practice and policy links, ensure that those findings inform current and future design, development and commissioning of interventions for birth mothers to be implemented within the health and social care system.

Project Plan

We propose a theory-led synthesis approach based on the related principles of systems thinking and realism (Bhaskar, 2013; J. Mingers, 2014) for two key reasons. First, interventions to support mothers at risk of repeated care proceedings are 'complex social interventions', whose influence is context-dependent. Activities delivered differ across local settings and between women depending on their needs, such that the 'intervention' is unlikely to be precisely definable or replicable with absolute fidelity. This complexity cannot be captured by traditional approaches that prioritise effectiveness questions, envision initiatives in a linear cause-effect way, focus just on the specifics of the intervention itself, and assess effectiveness against a primary outcome (Rutter et al., 2017). Instead, realist synthesis describes causality (i.e. change from an intervention) in terms of emergence from generative 'mechanisms', which comprise the composition and interactions within and between structures (e.g. social, conceptual) in a particular setting or context. Realist synthesis aims to generate middle range theories[1] to explain intervention influences in terms of both underlying mechanisms and setting (Hetrick et al., 2017; Pawson & Tilley, 1997; Porter, 2015). Rather than producing an intervention 'effect size', realist synthesis outputs are refined middle range theories addressing the questions, 'what works *[to influence mothers health and wellbeing and reduce care proceedings]*, for whom *[for which mothers]***,** in what circumstances *[in what context]*, and how [through *what mechanisms]?* (Justin Jagosh et al., 2015). The heuristic Context + Mechanisms = Outcome (C+M=O) is used to explore and test the middle range theory underpinning interventions (Pawson & Tilley, 1997). Adapting the model proposed by Dalkin et al (Dalkin et al., 2015) mechanisms can be further broken down into resource (i.e. the pragmatic intervention details) and response (the underpinning force that helps explain the outcome).

Second, there are multiple interrelated influences (a complex 'social system') directly and indirectly affecting care proceedings. While the development of middle range theory in realist synthesis focuses on the programme (intervention) level, 'systems thinking' is "an approach that views 'problems' (and interventions) as part of a wider, dynamic system" (Wolpert, 2018) (p.33). A 'system' is defined as a group of interdependent components that form a complex and united whole (Cabrera et al., 2008), with emergent causally efficacious properties resulting from its structural composition and inter-relationships (John Mingers, 2014). Relevant to this study, system components include social (e.g. mothers, their social support network, VCS organisations, statutory services, etc…), and conceptual (e.g. stigma, desire to self-manage) factors. This approach will facilitate understanding about how interventions to support the mental health and wellbeing of mothers at risk of repeated care proceedings interact with other system elements to affect the 'dynamics of change', to influence further care proceedings. It will also enable identification of where (at which parts of the system) and how (through which actions) these relationships/interactions can be improved or altered to enhance impact and to enable sustainable implementation' (Garcia, 2015; Hawe et al., 2009; Maini et al., 2018; Rutter et al., 2017; Salway & Green, 2017; Stroh, 2015).

Within our synthesis, we will draw on evidence from the international academic literature; local service evaluations and other grey literature; and involvement of stakeholders (mothers at risk of recurrent care proceedings, practice and policy colleagues). We will work with established groups (for example Birth Companion, Reform and Recovery Justice), health and social care services and our existing network to engage mothers. This approach will ensure appropriate support is in place for mothers before, during and after their involvement. Practitioner and policy stakeholders will be varied by employing organisation. Where possible, we will continue to engage the same stakeholders at each stage to promote ownership. However additional groups will be organised as

[1] A middle range theory are programme theories about how the mechanisms of an intervention work in a specific context to being about certain outcomes. They are specific enough to clearly explain the phenomenon, and general enough to apply across cases of the same type.

required in response to our evolving theory. Our synthesis of the evidence will be conducted in four iterative stages (Rycroft-Malone et al., 2012) over 18 months (see figure 1: flow of study diagram). These stages are:

1. Defining the scope and generating initial programme theories
2. Retrieving and reviewing the evidence
3. Extracting and synthesising the evidence
4. Synthesising the data

In keeping with the progressive intent of realist syntheses (Pawson et al., 2005), we will work closely with three stakeholder advisory groups iteratively throughout the project. These will be convened with: i) mothers who have experienced/are at risk of recurrent care proceedings; ii) practitioners involved in the care of mothers/their child(ren); iii) senior leaders/decision-makers from public health, social care and health. We will conform to the Realist And Meta-narrative Evidence Synthesis (RAMESES) quality and publication standards for realist synthesis (Pawson et al., 2005; Wong et al., 2013).

Stage 1: Defining the scope and generating initial programme theory(s) (objective 1-3)

1.1 Background searching

Within stage 1 we will define preliminary boundaries for the scope of the review and concept-mine the evidence (Rycroft-Malone et al., 2012). We will use this evidence to provide some initial explanation of how, for whom and in what circumstances interventions to support mothers are most likely to be successful at supporting their mental health, wellbeing and preventing their child being taken into care (Pawson, 2006). Based upon our scoping activities this far, we anticipate that this will include evidence relating to national programmes such as Pause, Family Drug and Alcohol Courts and local provisions (usually voluntary and community services). However, our PPI work has highlighted the importance of support for perinatal loss, housing, mutual aid and peer support and advice, education and advocacy. We will use this background evidence and PPI activity to formulate specific questions as lines of enquiry to inform our search strategy (Pawson, 2006). We will include explicit consideration of the interaction between the interventions and the wider care pathway for mothers at risk of recurrent care proceedings. This background evidence will be gleaned from a range of sources:

International academic literature

We will build upon a recent scoping review supervised by a member of our research team (JW) and carried out by one of our collaborators (CG) which synthesised literature on the health needs of parents in contact with child protection services and the interventions implemented to support these health needs (Grant et al., 2023). We will access the 20 studies on interventions to support the health of mothers in this review to investigate the range of approaches included, outcomes reported, and identify key elements in success (or not) and gaps in the academic literature.

UK-based grey literature

We will use the findings from '*Services for parents who have experienced recurrent care proceedings: Where are we now?* (2021) – a recent mapping exercise which identified two nationally funded services (Pause and Family Drug and Alcohol Court – FDAC) and 33 locally developed services provided within 38 local authorities in the UK (Mason & Wilkinson, 2021). We will use this service map to identify UK-based grey literature. Our initial scoping of this literature has found that many of these services have unpublished and published evaluations. We will access these evaluations to supplement the international academic literature.

Supplementary literature searches informed by PPI

We will conduct searches informed by PPI undertaken in the development of this application. On the basis of our work so far, we anticipate this will include a search for literature examining interventions for reproductive birth loss; supported housing (including mother and baby units) for mothers at risk of (first and repeat) care proceedings; advocacy in child welfare and family court; mutual aid and peer support. Additional areas of focus are likely to emerge through the realist process and further PPI activities.

We will use the diverse evidence identified from the above means to inform the formulation of the initial explanatory theories, for discussion within the stakeholder advisory groups.

1.2 Stakeholder workshops

We will conduct workshops separately with three stakeholder advisory groups: (i) senior leaders/policy colleagues (ii) mothers at risk of recurrent care proceedings and (iii) practitioners.

Role of the stakeholder workshops:

- Within the policy advisory groups, we will discuss policy priorities and agree specific practice approaches which may be of primary interest (e.g. health visiting, midwifery support, children's social care, voluntary and community sector models). This early engagement with policy colleagues will ensure the synthesis responds to current and emerging policy priorities and will provide the foundation for stage 4 of the synthesis (Synthesising the data).
- Within mother and practitioner advisory groups workshops, we will develop explanatory models informed by group member experience and the evidence from the background search. Workshop discussions will also focus upon the interaction between the intervention and the health and social care pathway(s) which mothers at risk of recurrent care proceedings may interact with (for example, the interaction between perinatal loss support during and following removal and future care pathway entry points with subsequent pregnancies). These early explanatory theories will be formulated as 'if, then statements' (Pearsons et al., 2022) postulating the interaction between the context and mechanism, and will become the focus of the realist enquiry, providing a framework for the searching, extraction and synthesis of literature (Pawson et al., 2004; Rycroft-Malone et al., 2012) (see box 1 for examples).

Box 1: hypothetical if, then statement (for illustration purposes only)

> If a mother's grief is acknowledged, then she may be able to cope better.
>
> If previous care proceedings have happened smoothly, a mother is more likely to engage with future child protection intervention with reduced anxiety.

Stage 2: Retrieving and reviewing the evidence (objective 4)

2.1 Search strategy

We will develop our search strategy using the Context-Intervention-Mechanism-Outcome (CIMO) framework recommended within realist synthesis (Booth et al., 2018). This search strategy will be informed by the output from stage 1 (described above). We will implement the search strategy within the following databases: MEDLINE (OVID), PsycINFO (OVID), EMBASE (OVID), Cochrane Library, CINHAL, Applied Social Science Index and Abstract (ProQuest) and Scopus. This will be supplemented by website searches of relevant organisations including Nuffield Family Justice

Observatory, Research into Practice, Barnardo's, NSPCC. The CIMO will be based upon the initial explanatory theories developed with our advisory groups and initial searches within stage 1. The theory-driven approach inherent within realist synthesis allows for learning to be transferred from elsewhere (i.e. interventions provided to populations who have not experienced child removal), where it is postulated that the same mechanism may be activated in the same context (Wong, 2018). For example, the PPI work we conducted during the development of this application has highlighted to us that mothers who have experienced recurrent care proceedings have often had adverse childhoods (Broadhurst et al., 2017); perinatal separation and loss trigger complicated grief responses in mothers whose children are removed; and the experience of loss can create substantial anxiety and attachment difficulties in subsequent pregnancies. Based upon our PPI work, and our existing knowledge of the evidence, we anticipate a search strategy informed by the following CIMO:

Context: we will target contexts including mothers (and/or fathers) who experience/are at risk of recurrent care proceedings; mothers (and/or fathers) in contact with child protection services; mothers (and/or fathers) who have experienced perinatal stillbirth and reproductive loss; parents who experience difficulties and/or disadvantages that increase the likelihood of repeat care proceedings (care experienced, young parents, use substances, experience mental health problems and/or domestic violence), adults who have experienced adversity in childhood.

Intervention: we will include a wide range of interventions that are delivered within the contexts described above. These include but are not limited to Pause and equivalent locally developed programmes; Family Drug and Alcohol Court, Specialist Domestic Violence Courts; Centre for Family Safeguarding (Hertfordshire model); supported accommodation (including mother and baby units); attachment-focused interventions; parent skills training (including those integrated with specialist health services such as substance use and mental health treatment); grief counselling trauma-informed care and trauma-specific therapies; family nurse partnership; innovation within health and social care services including support for care experienced parents.

Mechanism: we will include both resource and response mechanisms (Dalkin et al., 2015). Examples of resource mechanisms include relational practice; emotional support; advice, information and education; mutual aid and peer support. Examples of response mechanisms include skill enhancement; parental reflexive functioning; confidence building; empowerment. Unless extracted from realist work, response mechanisms are often not made explicit in the literature. We will therefore examine all published sources for signs of underpinning mechanisms linking the particular contexts to the outcomes measured.

Outcomes: Our review is focused upon maternal mental health (promotion), ill-health (prevention and reduction) and improvement in wellbeing. Our definition of wellbeing was co-produced with mothers during the development of this application and includes wider outcomes and indicators including reduction in parental risk factors (e.g. substance use, domestic violence and offending behaviour); reproductive, sexual health and family planning; preparation for parenthood; improved experience of separation and loss; service engagement; housing security and stability. Child outcomes of prevention of care entry and reduction of number of days in care will also be included.

As recommended within realist syntheses, the search strategy will be modified and re-administered iteratively as and when new lines of enquiry emerge (Booth & Carroll, 2015; Wong et al., 2013). For example, new searches may be required following an appraisal of the evidence which identifies only low rigour evidence (discussed in 2.3); where programme theory(s) may require further evidence to support iterative testing and refinement (as discussed in 2.2 and 3.1) or to inform actionable recommendations which address system level factors (as discussed in stage 4). These new lines of enquiry will be continually considered within advisory group workshops.

2.2 Selecting and extracting and appraising data

Two reviewers will independently screen all titles and abstracts using the inclusion and exclusion criteria agreed with the advisory groups in stage 1, retrieving full papers for all potentially eligible studies, and evaluating in full text. Discrepancies at each stage will be resolved by discussion between reviewers or by consulting a third researcher if consensus cannot be reached. Relevant data within included evidence relating to the interactions of context, mechanism and outcomes will be extracted to enable testing and refinement of the explanatory theories. A bespoke data extraction template will be developed to allow for consolidation of data across evidence sources included within the synthesis. The template, based on the initial programme theories, will structure the extraction in order that evidence on what appears to work, for whom, how and in what contexts is documented. We will use broad questions within defined fields to focus extraction on key themes of the research, whilst not restricting data extraction in relation to the diversity of information presented within the papers. The following broad data extraction fields will be used:

- Publication details (author/title/date)
- Study description (location/sample size/study period)
- Intervention details (summary/key mechanisms)
- Contextual conditions (description)
- Outcomes (description)

The data extracted will be used to test and refine the context-mechanism-outcome (CMO)[2] configurations relating to the initial explanatory theories, identifying weak points in the chain (see 2.3 appraising the evidence). We will start by considering outcomes, looking for patterns within these or 'demi-regularities' and then seek to explain them through CMO configurations (Cooper et al., 2020). This evidence will be discussed iteratively in advisory group workshops and synthesised to refine, adjudicate between, or refute developing programme theory(s) (as discussed in 3.1).

2.3 Appraising the evidence

Our review will gain explanatory depth from using a wide range of evidence sources. As such, traditional quality appraisal tools utilised within systematic reviews is insufficient. Instead, we will appraise the evidence based upon rigour, richness and relevance (Booth et al., 2013; Wong et al., 2013). Evidence which is of high relevance and richness will be included. We define this as both conceptual richness (the extent to which an evidence source explains how an intervention is expected to work) and contextual richness (the extent to which an evidence source enables the reader to establish what is occurring in the context) (Booth et al., 2013). In recognition of the iterative nature of realist reviews, evidence that is of low relevance and/or richness may be excluded initially and retained for future consideration according to its fluctuating utility to the developing theory (Dada et al., 2023). Studies which are included based upon relevance and richness will then be assessed on rigour (Wong et al., 2013). As recommended by recent guidance (Dada et al., 2023), we will appraise trustworthiness at a data level based upon methodological quality whilst theory level trustworthiness will be determined by its coherence. We define a coherent theory to be consilient (explains the data), simple (makes few assumptions), and analogous to substantive theory (aligns with existing credible theories) (Dada et al., 2023). High rigour evidence will be included whilst low rigour will result in further evidence being sought or the transparent reporting of the resulting theory as being of lower confidence (Dada et al., 2023).

[2] Whilst realist search strategies are structured as CIMOs is recognition that many studies will describe interventions by 'type' rather than their active ingredients, programme theories focus upon mechanism (resource and response) and not interventions hence they are referred to as 'CMOs'.

Box 2: hypothetical if, then statement progressed (for illustration purposes only)

> Following child removal (context), if a mother feels validated in her grief (mechanism), she may cope better and be less likely to develop anxiety and depression (outcome).
>
> When a mother has already experienced care proceedings (context), if this was undertaken in a compassionate way (mechanism), she is more likely to engage willingly in subsequent child protection invention and care entry is more likely to be avoided (outcome).

Stage 3: Testing and refining programme theories (objective 5)

3.1 Stakeholder advisory groups

Within stage 3, we will conduct a minimum of four theory-driven workshops with the advisory groups (two with mothers and two with practitioners). We will present and discuss themed evidence within and across our initial explanatory theories. Taking our original 'if-then' statements, we will co-construct chains of inference to develop CMO configurations (Pawson et al., 2005; Rycroft-Malone et al., 2012), with explicit reference to the underpinning sources of evidence. Findings from different studies will be compared and contrasted to identify occasions of confirmation and contradiction, with a detailed record of the process documented. We will use a combination of abductive[3] reasoning to seek the most plausible explanation for the hypotheses, and retroduction[4] to identify hidden causal forces that lie behind identified patterns. We will then examine complexity within the context with specific reference to the interaction between the mother and the health and social care systems, and how this contributes to the activation (or not) of the intervention mechanisms. We will apply deductive reasoning[5] to test the programme theories with the advisory groups. The iterative engagement with evidence will result in the consolidation of the programme theory(s). We will co-produce vignettes with advisory groups relating to each programme theory for final discussion within stage 4 stakeholder advisory groups.

Stage 4: Synthesising the data (objective 6-8)

Our synthesis will produce a programme theory(s) of what works to support the mental health and wellbeing of mothers at risk of recurrent care proceedings and/or prevent care entry of their children, the circumstances in which this happens and why. For illustration purposes we have included example programme theories which are informed by our previous and on-going work with birth mothers at risk of recurrent care proceedings (box 1 and 2). We will examine the patterns of outcomes relating to the mental health and wellbeing of mothers and care proceedings/duration of care separately (see box 2), as well as how they interact with one another. This recognises the 'ripple effect' of interventions (J. Jagosh et al., 2015) wherein support for mothers at risk for recurrent care proceedings are 'events in the history of a system, leading to the evolution of new structures of interaction and new shared meanings' (Hawe et al., 2009). This consideration of outcomes as they relate to one another will provide a framework to better understand how support accrues (or not) in stages, with the outcomes of one stage of the pathway informing or transforming the context for subsequent stage (see box 3).

[3] Abductive reasoning is a form of logical inference that seeks the simplest and most likely conclusion from a set of observations.

[4] Retroduction involves going back from, below or behind observed patterns or regularities to discover what produces them.

[5] Deductive reasoning is a logical approach to progressing from general ideas to specific conclusions.

Box 2: hypothetical programme theory of single outcome (for illustration purposes only)

Non-judgmental emotional support in the form of time with their baby, memento provision and companionship provided to the mother (resource mechanism) during, and within the period immediately following, removal (context) may result in the mother feeling her grief is recognised and validated (reasoning mechanism) and prevent the development of a mental health problem or increase in substance use (outcome).

Box 3: hypothetical programme theory of interaction of outcomes (for illustration purpose

only)

A mother whose prior experience of removal consisted of non-judgemental and compassionate support means she anticipates a caring service during a subsequent pregnancy (context). When a new child protection plan is implemented (resource) she experiences reduced threat; viewing the system to be concerned with her needs, as well as that of her baby (response), meaning that she is more likely to engage proactively, and care entry is more likely to be prevented (outcome).

We will discuss the CMO configurations and the evidence underpinning these within the advisory workshops (Rycroft-Malone et al., 2012). We will conduct separate workshops with all three of our advisory groups, presenting the vignettes developed following stage 3 and discussing what needs to be in place for implementation of programmes to support mothers, with specific reference to supporting the mental health and wellbeing of this population and preventing care entry of their children.

After consolidating the programme theory(s), we will apply a system lens to our programme theory by building upon the stage 1 policy workshop and the system complexity examined in our theory-driven advisory groups. Using systems mapping techniques, we will collaboratively explore visually how interventions interrelate and interdepend with differing health and social care systems. Drawing on critical systems heuristics (Ulrich, 1996) we will assess stakeholder judgements and understandings of intervention boundaries to better understand their complexity and interaction with the wider system. We will characterise the service models, pathways and the wide range of formal 'carescapes' to co-design accessible maps (Dalkin et al., 2018) which capture details of health and social care provision for mothers at risk of recurrent care proceedings. See Figure 1 as an example systems map from an NIHR-funded study on inter-service co-ordination for children experiencing domestic abuse and mental health difficulties. The maps represents positive and mixed communication experiences between services from the perspectives of service professionals.

Figure 1 – Map of inter-service relationships[6]

We will characterise the service models, pathways, specialist interventions and innovative practice, examining contextual factors that our analysis suggest will influence success. We will employ a transformation approach to our systems methodology, facilitating stakeholders to identify enabling conditions (García-Moreno et al., 2015) for more effective working practices. In doing so, we will co-produce the system modifications, promoting contextual relevance and practice implementation of interventions to support the mental health and wellbeing of mothers at risk of recurrent care proceedings and prevent their children being taken into care. We will overlap our programme theory to this systems thinking to co-produce actionable policy recommendations about how interventions should be implemented (Claire & Geoff, 2023).

[6] Taken with permission from a forthcoming publication from the Children and Families Policy Research Unit. This study is funded by the National Institute for Health and Care Research (NIHR) through the Children and Families Policy Research Unit (PR-PRU-1217-21301). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care

Project timelines

Table 1: Project timeline

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Apply for ethical review																		
STAGE 1: DEFINING THE SCOPE																		
background search																		
Develop initial explanatory models																		
Stakeholder workshop (senior leaders)																		
Stakeholder workshop (mothers)																		
Stakeholder workshops (practitioners)																		
STAGE 2: RETRIEVING & REVIEWING DATA																		
Develop & implement search strategy																		
Select, extract & appraise data																		
STAGE 3: TEST & REFINE PTs																		
Stakeholder workshops (mothers)																		
Stakeholder workshops (practitioners)																		
Develop vignettes																		
STAGE 4: DEVELOPING A NARRATIVE																		
Consolidate programme theory(s)																		
Stakeholder workshop (mothers)																		
Stakeholder workshop (practitioners)																		
Stakeholder workshop (senior leaders)																		
Co-produce actionable recommendations																		
Produce HTA report																		

Equality, diversity and inclusion

We are committed to equality, diversity and inclusion both within this particular evidence synthesis and also in achieving equitable services and support for mothers at risk of recurrent care proceedings. Mothers at risk of recurrent care proceedings are a marginalised group. They often report that services do not respond effectively to their needs and are underserved in research. As such, this project in itself is important in promoting the equality, diversity and inclusion of marginalised mothers. However, mothers who are at risk of recurrent care proceedings are not a homogenous group. They experience multiple disadvantages, the accumulative effective of which has been referred to as 'intersectional stigma'. The needs and experiences of mothers will vary particularly for mothers from underserved communities of Black, Asian and ethnic minority communities, mothers who have physical and learning disability, young mothers and mothers who are care experienced. These diversities are further influenced by frequent experiences of disadvantage such as substance use, domestic violence, mental health and imprisonment. These varying social identities of groups and individuals result in unique combinations of discrimination and privilege, producing contexts affect the activation of the intervention mechanism. Our realist approach recognises the importance of context and asks 'for who and in what circumstance' an intervention works (or not) and is therefore well suited to engaging with equality, diversity, inclusion and issues of intersectionality.

We will engage fully with these issues of intersectionality throughout. Specifically, we will:

- search for and synthesising evidence relating to different groups of mothers and continually pose the question: 'how does this theory apply to mothers whose social grouping is…[varied by age, socio economic status, ethnic and cultural background, sexual orientation, gender identity, care experience]. Evidence will be sought from countries with similar health and social care systems and not restricted to the global North.

- Convene diverse stakeholder advisory groups. We recognise that failure to engage diverse advisory group membership will result in important voices not being heard and programme theories which fail to consider potentially influential contextual factors. To mitigate this risk, we will engage a maximum diversity of advisors, taking into consideration NIHR equality, diversity, and inclusion guidance alongside available evidence about the key group and individual identities which contribute to their disadvantage (young mothers, care experience, substance use, domestic violence, mental health, learning disabilities, physical health conditions).
- We will engage mothers through established groups and services (such as Birth Companion, Reform, Recovery Justice, Pause and supported housing) to ensure appropriate support is in place before, during and after engagement activities.
- Convene additional, targeted advisory group(s) to address equality, diversity and inclusion characteristics based upon our evolving theory and/or gaps in our current advisory group membership. We anticipate a minimum of one stakeholder workshop convened with (additionally) minoritised mothers (for example via Motherhood Group who represent birthing people of Black ethnicity and NIHR Maudsley Biomedical Research Centre Race and Ethnicity Advisory Group)and/or mothers with disabilities (for example via Plymouth Highbury Trust | Supporting People With Learning Disabilities).
- We will work with interpreters as required.
- The research team will undertake EDI training.

We have worked with our PPI Lead co-applicant (KC) from Birth Companions and collaborators within local and national organisations supporting birth mothers (including Reform, Recovery Justice, Change, Grow, Live) and policy, practice, and academic colleagues from across public health, clinical psychology, social care, and the voluntary and community sector to develop this application. The composition of the research team provides maximum opportunity to recognise and respond to the equality, diversity and inclusion requirements of this project.

Ethics

As we are not undertaking primary research, ethical review is not usually required. However, our comprehensive PPI plan consists of multiple stakeholder advisory groups, including those convened with mothers at risk of recurrent care proceedings. Whilst mothers will be advisors (and not participants), we recognise the sensitive nature of this review. As such, we will apply to Newcastle University Faculty of Medical Sciences Research Ethics Committee.

We are aware that when discussing the sensitive topic of recurrent care proceedings, language is of pivotal importance. We will be mindful of language used within workshops to ensure that topic and cultural sensitivity is applied. We will be supported by working closely Birth Companions, Reform and Recovery Justice, alongside our practice collaborators. These colleagues will review all study documents, incorporating language that is inclusive and non-stigmatising.

Dissemination, outputs and impact

Dissemination

We will start early conversations with policy colleagues from the Department of Health and Social Care, NHS England and Department for Education. Through JW's existing networks and the DHSC liaison officer for the NIHR Children and Families Policy Research Unit (Co-Directed by JW), we will invite policy colleagues working on the following areas: Women's Health Strategy (DHSC), Start for Life (DHSC, conception to age 2y), Mental Health (DHSC), Safeguarding (NHS England and DHSC) and

multi-agency working in children's social care (DfE). We will produce and disseminate 2 page policy briefings with findings from each of our three stages (see timeline) around months 3, 12 and 16 months into the study, with opportunity for interested policy colleagues to have a virtual meeting with the research team after each of these 3 briefings. These meetings will take the form of group Q&A sessions or individual conversations, depending on level of interest and availability of policy colleagues.

Our review team benefits from the inclusion of a range of stakeholders and our research plan includes early and consistent engagement with government policy colleagues, senior leaders and practice colleagues (from across social care, health and public health). This is important to our knowledge mobilisation plans. Within stage 1 of the review, we will agree priorities for policy and practice, therefore producing evidence that is relevant and responsive. Within stage 4, we will employ a transformative approach to our system mapping, engaging services within the North East (where need is highest) and overlapping our programme theory with the local care pathway. This will result in co-produced system modifications, with actionable recommendations for policy and practice that is transferrable to other geographical locations. Our review team includes Birth Companions, who have an ongoing campaign for a national health and social care pathway for women who are at risk of child removal at birth. Our findings will be disseminated as part of this national campaign. Additionally, we will feed our findings into Integrated Care Boards and Associate Directors of Children's Social Care.

To further disseminate our findings, we will utilise our extensive networks and involvement in NIHR infrastructures. This includes holding a workshop co-badged with Fuse, Centre for Translational Research in Public Health: NIHR School for Public Health Research – SPHR) and NIHR Applied Research Collaboration Nort East North Cumbria (ARC NENC). These infrastructures both consist of an established network of practitioners from NHS, Local Authority, Office for Health Improvement and Disparities (OHID) and local and national third sector organisations. The PI (RM) leads the Children, Young People and Families research theme of the SPHR on behalf of Fuse and is deputy lead to co-investigator (JR - lead) of the Supporting Children & Families research theme for ARC NENC. We will produce a practice briefing report accessible via ICB nationally and disseminated via co-investigator associated local networks including the NENC Child Health and Wellbeing Network (JR is a Board member).

Outputs and anticipated impact

Key outputs will include evidence that will inform policy and practice and future research. In additional to producing the HTA report and a minimum of two academic journal articles, we will co-produce a system-level theory of change that will provide a conceptual framework and underpinning of interventions to support the mental health and wellbeing of mothers at risk of recurrent care proceedings, and where, how and why these interventions work (or not). This will be informed by engagement with mothers, practice and policy stakeholders about current strategies and policies. The theory of change will be of value to practitioners, commissioners and policy makers and aid them in decision making relating to the care pathway for mothers at risk of recurrent care proceedings. These research outputs will be relevant for a range of beneficiaries including researchers developing interventions for mothers at risk of recurrent care proceedings; health and social care practitioners, including those working in the community and voluntary sector; mothers at risk of recurrent care proceedings and their children and policy makers. Working in partnership with representatives from these groups will enable us to achieve these outputs and impacts.

An additional goal of this project is to inform and develop further interventions that can be evaluated in future research, for example through NIHR Health Technology Assessments, NIHR Health Services & Delivery Research or the Research Programme for Social Care. Specifically, we

anticipate a future project will evaluate the system-level changes achieved in the North East (via the North East targeted activities within stage 4), in order to produce evidence to inform service and system development nationally. A summary of the findings in lay language (inclusive of an infographic) will be produced. This will be provided to stakeholders who indicate they wish to receive a summary of the findings as well as being disseminated widely and available on key platforms (such as Birth Companions website).

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