Realist evaluation of an Integrated Pregnancy and Parenting Support Service (IPPSS) for mothers with drug and alcohol problems in Scotland

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Abstract

Background

Integrated multidisciplinary team approaches have been widely promoted for maternity services for women with drug and alcohol problems to support sharing of information, coordination of care and improve maternal and infant outcomes. National Institute for Clinical Excellence (2010) guidelines recommend woman-centred care, co-location of services, integration of multi-agency approach and non-discriminatory practices for this population. However there has been little research to evaluate the impact of this approach in the UK context.

Aim

To evaluate a local service in Scotland to identify how the service works, for whom and in what way and what context to achieve effective communication, information sharing and service user engagement in order to achieve improved maternal and infant outcomes.

Methods

The evaluation was in three phases: developing initial programme theories, testing theories and refining theories. A mixed methods approach included: shadowing practitioners, and conducting interviews and questionnaires with service users, staff and key stakeholders. Middle Range Theories including Trust Level Theory and Interactionist theories were utilised throughout the study to support theory development, testing and refinement.

Findings

Findings include:

1. Relational based practices reduce barriers to support and engage service users longer term.

2. Service ethos must be consistent across all agencies in policy agenda and practice to support integration.

3. Transparent approaches promote compassionate team working, improving staff morale and communication.

4. Stigma remains embedded within the wider social context and affects the interactions and success service users have with services.

Conclusion

To support the wider holistic needs, practitioners should be encouraged to embrace personal approaches moving away from professional facades. Overall, services should consider what practices and interactions might contribute to stigmatising and discriminatory experiences for this population. These findings advocate for reflection on organisational integration, promotion of relational based practices and consideration of the barriers to integration such as incongruent policies, guidelines, agendas and practices.

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I would like to dedicate this thesis to a courageous, passionate, yet gentle woman who always encouraged me to pursue my dreams and step up to challenges; my Granny, Margaret Gamble Golder Imrie.

Glossary

Definition of key terms

The terminology used regarding substance use, misuse and dependence has been widely debated and changed over time (Saunders, 2017). The two main sources for definitions are the International Classification of Diseases 11 (ICD-11, World Health Organisation, 2018) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, Williams and First, 2013). Many research sources and American clinicians traditionally use the DSM-5 definition of terms whilst European clinicians typically use ICD-11. Differences in terminology causes issues when comparing and contrasting research over time as definitions change and are used interchangeably.

Whilst health research aims to increase patient and public involvement it is highly important to use language which is accessible and non-stigmatising (Scottish Drugs Forum (SDF), 2020). Therefore, the following clinical terms have been defined, however several key terms will be used interchangeably throughout this document. I have chosen to use the terms “substance use” and “problem alcohol and drug use” when referring to “substance use disorder”. Terms including “misuse” or “abuse” will be avoided where possible as these have been noted through discussions with patients and public to be negative and stigmatising (SDF, 2020). When discussing or referring to a person, “people-first language” (SDF, 2020) will be used to ensure the person is credited with respect. Terms such as “person with drug use” will be instead of “drug user” and acronyms will be avoided.

Substance use disorder, as defined by the American Psychiatric Association (Williams and First, 2013) is: “a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress.” (This is classified as mild, moderate or severe depending on how many identifying factors someone presents in 12 months).

Disorders due to substance use: Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunction and sleep-wake disorders (ICD-11, WHO, 2018)

Disorders due to use of alcohol: Disorders due to use of alcohol are characterised by the pattern and consequences of alcohol use. In addition to alcohol intoxication, alcohol has dependence-inducing properties, resulting in alcohol dependence in some people and alcohol withdrawal when use is reduced or discontinued (ICD 11, WHO, 2018).

Problem drug use: Drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them (Advisory Council on the Misuse of Drugs, 2003)

Substance use: refers to the use of alcohol and/or another substance however does not include smoking of tobacco within this study.

Abbreviations and terminology

The Integrated Pregnancy and Parenting Support Service (IPPSS): Integrated co-located multidisciplinary team of health and social care practitioners who provide care in an outpatient capacity for pregnant and parenting women who have alcohol and/or substance use. Pregnant women are referred to the service from multiple sources e.g., midwife, GP, police, drug worker etc. An intensive outreach model is applied which encourages practitioners to work together to engage clients with the service, treat problem drug use and support families to meet the expectations of social work to allow them custody of their child. The service continues to work with parents for the first two years of the child's life although shorter intervention is more common. The multidisciplinary team comprises the following roles:

Addiction Psychiatrist: Practitioner who works closely with the Community Psychiatric Nurse (CPN) to provide mental health and substance use services for clients. Has overall responsibility for prescribing and care plans and assess and treats mental health.

Community Psychiatric Nurse (CPN)/ Drug/Addiction worker/ Community Mental Health Nurse (CMHN): Practitioner who supports clients with their substance use and mental health. Works to support harm reduction, recovery and abstinence and provides prescriptions for Opioid Substitution Therapy (OST) mainly Methadone and Buprenorphine.

Early Years Officer (EYO)/ Parenting officer: Practitioner whose responsibility it is to support parents to parent safely and assess their capacity to parent. This practitioner works closely with social workers to provide recommendations for child protection decisions as well as offering emotional and practical support to families.

Father worker/ Dad's worker: Practitioner who provides support specifically to partners of women who are involved with the IPPSS. Offering support to improve their health and social circumstances, encourage substance use treatment and offer emotional and practical support.

Health Visitor: Practitioner who provides support and care for the health, wellbeing and development of the infant, from pre-birth to school age. Also supports parenting and wellbeing of the whole family.

Midwife: For the purposes of this study a midwife within the IPPSS is a practitioner who provides community maternity care during pregnancy and the early postnatal period.

Obstetrician: Practitioner who provides obstetric care during pregnancy and postnatal period for women with complex or additional needs during pregnancy.

Terms used within the thesis

Throughout this thesis specific terminology has been used which are common within the local practice area. Additionally local dialect as outlined in Table 1has been used in the interview transcripts.

Case: The term "Case" is used throughout the thesis as a general term referring to a woman and her wider family e.g., partner, child in relation to their involvement with the IPPSS. Practitioners often use the term "case" when collectively referring to the management of service users receiving the IPPSS.

Client/Woman/Service User: Interchangeable terms used by participants to describe someone who is participating in the IPPSS.

Contact visit/ "contact": A supervised or unsupervised pre-arranged time for a parent to spend time with a child who is not in their custody.

Looked After Children (LAC): A placement for a child to live whilst not in the custody of their parents e.g., Foster Care, Kinship Care, Adoption. A LAC review is when this arrangement is reviewed in order to plan for a permanent place of residence.

Parallel Planning: Planning for two options for the infant, a permanent out-of-home placement or reunification with the parents.

Permanency Planning/ Permanency: Plans to arrange for a child to reside in a permanent out-of-home placement family e.g., kinship care or into another family.

Table 1. Local Dialect

Local dialect	
Arnae	Are not
Aye	Yes
Bairn	Child or baby
Cannae	Can't
Couldnae	Couldn't
Dae/ daeing	Do/Doing
Dinnae	Don't
Doesnae	Doesn't
Doon	Down
Fae	From
Hame/ hoose	Home
Ken	Know
Mair	More
Nut	No
Tae	To
Wasnae	Was not
Wee	Small
Wouldnae	Wouldn't

Overview of thesis

Introduction

This section provides an overview of the study, outlining the structure of the thesis, and the importance of my positionality in order to conduct ethical research. I will briefly situate maternal substance use within the Scottish context before describing the service that was evaluated as part of this realist evaluation. An overview of the policy context of maternity, child health and drug use strategies and guidelines will raise questions as to their utility in integrated services, leading onto development of the research questions for this study.

The need for evaluation

> *If I fell pregnant again…I would avoid going to the doctor to stop having to engage with [the service].*
>
> (Jo.)

> *They [the service] are just amazing [at] what they do, they should open [similar services up] in other parts of [Scotland].*
>
> (Morven.)

These two statements provide opposite views and experiences from two women who experienced the same service. Variations in success are inevitable, services do not get it right for everyone every time as wider contextual factors impact how services work. However, gaining insight into how services work or do not work for certain people can give services an opportunity to change and optimise, providing a better understanding of how future services may be more successfully implemented.

My position as a midwife has given me an opportunity to meet and support hundreds of women on their journey to motherhood. For most of the women I cared for, this was relatively straightforward. They became pregnant, enjoyed their pregnancy with the usual manageable symptoms, approached birth with trepidation whilst filled with excitement of meeting their baby and returned from the birth environment with their new addition to their family.

This expectation is not met by all women. The joyful experience of bringing a new child into the family can be clouded by risk, guilt, fear and judgement. For women who have drug and alcohol problems, the risk they pose to their child is acutely considered by health and social services during pregnancy and in many cases thought to be too high to allow the mother to care for her child. For these women, pregnancy is an anxious time, where they may feel guilt for how their actions may be affecting their baby. They may fear child protection services will remove their child from their care. Their mental and physical health is often poor, they face poverty and in many cases are affected by domestic abuse. Their lifestyle "choices" and behaviours are frequently examined under a Microscope and professionals pass judgement until the woman's capacity to parent has been decided (Stone, 2015). The transition to motherhood for women with drug and alcohol problems is far from the exciting and joyful experience had by most.

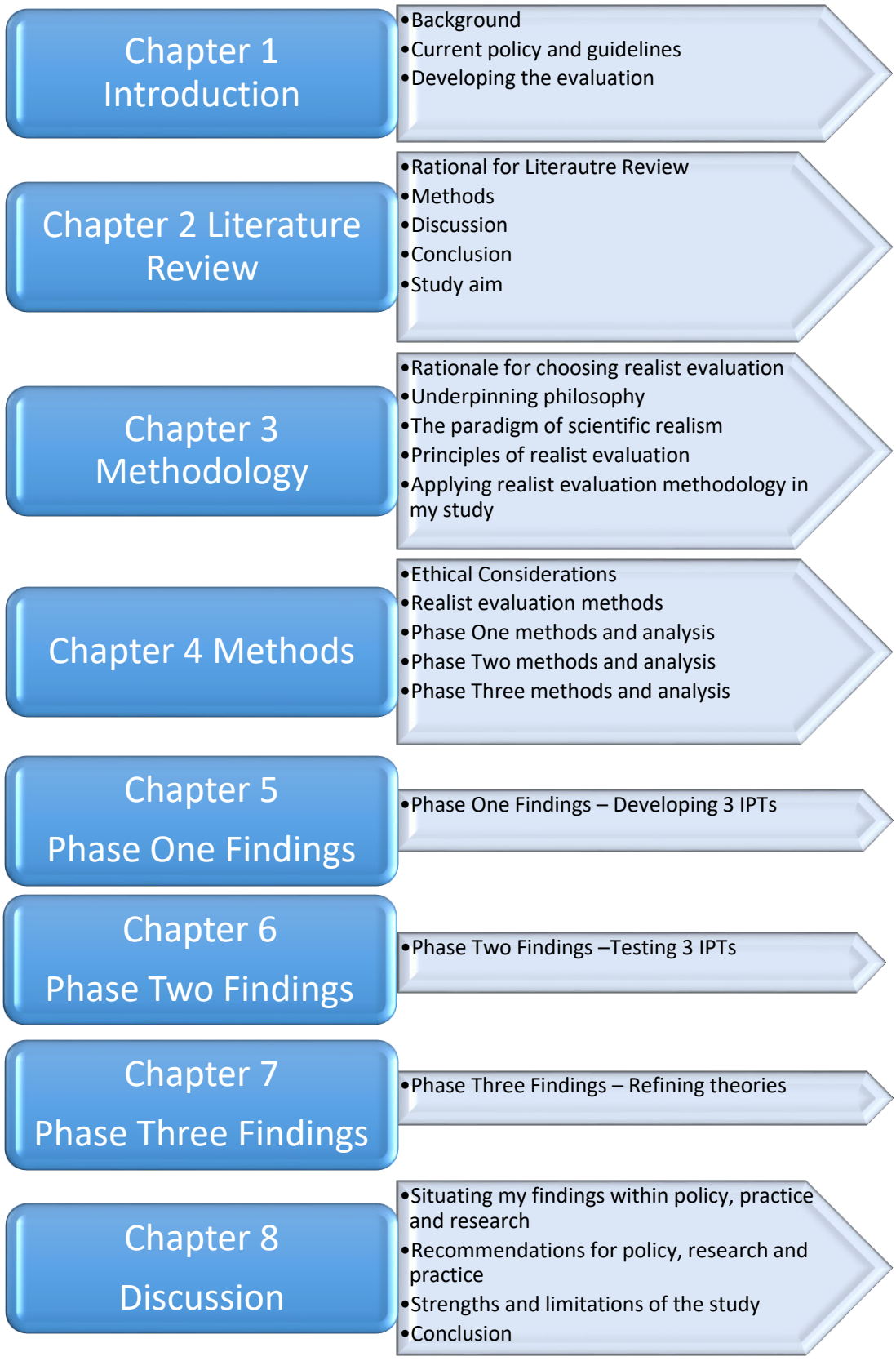
In many parts of the UK, integrated services are employed to improve outcomes for this population of women. This study aimed to evaluate an integrated programme for pregnant women with drug and alcohol problems. The service is a multidisciplinary team of health and social care practitioners who work with women who use drugs and alcohol, in an urban area of Scotland. The service aims to improve health and social outcomes for mothers, their babies and their wider family. This study aims to understand the complexities of integrated programmes for this population and how different outcomes are generated for different women. This study is not a critique of social work practice in Scotland, and it does not serve to undermine the seriousness of potential risk for unborn and newborn children. However, it does shed light on the implications of policy and practice agendas on individuals and how risk-averse practices can become embedded in all aspects of society. Thus (re-)producing mechanisms of Ethos and Stigma, which work strongly to counteract the positive mechanisms of Transparency and Inter-being, which need to be nurtured to provide a holistic and person-centred understanding. This study describes how these core mechanisms, at the centre of the intervention, work in both positive and negative ways to trigger different outcomes. These mechanisms are based on interactions at the Macro, Meso and Micro levels and work in conjunction with each other. As each mechanism interacts with another, their complex relationships and interchanges produce an overarching process which is greater than the sum of its parts.

Thesis structure

The thesis is structured into seven chapters, which explain the three-phase realist evaluation design of my study and is depicted in Figure 1.

- Chapter 1 Introduction, introduces the subject area of integrated services for pregnant women with drug and alcohol problems, including the service being evaluated.
- Chapter 2 Literature Review, comprises a narrative scoping review of the literature which considers the efficacy and experiences of integrated services for this population.
- Chapter 3 Methodology, outlines the principles and underpinnings of realist evaluation methodology and its origins in scientific realism.
- Chapter 4 Methods, outlines the ethical considerations, data collection methods and analysis applied in this study in a three-phase approach.
- Chapter 5 Phase One Findings, presents the findings from phase one (building programme theory)
- Chapter 6 Phase Two Findings presents the findings from phase two (testing programme theory).
- Chapter 7 Phase Three Findings, presents the findings from the final phase (refining programme theory) and outlines four key mechanisms which demonstrate the workings of the service.
- Chapter 8 Discussion, concludes the thesis, with a discussion on the implications of the study findings, strengths and limitations of the study and future research aims and recommendations.

Figure 1. Thesis Structure



Researcher position

My position within this study influences all aspects of the study from direction of research question, the delicate process of data collection with study participants and the intricate subjective analysis. The values, beliefs, experiences and perceptions I hold, permeate the decisions and interpretations I made. Researcher positionality has been reported to "affect the totality of the research process" (Holmes, 2020, p. 3) and is vital to explain in order to ensure the researcher has an awareness of their influences and ability to be accountable to their bias (Holmes, 2020). With this in mind, I would like to introduce myself to you the reader, to support your understanding of how this PhD study came to be, the process I undertook and the conclusions I have drawn.

I could now list for you several demographic descriptors, which you could interpret for yourself, however this would not do justice to my understanding of the social world. For you see, I believe there is more to a person than their labels. I view the social world as a wealth of interconnected moments, which help to grow the individual people we are with our unique qualities.

I am a compassionate and deeply caring person who has always been drawn to support the most vulnerable. By "vulnerable", I refer to those who face adversity due to external structures and internal resources rather than a blanket presumption of people unable to conform to societal norms (Brown and Wincup, 2020). When I was a school child, I would show empathy to the many homeless people I passed on my way to school. Always wanting to help them by offering a simple smile, all I could do at a young age. My mum would refer to the homeless as my "friends" as she recognised my interest, intrigue and genuine compassion for these vulnerable people.

As a midwife, I have continued to support vulnerable people – pregnant women. A strong desire to support women during the vulnerable and intimate process of becoming a mother led me to experience an almost inhumane labour suite in Tanzania. I held hands with a woman as we begged for doctors to show mercy and perform a lifesaving caesarean section whilst her family struggled to find the funds to pay for it. For me this was a glance into the inequalities that women, especially women in poverty, experience in developing countries.

However, working in New Zealand, I became part of the institutional effect that reproduces inequalities on many levels. I allowed a woman in my care to birth alone at home due to my naive perceptions of rules and processes which stood between the organisation, my autonomous practice and the woman's choice. Organisational structures and processes meant I left the side of women as they transitioned from primary to secondary care, freeing me to attend low risk women, only to benefit the pockets of my employer. I was no longer the help and support I wanted to be for women, I was part of the institutional problem, disregarding the person in the process.

I have also experienced the most vulnerable in my own neighbourhood, caring for a woman refugee who moved to Scotland to escape genocide when she was 35 weeks pregnant. In the two short weeks I cared for this woman before she transferred to Glasgow, I built the strongest relationship I have ever had with a patient in my care. We both had the same aim, to protect and ensure safety for her, her partner and her new child. I used the resources I had as a midwife and the empathy I held within me to ensure we met this goal. At this time, I had recently become a parent myself and reflected on this woman's vulnerability trying to imagine how I may have felt in a similar situation. Fortunately, I have not had to face such hardship.

However, I do not stand on one side of these experiences offering help and support, and never needing to receive it. I have also experienced personally, the effects substance use has on the family and friends who surround the person with substance use issues. This has given me insight into the different ways in which people manage their substance use, justify their use and what draws someone to the extent of their use.

With these experiences, I have a varied perspective on vulnerability, inequalities, institutional power, relationship building and insight into the lived experiences of those with substance use issues. Therefore, when I was given the opportunity to carry out this research project focusing on services for pregnant women with drug and alcohol problems I was highly motivated to undertake a valuable and useful piece of work. My decision to pursue realist methods, was both a strategic one (as outlined in Chapter 2 Literature Review, Chapter 3 Methodology and Chapter 4 Methods) and a personal one. I perceive my behaviours, and those of others, to be constructed by our interactions with the world around us. This aligns my perception of social reality with

realist epistemology and ontology (outlined in Ontological and epistemological perspectives), accepting that everything is real, even the unknown.

Despite these acknowledgements of my values and perceptions, I also accept that there is a part of me that I am unaware of as described by the Johari Window (Luft 1961, Figure 2). My researcher position highlights my open and hidden self but cannot account for my blind self and unknown self. However, the PhD process has reduced my blind self through reflective and reflexive practice. The process of reflection coupled with data collection and analysis has developed my skills in gaining perspective, self-awareness and strengthened the research process. Through my data collection methods I have followed the principles of realist methods, aiming to reach objectivity through repeated, rigorous subjectivity. Throughout this thesis, my reflective and reflexive accounts are presented to justify the decisions I made and conclusions I have drawn. It is my hope that my researcher position has strengthened the research process and contributed to a valuable contribution to knowledge which supports practitioners like me and the "vulnerable" families we support.

Figure 2. The Johari Window

	Known to Self	Not known to Self
Known to Others	**Open Self**	**Blind Self**
Not known to Others	**Hidden Self**	**Unknown Self**

Note. Adapted from Luft (1961)

Chapter 1 Introduction

Background

Substance use is a significant issue impacting multiple realms of society and estimated to cost the Scottish economy £3.5 billion annually (Scottish Government, 2009). The prevalence of substance use is suspected to be underestimated as alcohol and drug use is under-reported. Current prevalence data from general population surveys, state 6% of adults in Scotland reported using drugs in 2014/2015 (The Scottish Parliament and Scottish Parliament Information Centre, SPICe, 2017). Although this has reduced from 7.6% in 2008, Scotland has proportionally more people experiencing problem drug use than other European countries (The Scottish Parliament and Scottish Parliament Information Centre, SPICe, 2017). Data from maternity records in Scotland, show that 707 women reported drug use during their pregnancy in the 2015/2016 period (Information Service Division, 2016). Those living in the most deprived areas were five times more likely to use drugs during pregnancy, highlighting the association with social inequality (Information Service Division, 2016).

Problem alcohol and drug use in adulthood is closely associated with adverse childhood experiences (ACE), including abuse, neglect and witnessing violence (Anda et al., 2002). Many pregnant women with problem drug use are also affected by gender-based violence, poverty, low educational attainment and have experienced trauma (Dube et al., 2005). These social inequalities affect women's access to, and engagement with, maternity and other services and can often lead to late presentation to health services in pregnancy (National Institute for Health and Clinical Excellence, NICE, 2010).

Substance use during pregnancy is known to negatively impact neonatal birth outcomes and subsequent child development (Holbrook and Rayburn, 2014). Specifically Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD) are widely reported (WHO, 2014). Children living in families with substance use are at higher risk of witnessing domestic violence and experiencing violence, abuse and neglect (Velleman and Templeton 2007). An accumulation of health inequalities is thought to affect cognitive development (Hatzis et al., 2017) and toxic stress has been shown to impact health outcomes in adulthood (Harris et al., 2017).

Scotland's drug problem increased significantly in the 1980s when rising unemployment rates, and easier access to drugs led to younger and more vulnerable groups using drugs (Buchanan, 2006). Environmental factors in addition to epigenetics shows there is a clear trans-generational impact of substance use on families (Merikangas et al., 1998) and the wider society in Scotland (The Scottish Parliament and Scottish Parliament Information Centre, SPICe, 2017), highlighting the legacy on health of generations in poverty. In order to address these inequalities and improve the health and social wellbeing of the mother, baby and the wider family, complex interventions are required to address multiple factors (NICE, 2010). In response, "integrated" services for pregnant women with problem alcohol and drug use have been established since the 1980s (Klee et al., 2003) and there are now specialist teams in most major urban areas in Scotland and the UK.

Addiction services have been predominantly male dominated by androcentric approaches to health and social care research in general (Rosser, 1994, Holdcroft, 2007). Whilst women make up a smaller percentage of the drug using population (SPICe, 2017), they face disparate social comorbidities and require specific treatments and approaches (Valentish, 2018, National Institute on Drug Abuse, 2019). As highlighted above, experiences of trauma are antecedent to substance use issues. A recent shift towards a greater understanding of trauma and the need for trauma-informed services has been evidenced (Waddell and Karatzias, 2019) and included in policy (Scottish Government, 2021) and practice (Poole, 2013). This approach considers the bigger picture, expanding the narrative from substance use and acknowledges the causes for the behaviour (Dowsett Johnson, 2013).

The service

The Integrated Pregnancy and Parenting Support Service (IPPSS) is a multidisciplinary (MDT), multi-agency, co-located model which cares for up to 30 women per year, with drug and alcohol use, who are otherwise disengaged from services. Based on current recommendations by NICE (2010) and current Scottish policies for the provision of health and social care for families affected by alcohol and drug use: Getting our priorities right: good practice guidance for children and families affected by parental substance misuse (Scottish Government, 2013b), the service aims to: "reduce substance misuse and related harm to mother and child by providing health care,

social care and support throughout the pregnancy and where necessary up to two years post birth" (Anon, 2021).

The service has been established in an urban area of central Scotland for 15 years, changing focus over time depending on policy and funding opportunities. The service consists of practitioners from maternity, addiction, child and mental health services who offer pregnancy and health care, drug counselling, parenting and social support, in one service. Whilst the service covers maternity, addictions and social care, the service does not function in a "one stop shop" approach which allows clients to see all professionals in one clinical space, instead it provides an inter-agency outreach model in which practitioners provide appointments in clinical and home settings. The aim of the service is to improve outcomes by engaging women, commencing treatment for alcohol or drug problems, improving social stability, healthy lifestyles and parenting capacity.

Figure 3, demonstrates the care pathway from referral to outcome. Women are referred to the service through their GP or midwife, by social work services and in some cases the police, following disclosure of pregnancy during arrest. Each woman is allocated a case co-ordinator who is responsible for co-ordinating the practitioners for her case. The initial priority is for women to book their pregnancy with the specialist midwife and commence harm reduction therapy with the community psychiatric nurse (CPN often referred to as mental health nurse or drug worker). Harm reduction therapy (as discussed further in section Approaches to treatment) predominately involves opioid substitution therapy (OST), commencing a therapeutic prescription to avoid the use of street drugs. In most cases this is the prescribed use of Methadone or Buprenorphine to substitute opioids such as Heroin.

Following these initial steps, an Early Years Officer commences work with the woman and her partner if she has one. This involves building on the parents' strengths and working through a parenting programme: Parents Under Pressure (PUP). This programme has been formally evaluated elsewhere (Barlow et al, 2019). An obstetrician oversees the maternity care in close coordination with the midwife and an addiction psychiatrist oversees mental health care and substance use treatment with

the support of the CPN. All practitioners liaise with the unborn baby's allocated social worker who is separate to the team.

Women are encouraged to enrol in Self-Management and Recovery Training (SMART) Recovery, a 12-step model based on peer support (Beck et al., 2017) and practice relapse prevention techniques as part of harm reduction strategies, with the CPN. During the study the service had a specialist dad's worker who was employed to provide one-to-one support for partners, however this service has since stopped and funding has been reallocated to secure a further CPN to work with partners. Practitioners refer families on to Family Group Decision Making and Family Based Care, two services to support families through foster care and kinship care processes. The basis of these services aim to identify care providers for the unborn baby early, to support relationship building between the parents and guardian.

Following birth, the health visitor supports families at home with parenting skills and monitors the child's development. If the child is not in the parents' custody, the health visitor supports the guardians and liaises with the parents. In most cases Early Years Officers carry out a parenting capacity assessment (see Ward et al., 2014) with the parents which provides information for the social worker on the parents' ability to safely care for their child. This assessment and other child protection assessments, allow practitioners to decide what recommendations should be made in each case.

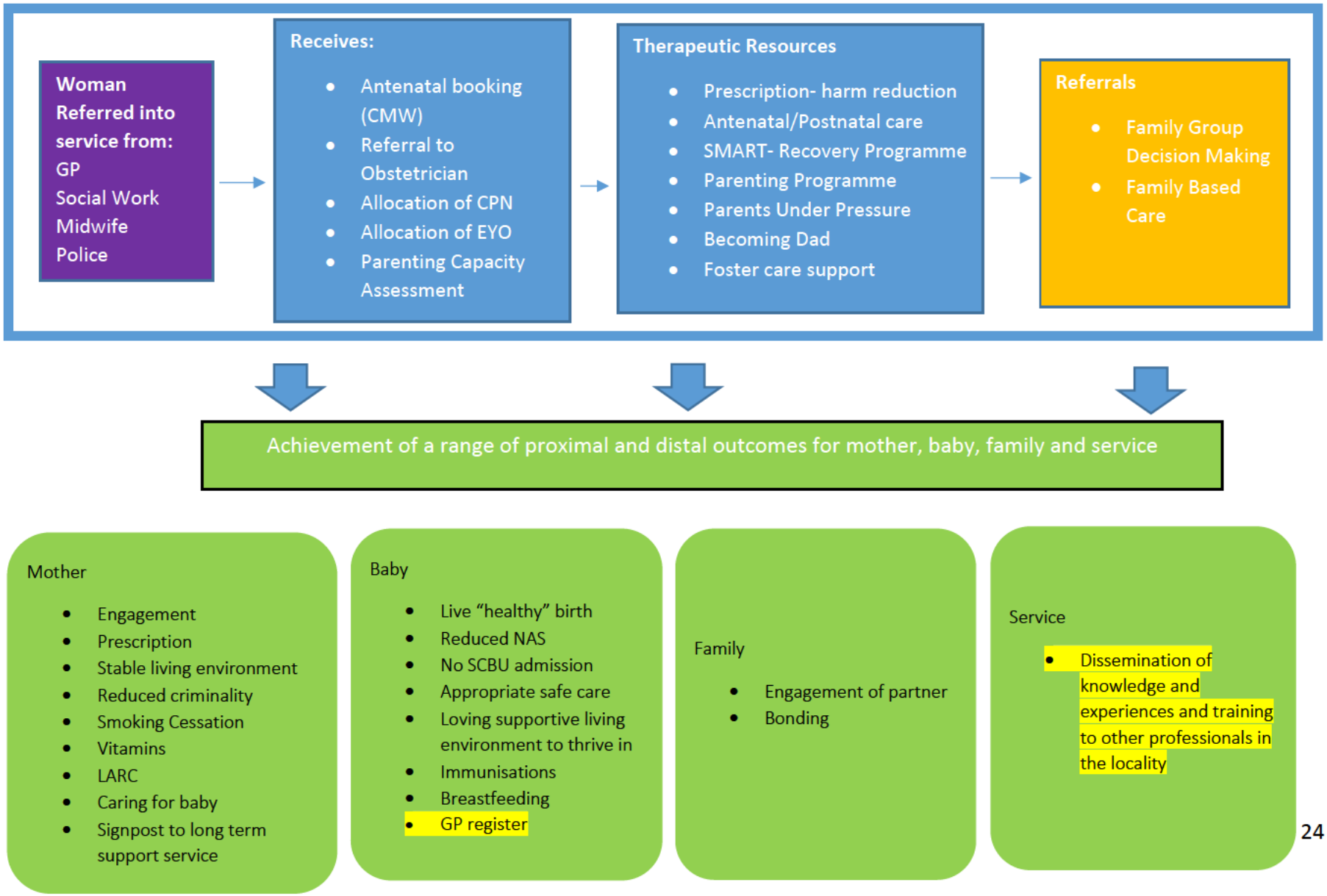
Throughout the service, national children and family wellbeing guidelines are followed in line with "Getting It Right for Every Child" (GIRFEC) (Scottish Government, 2016) which are further discussed in section Current policy and guidelines. Following these guidelines requires the development of a personalised "Child's Plan" (Scottish Government, 2016) to outline steps to ensure the safety of the child. During pregnancy, Interagency Child Protection Case Conferences are held to discuss and identify risks to the unborn baby and to decide if the unborn baby should be placed on the Child Protection Register in line with Scottish law. This register is held to inform all agencies that the child is considered to be at risk of abuse and neglect and that a Child's Plan is in place. Core groups are formed with the most important key professionals from health, education and social care, who are involved to support families whose child has a Child's Plan in place. A pre-birth planning meeting is held by

the core group prior to the child's birth to outline the expectations and support for the family. Following birth, a discharge planning meeting is held in the hospital by the social worker and members of the IPPSS prior to discharge of the woman and baby. Each individual case is context specific, and a variety of outcomes can present. Depending on whether a child is placed in the care of their parents, kinship care (placed with a family member) or are accommodated by local authority (Looked After Child- LAC), further reviews of the Child's Plan are carried out periodically. Throughout this time the IPPSS continue to offer support to parents with their drug and alcohol use, mental health and parenting skills. Point of discharge from the service is case dependant however, most families are discharged by the time their child is one year old. This time point varies depending on the parents' substance use, progress of the "child's plan" and child protection proceedings.

A range of proximal and distal health and social engagement measures and healthcare outcomes are achieved by the service for the woman, child, wider family unit and the service as outlined in Figure 3. Key proximal outcomes include engagement by women and their partners, live births and Opioid Substitution Therapy (OST), whilst distal outcomes include adherence to immunisation protocols, and dissemination of skills to other services.

Figure 3. The Service Care Pathway

Key: Purple — referral process, blue — inputs and outputs, orange — external referrals, green — outcomes.



The service model is based on an ecological approach to child development and uses Bronfenbrenner's theory of human development (Bronfenbrenner, 1977) and Maslow's Hierarchy of Needs (McLeod, 2018) to structure its approach. Bronfenbrenner's (1977) theory focuses on five environmental systems (Microsystem, Mesosystem, exosystem, Macrosystem and chronosystem) which interact with each other affecting child development (Bronfenbrenner, 1977) whilst Maslow's (1943) approach focuses on the physiological, safety, belonging, esteem and self-actualization needs of each child. In line with the principles of GIRFEC the child is placed at the centre of the service.

Most women entering the service have polysubstance use with most using heroin, benzodiazepines and Methadone. However, there has been a noticeable increase in crack cocaine and alcohol use in recent years. In the year prior to the study commencing, 33% of IPPSS babies were discharged at birth to the care of their mother which increased to 60% at point of discharge from the IPPSS. However, for the time period of my study data collection and the following year (2019 to 2020), 43% were discharged home at birth only increasing to 50% at point of discharge from the IPPSS. Most cases (88%) were managed by child protection procedures requiring placement on the child protection register with a small minority being managed via GIRFEC guidelines. Child protection concerns requiring children to be placed on the CP register in Scotland vary across local authorities with an average of 36% of cases relating to parental substance use (Scottish Government, 2016).

Current policy and guidelines

Maternity

At the time of the study commencing, The Refreshed Framework for Maternity Care in Scotland (Sottish Government, 2011) was the current framework in practice for maternity services in Scotland. This guideline highlights key aspects of maternity care provision which should be addressed in all local maternity services in Scotland. The framework aims to protect and promote the health and wellbeing of both the mother and family by providing person-centred, safe, effective and efficient care (Scottish Government, 2011). Emphasis on partnership working between maternity, local authority and third sector services aims to reduce health and social inequalities and improve the health and wellbeing of those most at risk (Scottish Government, 2011).

Recently, 'The Best Start' (Scottish Government, 2017a) was introduced as a five-year plan for the development and provision of maternity services across Scotland. The recommendations aim to address current changes in population health. Birth rates are increasing and women entering maternity services are older and have more comorbidities (Scottish Government, 2017a). There are also anticipated issues regarding workforce sustainability and retention due to an ageing workforce. The redesign of maternity services focuses on improving the quality of maternity services through multidisciplinary working, local accessible services and family-centred care as a national standard (Scottish Government, 2017a). Continuity of midwifery carer is at the centre of the maternity services redesign to optimise maternal and newborn outcomes by improving communication and effective relationships (Scottish Government, 2017a).

The National Institute for Health and Clinical excellence (NICE) published guidance for antenatal care for women with complex social factors (NICE, 2010), which includes women with substance use. These guidelines outline recommendations for the structure of services and build on the importance of a "woman-centred" approach to reduce stigma and improve engagement in services. However, the evidence base which underpins this guidance was considered poor in many aspects, as the studies reviewed were mainly outwith the UK context and it was not clear how aspects of service provision directly affected outcomes. The guidance was reviewed in 2018 however no further updated studies altered the guidance and the recommendations remained the same.

Woman-centred care

Principles of woman-centred care originate in feminist ideology drawing on the concepts of choice and control (Morgan, 2015). This approach has been a key principle of midwifery practice since the Changing Childbirth report (Department of Health, 1993) which highlighted the importance of services meeting the needs of women. Woman-centred care is a holistic approach to providing services, including the "emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself" (Fahy, 2012, p. 150). These principles assume that by supporting the individual woman, the wider family and community also benefit, thus increasing social capital (Putnam, 1995). Fundamental to this understanding of

midwifery practice is the relationship between midwife and woman and the fostering of trust to instil empowerment (Brady et al., 2019). However, an integrative review of woman-centred care (Brady et al., 2019), highlighted that the concept was interpreted as tokenistic, lacking depth and understanding. This raises issues in terms of service structure and implementation in practice when embedding principles of woman-centred care. This is especially relevant when risk is involved, be that maternal or neonatal risk. When providing care for a woman who has additional or complex social and or physiological needs or whose care preferences do not align with current obstetric guidelines, the midwife can risk working "with institution" (Divall, 2018, p. 28) instead of "with woman" (Bradfield et al., 2019, p. 1). Embedding woman-centred care within a child-centred agenda, also raises challenges for the midwife's ethical practice. In terms of maternity care for women with drug and alcohol problems, woman-centred care can be overshadowed by the dominant risk-averse nature of child protection (Lupton, 2012). However, in a society which is wakening up to the inequalities and prejudices towards women, as recognised in the highly publicised #MeToo Movement (Me Too Movement, 2017), a shift towards woman-centred care has gained momentum (Hill, 2019).

Early years

Early years guidelines have developed in Scotland following several pivotal changes in policy recommendations. Since the devolution of power to the Scottish Government in 1999, a strong political focus has been the investment in early years (Tisdall and David, 2015). The Getting It Right for Every Child (GIRFEC) (Scottish Government, 2016) practice model, recommendations from The Report of the Caleb Ness Enquiry (O'Brien et al., 2003) and Getting Our Priorities Right (Scottish Government, 2013b) focus on the integration between health, social care and education in order to safeguard children in Scotland. These guidelines have child protection at the focus of their agenda whilst acknowledging support for parents and the wider family is essential. A UK policy which shaped the landscape in terms of guidance, service structure and child protection practices with regards to parental substance use was Hidden Harm (Advisory Council on the Misuse of Drugs, 2003). This highly influential report highlighted the link between parental substance use and the implications it has on child development, and risk of child abuse and neglect. The report was produced

around the time of two high profile child protection cases (O'Brien et al., 2003, Laming, 2003), which added to the political context. The principles of the Hidden Harm report (Advisory Council on the Misuse of Drugs, 2003) embedded risk-averse policy and practice across the UK with regards to parental substance use.

Child-centred care

The GIRFEC National Practice Model (Scottish Government, 2016) was developed to assess risk and children's needs, in order to promote child wellbeing. Eight principles (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) feed into wellbeing at the centre of the model which works in conjunction with the 'My World Triangle' promoting consideration of the child's "whole world". The approach was introduced to support integration of services and work as an early intervention to improving outcomes for children, however a lack of definitions such as that of "wellbeing", raised criticism of the model (Tisdall and Davis, 2015). Findings from a review of the model reported "tensions" (Coles et al., 2016 p. 340) with regards to the role of professionals and how and for what purpose information is shared. The report also raised concerns regarding the scope to support young people's wellbeing and safeguard children (Coles et al., 2016). This model as with the other underlying early years' guidelines promote child-centred care, ensuring the child is at the centre of practitioners focus at all times to support their holistic needs.

Drug use

UK clinical guidance for the treatment of problem alcohol and drug use was recently revised by the Department of Health (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017). These guidelines focus on the importance of multi-agency involvement in drug treatment with a keyworker at the centre to develop and review treatment plans. The guideline highlights the need for trauma informed, stigma free services which deliver holistic person-centred treatment (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group 2017). In relation to pregnancy the focus is on 'stability' and harm reduction measures to improve pregnancy and neonatal outcomes.

The Scottish guideline "Rights respect and recovery" (Scottish Government, 2018b) builds on the UK guidance on drug policy within the Scottish context. Reiterating the

importance of integrated services, this drug and alcohol strategy focuses on the "human rights-based approach" (Scottish Government, 2018b) ensuring all aspects of human rights are addressed including health, social and environmental factors. Reducing stigma across society and a wider public health approach are recommended by the strategy to reduce barriers to treatment and improve the lives of those affected, including children and families (Scottish Government, 2018b). In relation to family rights Article 16 of The Universal Declaration of Human rights states: 'The family is the natural and fundamental group unit of society and is entitled to protection by society and the State' (United Nations, 1948), which was in place in the UK and Scotland at the time of this study. These guidelines and frameworks highlight the importance of multidisciplinary working to address the needs of the individual and focus on the tailored needs for the most at risk vulnerable families.

Family-centred care

"Rights, respect and recovery" (Scottish Government, 2018b), promotes a "whole family approach" through invested funding for families affected by substance use and joint working with all services. The guideline recognises the individual is likely supported by family, who shoulder the burden of their drug use and are affected in many ways. Children experiencing parental drug use are key in this and through joint working and integration of services, policies such as "GIRFEC" (Scottish Government, 2016) and "Rights respect and recovery" (Scottish Government, 2018b) can overlap and work in conjunction. However the guideline also advocates person-centred care which is trauma informed and stigma free, which are vital to engage people in services and promote holistic interventions. Acknowledgement of disparities in gendered experiences of drug use are recognised, especially with regards to parenting roles, highlighting a need for further research on maternity services for pregnant women with drug use.

Approaches to treatment

The current policy landscape overlaps in many areas such as the importance of centring the service around the person in its care. However, with competing demands of parent and child and overlap of their individual needs, it is no surprise that service integration has been a political target for the Scottish Government for over 20 years. The debate between abstinence and harm reduction has also been explored in relation

to parental substance use. Abstinence is the practice of refraining from any substance use as promoted in disease models of addiction (e.g., 12 step programmes such as Alcoholics Anonymous (AA) (Wilson, 1939)), whilst harm reduction involves several steps to minimise risk and stabilise the persons use (McMaster, 2004). In substance use treatments for pregnant women, harm reduction is the initial aim to reduce many risks including: Blood Borne Viruses (BBV), polysubstance use, risky sexual behaviour and criminality. By introducing a prescribed daily dose of opioid, Opioid Substitution Therapy (OST), can prevent withdrawal symptoms. Wider harm reduction measures as incorporated into integrated services have been evidenced to improve outcomes for mothers and babies (Racine et al., 2009, Niccols et al., 2012, Wright et al., 2012).

Developing the evaluation

The IPPSS has been highlighted as an example of good practice by NICE (2012), however the guideline produced by NICE (2010) is predominantly based on studies outwith the UK. Therefore it is not known how impactful the recommendations are within the Scottish social and policy context. As many disciplines work together drawing on different policies and guidelines there are potential tensions at play within practice. Although woman-centred services are recommended by the maternity frameworks, (NICE, 2010), child protection remains the focus for the early years guidelines (Scottish Government, 2016). Intense focus on the health and wellbeing of the fetus termed “natal-panopticonism” (Terry, 1989) is suggested to diminish a woman’s sense of power and ability to provide for and protect her pregnancy (Fahy, 2002). Lack of empowerment has been found to impact women’s engagement with services and the anticipated negative responses from midwifery and medical professionals is known to cause resistance in women (Morris et al., 2012). Therefore, these tensions in practice could negatively impact health and wellbeing outcomes for women and infants.

This study aims to evaluate the service using the principles of realist evaluation methodology (Pawson and Tilley, 1997). The study will explore the interactions between the contextual factors, programme resources and actors’ (practitioners and service users) responses to the programme, which may result in, and explain, different outcomes. With data supporting the efficacy of integrated programmes as outlined in Chapter 2 Literature Review, realist evaluation will allow for a greater understanding of

how, to what extent and in what circumstances, integrated services work. Identifying the relationships between disciplines in the service will highlight how the service offers a blended approach or produces tensions in practice. The study will take a predominately qualitative approach to data collection and analysis (interviews and observations) with additional questionnaires providing descriptive data. Routinely collected annual data in the form of service reports will be reviewed to provide an overview of the service.

The funding for this study was provided as part of the Clinical Academic Research Careers (CARC) Scheme between academic institutions, NHS providers and NHS Education for Scotland (NES). The purpose of the scheme is to "generate high quality, service-led clinical research to the benefit of patients and their families and embed research and systematic enquiry within service culture" (Lothian Clinical Academic Research Career (CARC) Scheme, n.d.). The study topic was selected by a local midwifery research champion group which is made up of clinical and academic midwives from the local health board and academic institutions. The focus of the study on a local multi-agency service for pregnant and parenting women with drug and alcohol problems was prioritised in line with Scottish Government focus to improve health and wellbeing outcomes for people from low socio demographic status (Scottish Government, 2013a). This study therefore focuses on the local setting of a service provided within an NHS health board in urban Scotland and provides a Scottish perspective of women with drug and alcohol problems during pregnancy. I applied to the CARC Scheme to undertake this evaluation as part of a PhD programme funded and supported by a local academic institution and NHS health board. The study was to evaluate a local service for pregnant women with problem alcohol and drug use (see section Definition of key terms) as the service had been in place for several years with no independent evaluation. I assumed the position as part of a clinical academic post to incorporate my clinical background in midwifery with the application of academic research in the local area. To ensure confidentiality of this small specialist service and the service users and practitioners involved in the service and the study, the service will be referred to as the Integrated Pregnancy and Parenting Support Service (IPPSS).

Chapter 2 Literature Review

Rationale for literature review

Two sequential systematic literature reviews were conducted to critically appraise the underpinning evidence for "Integrated" services and identify important elements for the evaluation process and inform my IPPSS evaluation. When the funding was granted, my research aimed to compare IPPSS with routine care in the same health board. However, when I began scoping the relevant literature it became evident that comparison studies and other methods had already been used to explore and test their impact on a variety of outcomes (Milligan et al., 2010a, Milligan 2010b, Milligan et al., 2011, Niccols et al., 2012). To identify any evidence gaps and strengthen the design of my evaluation I decided to conduct a systematic review of studies that compared the outcomes of integrated services for pregnant and parenting women with drug and alcohol problems to other types of services. I took a systematic approach to focus the literature search, critique the quality of evidence and synthesise the findings (Unit One: Background to Systematic Reviews, 2005). However due to the nature of integrated services as a complex intervention (Guise et al., 2017), a single systematic review did not provide the answers to the review questions and in fact raised more questions. Therefore, a second systematic review of qualitative studies was conducted. This chapter presents the findings from these two sequential systematic reviews.

Methods

Initially this review aimed to answer the question: 'Do "Integrated Programmes" improve outcomes for pregnant women who use substances?' focusing on experimental literature (Phase One). However, during the review process significant limitations were identified within the published evidence and a strong focus on neonatal outcomes rather than the woman centred approach highlighted in policy, became apparent (WHO, 2014, NICE, 2010). Therefore the scope of the review was broadened (Phase Two) by a second review to also answer the question: 'what are women's experiences of integrated programmes' and 'what are practitioners' experiences of delivering integrated programmes'. The methods used for Phases one and two are reported together in the next section but in reality, an iterative approach

was used going backwards and forwards between the two distinct bodies of literature to answer the review questions and to inform the evaluation design.

Search strategy

Definitions: An “Integrated Programme” was defined as a service which provides both antenatal care and drug services either as a co-located service or within a multidisciplinary team. The review was conducted in two phases: Phase One identified quantitative studies to determine effectiveness of Integrated Programmes on maternal and neonatal outcomes and Phase Two explored the experiences of women and staff working in or using an Integrated Programme. The PICO/ PEO framework (Stone 2002, Pollock and Berge, 2018) in Table 2 was used to inform the inclusion and exclusion criteria (Table 3). As the review was to support the design of the evaluation, inclusion and exclusion criteria were based on contextual factors. “Integrated programmes” which consisted of similar service providers as “The IPPSS” and residential programmes were excluded as this is not common practice within the UK setting.

Table 2. PICO/PEO

PICO	**Phase One: experimental**	**PEO**	**Phase Two: exploratory/qualitative**
P: Population	Pregnant substance misusing (as defined by WHO ICD-10 criteria) women	P: Population	Pregnant substance misusing (as defined by WHO ICD-10 criteria) women or Health Professionals working in Integrated programmes
I: Intervention	Integrated Programme (as previously defined)	E: Exposure	Integrated Programme (as previously defined)
C: Control or comparison	Routine care		NA
O: Outcome	Outcomes of importance: clinical and wellbeing outcomes for infant and women, pregnancy outcomes, addiction, behaviour change, satisfaction, empowerment	O: Outcome	Studies exploring women or staff opinions or experiences of using or working in an Integrated Programme
Design:	Experimental: RCT, Cohort and cross sectional studies		Exploratory using defined qualitative methods

Table 3. Inclusion and Exclusion Criteria.

Inclusion Criteria	Exclusion Criteria
• For Phase One only: Experimental studies are comparative studies examining an "Integrated Programme" vs control. • "Integrated Programme" is clearly defined within the study as including antenatal care e.g. midwifery or obstetric care combined with an addiction specific service as a minimum. • Population of participants involved in intervention are pregnant at the point intervention/or engagement with programme commenced. • Population must have a current alcohol or drug use disorder (as defined by WHO ICD-10 criteria) during participation.	• Studies which included residential programmes or interventions in which women are mandated to treatment via criminal justice system or child protection system. • Studies in which women's drug use was primarily for the treatment of a medical condition other than alcohol or drug addiction (as defined by WHO ICD-10 criteria). • Studies where participation commences after birth or during the early years.

PsycINFO, CINAHL, Medline and Web of Science databases were selected due to relevance to midwifery, health care and addiction. The search was conducted using Mesh headings and key words as outlined in the PICO and PEO practice (see Appendix 1. PICO and PEO MESH terms). A systematic approach was applied to database searching, screening and inclusion of studies in this review. Database searching took place in April 2017 and in addition, articles were identified through bibliographies of previous meta-analyses (Milligan et al., 2010a, Niccols et al. 2012). Duplicates were removed during exportation to EndNote reference manager. Titles and then abstracts were screened for relevance and subsequent full text articles were assessed by myself and one of my supervisors to determine eligibility for inclusion. Assessment was

conducted separately and any disagreement was resolved through discussion with another supervisor. The majority of excluded papers were studies of residential programmes, non-pregnant participants or descriptive articles. Appendix 2. PRISMA Table Phase One and Appendix 3. PRISMA Table Phase Two outline the process of study identification and inclusion through PRISMA diagrams. Although it is customary to re-run database searching if significant time has passed between the initial search and publishing review findings, I decided against this practice. As realist methods are a theory driven approach, I considered it antithetical to the methodology to update the literature search as theory development was initially stimulated by the original search and a subsequent search would have potentially altered these initial theories.

Analysis and quality appraisal methods

A data extraction table was used to outline each paper detailing author, year of study, country of study, participants and recruitment, intervention and comparison, data collection methods and results. Initially each study was critically appraised using the CASP tool (Critical Appraisal Skills Programme, 2017) by myself and my supervisors individually. However, it became clear due to the poor description of methods within the empirical literature that the CASP tools were too restrictive. Therefore a narrative reporting to the broad headings of the CASP tool was used to explore potential limitations and biases within each paper. The findings are presented under the following CASP headings: Are the results of the study valid? What are the results? Will the results help locally? Narrative reporting of the findings were considered the most appropriate method due to the significant heterogeneity of study methods, design and time span of studies.

Results of Phase One- Quantitative studies

Six studies were included in Phase One (MacGregor et al., 1990, Chang et al., 1992, Carrol et al., 1995, Egelko et al., 1998, Sweeney et al., 2000 and Armstrong et al., 2003). These studies dated between 1990 and 2003 and were all from the United States of America (USA). The studies comprise a retrospective cohort study (MacGregor et al., 1990), pilot study (Chang et al., 1992), RCT (Carroll et al., 1995), case control study (Sweeney et al., 2000) and two service evaluations (Egelko et al., 1998 and Armstrong et al., 2003), of which details are summarised in Table 4. The heterogeneity in study design, methods and outcomes contributed to significant

challenges when trying to compare the studies. Furthermore across all six studies limitations in study design were likely to introduce bias in interpreting study results. The potential biases included; limited information about methods and definitions, recruitment and group allocations, overlap between intervention and control conditions.

Table 4. Phase One Quantitative Studies Characteristics

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
MacGregor, S. N., Keith, L.G., Bachicha, J.A. and Chasnoff, I.J. (1990) Cocaine Abuse During Pregnancy: Correlation Between Prenatal Care and Perinatal Outcome. *Obstetrics and Gynaecology.* Vol 74 (6) 882-885. USA — Retrospective cohort study	Pregnant women who gave birth at Prentice Women's Hospital of North-western University (Jan 1984-July1987) **Group 1** (n=120) Cocaine use and receiving prenatal care at Perinatal Centre for Chemical Dependence. **Group 2** (n= 21) Cocaine use who did not receive prenatal care (less than 2 appointments). **Controls** (n=120) Matched pregnancies to Group 1 in maternal age, parity, ethnicity, obstetric service (clinic vs private) medical complication. Participants gave birth at same institution with no	**Group 1 —** "comprehensive care" Multidisciplinary team (MDT) including obstetrics, paediatrics, psychiatry, social services, nursing and dietary counselling. (no further description) **Group 2 —** no antenatal care, not registered with the above programme, received less than two antenatal appointments. **Control —** no details of routine care.	Retrospective document review — no description of data collection methods. Self-reporting drug use. Maternal Characteristics: Age, Parity, Prenatal visit, Drug use Obstetric outcomes: Gestation, Preterm delivery, birth weight, SGA, Placental Abruption, Congenital anomalies. Neonatal Data: Apgar score, Umbilical artery pH.	Gestation at birth was statistically longer and birth weight was statistically higher for those in Group 1 than Group 2. However compared to the control group, Group 1 had poorer obstetric outcomes showing association with cocaine use and obstetric outcomes despite antenatal care. There is no analysis of treatment effect.	Differences in size of cohort. No analysis of treatment effect. No recruitment methods reported- Query-retrospective case note review. Not randomised therefore potential for sample bias	Antenatal care is associated with improved neonatal outcomes for women with cocaine use when compared to no antenatal care however women with cocaine use will have poorer neonatal outcomes compared to women without cocaine use

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
	history of cocaine use. No recruitment methods detailed.					
Chang, G., Carroll, K., Behr, H. and Kosten, T. R. (1992) Improving Treatment Outcome in Pregnant Opiate-Dependent Women. *Journal of Substance Abuse Treatment,* Vol 9 (4) 327-330. USA — Prospective cohort (non-randomised)	12 pregnant women, who self-selected to participate in enhanced (n=6) or standard treatment (n=6). Age range 20-33 years old, majority single or divorced, 1/3 on parole or probation, between 16-33% from ethnic minority The demographics of the two groups were comparable but participants in the enhanced treatment group were more likely to be new to methadone maintenance treatment and there were more women from ethnic minorities in the	Intervention (enhanced programme): methadone treatment and additional therapies including weekly antenatal care and relapse prevention group, therapeutic childcare throughout treatment and urine screening three times a week with incentives of $15 if consecutive urine toxicology results were negative. Control (standard treatment): daily methadone treatment, counselling and random urine testing.	Maternal outcomes: measured by a combination of self-reported drug use and positive urine drug screen. Pregnancy outcomes: collected data on birth weight, birth gestation, and number of antenatal appointments attended. Methods and process of data collection not reported.	Increased birth weight for newborns of women in enhanced treatment group	Sample size too small to show significant effect. No power calculation. Self-selection into study arm Participants in the standard treatment group had declined to participate in enhanced treatment suggesting sample bias.	Early study considering "comprehensive service" for women on methadone treatment.

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
	standard treatment group.					
Carroll, K. M., Chang, G., Behr, H. and Clinton, B. (1995) Improving treatment outcome in pregnant, methadone-maintained women: Results from a randomized clinical trial. *The American Journal on Addictions,* Vol 4 (1) 56-59. USA-Randomised Control Trial (RCT)	20 pregnant women who were enrolled in the "Methadone maintenance programme of the Division of Substance Abuse" October 1990-September 1992 were invited to participate. 14 women took part in the study (n=7) in intervention (n=7) control. Women's characteristics: "non-minority", single unemployed in their late 20s, "frequent users" of opiates. Demographics are described (not tabulated) however it was stated there were no significant differences in demographics.	Intervention (enhanced programme): daily methadone treatment, weekly group counselling, urine toxicology (three times per week), weekly prenatal care with nurse-midwife, weekly relapse-prevention groups, incentives of $15 a week for three consecutive negative urine samples and therapeutic childcare during treatment appointments. Control (standard programme): daily methadone medication, weekly group counselling, urine toxicology screening (three times a week).	Maternal outcomes: Urine toxicology screening for cocaine, opiates or "other drugs". Attendance rates, methadone dose at delivery. Pregnancy outcomes: weeks' gestation, birth weight, length of stay in hospital.	Not powered to provide statistically significant results. Non-statistically significant differences in enhanced treatment versus control group: higher birth weight and longer gestation 40/40 vs 38/40. No difference in urine toxicology screening.	Small sample size, non-generalizable findings or statistically significant results. Underpowered. No description of methodology- data collection or randomization.	Early study suggesting elements of complex programmes which are acceptable e.g. childcare, regular antenatal care, group counselling. Appreciation that different participants may need different/varied incentives depending on severity of drug use. Possibility that more antenatal care linked to improved newborn outcomes NOT methadone treatment.

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
Egelko, S., Galanter, M., Dermatis, H. and DeMaio, C (1998) Evaluation of a Multisystems Model for Treating Perinatal Cocaine Addiction. *Journal of Substance Abuse Treatment*, Vol 15(3) 251-259. USA — Service evaluation	48 perinatal women admitted to day treatment programme during Stage 1 — September 1992 - December 1993 or Stage 2 — January 1994 - December 1995. Intervention (n=27) perinatal women with cocaine use in multisystem gender specific treatment programme. Comparison: (n=21) perinatal women with cocaine use in standard gender specific treatment programme. Equivalent but not matched.	Programme included: 1 year multisystem gender-specific perinatal programmes, intensive 5 day per week, clinic based treatment focusing on abstinence. Course content: relapse prevention, 12 steps seminars and meetings, stress management, self-disclosure and feelings management, tailored psychosocial counselling. Further gender specific treatment included parent education, women's health, antenatal care, social assistance. Multisystem approach involved outreach to include participants' family and friends in the treatment programme to increase sense of family support.	Urine toxicology. Retention in treatment as measured by interval between first to last day or treatment visit minus gaps in attendance of 1 month or greater — categorised into 1 month, 3 months or 6 months.	Multisystem gender specific model improved retention in programme participation and lead to increased negative urine drug screens. Negative drug screening increased from 89.5% to 95.7%. Retention rates at one month increased to 89% for multisystem programme compared to 57% for standard.	Limited discussion of methods. Possible retrospective study through case note review. No standardised definition of "cocaine use". History of drug use through self-reporting. Comparison group not matched	Multisystems gender-specific model improved retention in programme participation and led to increased number of negative urine drug screens.

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
	Highly disadvantaged, Black minority, low educational attainment, majority homeless, family history of drug use and self-reported chaotic upbringing.					
Sweeney, P. J., Schwartz, R. M., Mattis, N. G. and Vohr, B. (2000) The effect of integrating substance abuse treatment with prenatal care on birth outcome. *Journal of Perinatology, (*4) 219-224. USA- Cohort study.	Cohort study Two groups of voluntary women who enrolled in Project Link. Intervention: (n=87) women received Project Link intervention during pregnancy. Comparison: (n=87) women received Project Link intervention during the postnatal period.	Project link: Intensive outpatient programme providing support for addictions, crisis intervention, psychosocial and substance use assessment, individual treatment plan development, individual and group therapy, family and child therapy, home visiting, parent education and support and infant development assessment. Team of social workers, case managers of coordinators working in "close proximity" to hospital and prenatal clinic	Retrospective note review. Socio demographic data. Neonatal/ Birth outcomes: Birth weight Gestational age, NICU admission, APGARS, Infant toxicology. Profile of substance use: frequency of alcohol use, frequency of cocaine use, previous treatment, family history, partner drug use,	Birth weight was 418gm higher for those receiving antenatal project link and gestational age at birth was two weeks older.	Inconsistency in recruitment and retention. Self-selection bias. Variation of intervention and comparison. Analysis of outcome not including all confounding variables e.g. gestation, APGARS.	Birth weight and gestational age higher for women receiving antenatal integrated programme vs postnatal only service.

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
			age first tried alcohol/drugs. Numbers of Prenatal appointments per trimester.			
Armstrong, M.A., Osejo, V. G., Lieberman, L., Carpenter, D. M., Pantoja, P.M. and Escobar, G. J. (2003) Perinatal substance abuse intervention in Obstetric clinics decreases adverse neonatal outcomes. *Journal of Perinatology,* (23) 3-9. USA-Service Evaluation-	Sample: 6774 KPMCP- Kaiser Permanente Medical Care Program registered pregnant women. Retrospective cohort study consisting of 4 cohorts. Screened Assessed and Treated (SAT, n=782), Screened and Assessed (SA, n=348), Screened (S, n=262), Control (screened negatively) (C, n=5382).	Early Start Programme offered to women in (SAT) cohort. Provides diagnosis of substance abuse problem, counselling techniques, motivational therapy, CBT, psychodynamic therapy. Intervention linked with antenatal appointments and co-located in clinical area as an integral part of antenatal care.	Socio demographic profile. Neonatal outcomes- assisted ventilation, birth weight, gestational age, NICU admission, infant toxicology. Prenatal visits Substance use risk factors — frequency of alcohol/drug use, smoking. Risk questions — not validated questions.	Results: SAT, SA, S groups younger, SAT group more <19, single, low education, < income Vs C. SAT and C more likely to book prenatal care <13 weeks gestation compared with SA and S. SA,S higher rates of low birthweight, ventilation, pre-term than C.	Inconsistent recruitment methods and referral. Poor reporting of methods. Variation of context and care location. No justification of outcomes measured. No justification for confounding variables in multivariate analysis.	Women receiving treatment were more likely to have birth and neonatal outcomes similar to non-drug using women. However admission to NICU was still increased for all babies of women with substance use compared to non-drug using women.

Author, Year Country, Design	Participants and Recruitment	Intervention and comparison	Data collection methods	Results	Quality or bias	Comment or bottom line
Retrospective cohort study	Data collected retrospectively from KPMCP database.					

Are the results valid?

The initial screening using the Critical Appraisal Skills Programme (CASP) tool (Critical Appraisal Skills Programme, 2017), questions the validity of the study by critically appraising the purpose, recruitment, methods and potential bias. Each study was reviewed for their strength, however no studies were excluded based on quality.

In all six studies there was limited information on the methods; in particular reporting of recruitment lacked clarity and consistency. Two early studies (Chang et al., 1992 and Carroll et al., 1995) state participants were "invited" and "screened" however there is no description of these processes. There is no description of the randomisation or blinding process within the randomised controlled trial (Carroll et al., 1995). The two retrospective studies (Sweeney et al., 2000 and Armstrong et al., 2003) do not report the criteria used to select the case notes for their retrospective review and MacGregor et al. (1990) failed to include the recruitment methods entirely.

Definitions and recording of substance use also varied across studies. "Opiate dependent" (Change et al., 1992) "Opiate-addicted" (Carroll et al., 1995), "cocaine abusing" (MacGregor et al., 1990), "cocaine addicted" (Egelko et al., 1997) "substance abusers" (Sweeney et al., 2000, Armstrong et al., 2003) were all used to identify and describe the population. Self-reporting of drug use history and current drug use was the most widely used method of gathering drug use data. Again, the methods or definitions of these varied greatly across the studies. Amount "in bags" (Chang et al., 1992) and frequency (Carroll et al., 1995) were used in the early studies whilst a more comprehensive approach including screening questionnaires and urine drug toxicology testing were used in a large service evaluation (Armstrong et al., 2003).

Various design limitations such as sample size and variations in comparison groups introduced bias to the studies. The pilot study and RCT both had small samples (Chang et al., 1992 and Carroll et al., 1995) leading to limited analysis of data. Sample size of the intervention and comparison groups differed greatly in one study (MacGregor et al., 1990). These limitations suggest that without power calculations the studies would fail to detect statistical difference in outcomes measures. Demographic differences between the control and intervention groups were noted in two studies relating to ethnicity, parity and treatment history (Chang et al., 1992 and Sweeney et al., 2000).

Variations in intervention and control conditions were noted in three studies (Carroll et al., 1995, Sweeney et al., 2000 and Armstrong et al., 2003). It is not clear from the studies to what extent the participants received all aspects of the routine or enhanced treatments as there was no measure of dose effect.

What are the results?

The outcomes measured varied depending on the focus and scope of the studies (see Table 5). Five studies reported birth outcomes including gestational age and birth weight (MacGregor et al., 1990, Chang et al., 1992, Carroll et al., 1995, Sweeney et al., 2000 and Armstrong et al., 2003). The findings suggest higher birth weights and greater gestational age for newborns of women who received integrated programmes. Studies which included non-drug using women as a control found birth weight and gestational age for intervention participants were more similar to control participants than women with substance use not receiving the intervention (MacGregor et al., 1990, Armstrong et al., 2003). However, these findings could be due to chance as the studies were not powered to detect statistically significant differences in outcomes measured.

Increased antenatal care and increased retention in treatment for intervention participants were reported by all studies. Whilst in all studies those attending integrated programmes had an increase in antenatal appointments as part of the intervention, Egelko et al. (1998) found retention rates significantly improved for prenatal participants who received the intervention of a multi-systems programme when compared to those receiving standardised treatment. This is a frequently reported key finding which suggests that integrated programmes are more acceptable to this population and result in better service engagement and retention. This in turn, can lead to better outcomes for mums and babies, depending on the quality of the service and the interventions delivered.

Regarding maternal drug use; one study found more negative drug toxicology results for women attending integrated programme compared to standard treatment (95% vs 89.5%) (Egelko et al., 1998). However there was no difference in toxicology results between intervention and control groups within the small Randomised Controlled Trial (RCT) (Carroll et al., 1995) as the studies were not powered to detect differences.

Table 5. Outcomes Reported per Study

Author	Demographic data	Self-reporting drug use	Methadone dose	Urine toxicology	Retention rates/ Number of antenatal appointment	Gestational age	Birth Weight	Apgar Scores	Ventilation	NICU admission	Umbilical artery pH	Infant toxicology	Length of hospital stay	Obstetric complication
MacGregor et al. (1990)	✓	✓			✓	✓	✓	✓			✓			✓
Chang et al. (1992)	✓		✓	✓	✓	✓	✓							
Carroll et al. (1995)	✓	✓	✓	✓	✓	✓	✓						✓	
Egelko et al. (1997)	✓	✓		✓	✓									
Sweeney et al. (2000)	✓	✓			✓	✓	✓	✓		✓		✓		
Armstrong et al. (2003)	✓	✓		✓	✓	✓	✓		✓	✓			✓	

Will the results help locally?

The studies reviewed suggest that integrated programmes may improve neonatal birth outcomes including gestational age at birth, birth weight and reduction in Neonatal Intensive Care Unit (NICU) admission (Chang et al., 1992, Carroll et al., 1995, Sweeney et al., 2000 and Armstrong et al., 2003). Integrated programmes could also increase antenatal care received (Chang et al., 1992) and retention in treatment (Egelko et al., 1998). Despite limitations of the studies the results lend support for integrated programmes as an approach to tackling the implications of substance use in pregnancy. However, there are a number of further limitations when interpreting these studies within the context of local applicability.

The American context in which these studies were conducted is very different to the UK context. Overall America has a privatised healthcare system that restricts access to services (Lester, 2004). In Scotland all maternity care, child health and drug treatment services are publicly available through the National Health Service (NHS) and Local Authority. Access to services can be a barrier to receiving treatment but the reasons for these barriers will differ depending on the context e.g. NHS services in theory are available to all at point of delivery, however lack of resources such as money and transport may reduce access.

Legislation and prohibition of drug and alcohol use differ greatly across cultures, communities and countries. In many states in America using drugs and alcohol during pregnancy is considered illegal and a form of child abuse due to “fetal rights” legislation and child maltreatment laws (Mans, 2004). America takes a criminalisation approach in relation to drug use (Grant, 2009), for this reason disclosure of such use is often withheld. This is specifically relevant as most studies used self-reporting drug use as method of data collection. Although a woman in Scotland would not be imprisoned for drug use alone during pregnancy, child protection concerns are raised when a woman is known to use alcohol and drugs during pregnancy. This can deter women from disclosing the extent of their drug use however can also encourage honesty and cooperation with services to improve the chances of their child remaining in their care. Cultural and political approaches which differ due to their abstinence versus harm reduction focus, illustrate the complicated landscape for evidence-based practice which remains context specific.

Many women included in these studies were from ethnic minorities who are reported to have increased rates of drug and alcohol use, experience significant poverty and marginalisation. However this is not always the case and in the USA the majority of people with drug use problems are white. This highlights disproportionate reporting and discrimination of reporting on drug use during pregnancy (Roberts and Nuru-Jetter, 2011, Paltrow and Flavin, 2013). Anecdotal evidence from discussing practice with practitioners has informed me that the majority of women accessing the IPPSS are white, however they do experience significant health and social inequalities. Women from different cultural backgrounds have different reasons for, or barriers to, accessing services. The political or legal setting in which the service is set may impact the stigma or prejudice experienced by women.

Since these studies were conducted there have been many changes in the diagnostic criteria for substance use and the definitions and terminology used. As stated these above studies were conducted in America over a time period between 1990 and 2003. During this time the Diagnostic and Statistical Manual of Mental Disorders made several key changes. DSM-3 published in 1980 moved to a more medical model of diagnosis and less of a psychoanalytical perspective to substance use disorders. DMS-3 introduced the abuse/dependence paradigm based on pathological and physiological elements (Robinson and Adinoff, 2016). However this was soon criticised for its validity in the preceding revision DSM-4 and DSM-4 TR, revised the need for physiological dependence for diagnosis of substance dependence. By 2013 DSM-5 removed the abuse/dependence paradigm entirely and introduced a severity scale to improve validity (Robinson and Adinoff, 2016). These changes in definition and diagnosis highlight the social and political influences on mental health research and practice. The changes in legislation around substance use are transparent in the adaptations of the diagnostic tool. Not only do these changes over time influence the development of treatment over time but also the importance of social, political and cultural context in which they are presented. Robinson and Adinoff (2016) highlight that different opinions within practice of the aetiology of substance use disorder presents difficulties in providing evidence based practice. With this in mind these studies highlight the importance of conducting research within the specific context of inquiry and exploring context of substance use and treatment with consideration of political, historical and

cultural factors. Therefore, it cannot be assumed that similar services would have the same outcomes in different contexts.

Specific outcomes have been highlighted by each study in order to evaluate the success of the integrated programme. Each study focused on outcomes which were viewed by the researchers as relevant to the research aim, the majority of which being neonatal outcomes, suggesting the focus of integrated programmes is to reduce impact of maternal drug use on the neonate. This child-centred focus may reflect the political and legislative climate in which the programmes are situated but also highlights the disciplines in which the researchers are aligned including three from Paediatrics and Obstetrics (MacGregor et al., 1990, Sweeney et al., 2000, Armstrong et al., 2003) and three from Psychiatry (Chang et al., 1992, Carroll et al., 1995, Egelko et al., 1998). Although this review aimed to find out if integrated programmes improved outcomes for women and their babies, the assessment of maternal outcomes is somewhat limited. This is possibly due to the study design which predominantly measure proximal outcomes e.g. neonatal and birth outcomes and not more distal outcomes e.g. woman's mental health and recovery.

Further reviews which did not meet the criteria of this review, examined the impact of integrated programmes on specific outcomes including maternal mental health (Niccols et al., 2010) and parenting outcomes (Niccols et al., 2012). A recent study (Milligan et al., 2016) which is included in Results of Phase Two: Qualitative studies, developed a theoretical model for integrated care focusing on therapeutic relationships which enable emotional regulation and executive functioning for the client group. These studies recommend improvement of research methodology, quality of research and reporting (Milligan et al., 2010, Niccols et al., 2012).

Summary of Phase One

This first phase of the review considered the evidence for the effectiveness of integrated programmes for improving outcomes for women and their babies. This has highlighted that integrated approaches may lead to better outcomes for neonates, however the studies have limitations and the context in which these programmes are set limit the generalisability of findings to the Scottish setting. The guidance for services for pregnant women with alcohol and drug problems in the UK (NICE, 2010)

recommend a woman-centred approach. These studies fail to explore proximal and distal outcomes for women receiving integrated programmes or women's perspectives of services. Therefore, it was considered necessary to conduct a second review to explore the experiences and perceptions of women receiving integrated programmes and the staff who provide the services.

Results of Phase Two: Qualitative studies

A total of three qualitative studies were identified. These comprised: individual interviews with service users and practitioners (Toner et al., 2008) and focus groups with service users only (Lefebvre et al., 2010, Milligan et al., 2016). Study characteristics are outlined in Table 6.

Table 6. Phase Two Qualitative Studies Characteristics

Author, Year, Country, Design	Participants and Recruitment And Context	Focus	Data collection methods	Findings	Quality or bias	Comment or bottom line
Toner, P., Hardy, E. and Mistral, M. (2008) A specialized maternity drug service: Examples of good practice. *Drugs: education, prevention and policy,* Vol 15 (1) 93-105. Informa UK Ltd. UK — Mixed methods.	Clients: 19-34 Heroin, Crack cocaine, Benzodiazepines Methadone. Average use of drugs 10 years. 6 women, (4 pregnancy, 2 postnatal). Practitioners: 18 professionals from BMDS[1] and Drug Strategy Team Recruitment: Purposive maximum variation sampling. Women were recruited either by their midwife who passes their details on	The qualitative element of a mixed methods study aimed to find out practitioner and service user views on: 1. Service provision 2. Any perceived gaps in provision 3. Problems and issues in particular around partnerships and management 4. Good practice.	18 practitioner interviews Six service users interviewed. Tape recorded and detailed anonymised notes. NVivo 2 was used to aid thematic analysis.	Multi-agency and multidisciplinary working Early Engagement Non-judgemental approach Challenges of complexity Consistency and clarity Development	No reference to the study protocol receiving ethical opinion. Recruitment-Interviews were conducted immediately after recruitment in the clinical setting. Potentially participants would not have had enough time to fully consider participating prior to the interview.	Engagement and outcomes improved with specialised teams however multi-agency working has its own challenges regarding service structure and collaboration.

[1] The Bristol Maternity Drug Service (BMDS)

Author, Year, Country, Design	Participants and Recruitment And Context	Focus	Data collection methods	Findings	Quality or bias	Comment or bottom line
	to the researcher or by practitioners who approached the women in the hospital and gave them an information sheet and then met the researcher at this time. Context: A specialised maternity drug service.				Minimal quotes reported along with findings.	
Lefebvre, L., Midmer, D., Boyd, J.A., Ordean, A., Graves, L., Kahan, M. and Pantea, L. (2010) Participant Perception of an Integrated Program for Substance Abuse in Pregnancy. *Journal of Obstetric, Gynecologic and Neonatal Nursing, the Association of Women's Health,*	Comparison of two sites providing Integrated Care Models (ICM) for substance use in pregnancy. Toronto Centre for Substance Use in Pregnancy (TCUP n= 14. Methadone, cocaine, benzodiazepines, cannabis, nicotine, alcohol. 21-30, white,	Qualitative study to assess participants' perceptions of an integrated model of care for substance abuse in pregnancy.	Focus groups and 1 in depth interview. The authors ran the focus groups, however they did not have any previous contact with participants. Audio recorded Pseudonyms used.	Non stigmatizing service, feeling listened to and respected, seen as a woman/mother not drug use as noted in standard service. Physician-patient communication — supportive by their physician who had time for them, frequency of visits, referrals to other	No background to validate why/what prompts were used. Missing data from transcriptions. Limited discussion of the analysis process or critical	Women preferred integrated programmes which was perceived as non-judgmental. They were more likely to return for follow up appointments and perceived the team to be good communicators. Group support was highlighted as essential element to

Author, Year, Country, Design	Participants and Recruitment And Context	Focus	Data collection methods	Findings	Quality or bias	Comment or bottom line
*Obstetric and Neonatal Nurses. (*39) 46-52. Canada — Qualitative study.	high school education. The Herzl Methadone Clinic n=5. Methadone treatment, 40-48, white, high school education. Context: two Integrated Care Models for women with substance use during pregnancy. 1 large urban service based in Toronto and 1 small rural based service in Montreal. Both part of a Family Medicine Clinic. Background describes a woman-centred model of care. Personalised care plans generated by		Three authors analysed data independently and then a list of categories were agreed upon.	service. Previous experiences of not being given support for substance use, no referrals. Team communication — positive team communication noted by women in TUCP and improved in Herzl with addition of specialist nurse. Support groups — need for peer support (weekly) and postnatal. Self-responsibility — encouraged to disclose substance use to child welfare services to improve chances of child custody.	examination of the researchers' role.	be added to the service.

Author, Year, Country, Design	Participants and Recruitment And Context	Focus	Data collection methods	Findings	Quality or bias	Comment or bottom line
	nurse/physician depending on obstetric and substance use history.					
Milligan, K., Usher, A.M. and Urbanoski, A. (2016) Supporting pregnant and parenting women with substance-related problems by addressing emotion regulation and executive function needs. *Addiction Research and Theory,* Vol 25 (3) 251-261. Canada — Qualitative element of wider service evaluation.	Six integrated programmes out of 36 in Ontario were purposively selected to represent a range of geographic locations, size, and years of operations. Practitioners assisted recruitment by telling women about the study and disseminating flyers written by the researchers. N= 50 women currently or previously involved in one of six integrated programme were recruited. Six focus groups in total.	To develop a theoretical model of integrated treatment by examining how qualities and behaviours within the therapeutic relationship supports positive outcomes for pregnant and parenting women with substance-related problems. ER and EF lens applied to guide analysis.	Socio demographic questionnaire. Six Focus groups of total 50 women. $30 gift card to all participants. Audio recorded, transcribed verbatim. Two authors who attended the focus groups, separately coded the transcripts. Comparison and discussion took	Emotional Regulation: Non-judgement Empathetic listening Supportive Commitment In the moment and pre-emptive support for ER Flexibility based on client need Executive functioning:	Those recruited were those who had previously received treatment-possible bias results due to more motivated population. Lack of discussion regarding researchers' role.	The study developed a theoretical framework to support Emotional Regulation and Executive Functioning among women with substance use (pregnant and parenting). The model supports the importance of therapeutic relationships within integrated programmes and possible use of the theoretical model across other populations such as mental health.

Author, Year, Country, Design	Participants and Recruitment And Context	Focus	Data collection methods	Findings	Quality or bias	Comment or bottom line
			place iteratively throughout the analysis process.	Simplification of procedures/ navigating systems Action orientated/goal directed plans. Cueing, contacting reminding Parent coaching adapted to maternal learning style.		

Are the findings credible?

The initial screening using the Critical Appraisal Skills Programme (CASP) tool, questions study credibility by critically appraising the aims, recruitment, methods and potential bias. Overall the three studies had clear aims and the methods used to reach these aims were justified and appropriate. Two studies (Toner et al., 2007 and Milligan et al., 2016) were clear in their methods of recruitment and considered the possible ethical implications. Lefebvre et al. (2008) had limited description of recruitment although it was clear the participants had previously received the integrated programmes. A clear account of iterative analysis was evident in one study (Milligan et al., 2016) and another described thematic analysis process although was lacking in quotations to present data (Toner et al., 2007). Lefebvre et al. (2008) describe inter-rater reliability however limited description on the analysis process was given. Overall the three studies lacked reflexivity in their accounts of study design, data collection and analysis. There was limited description of the researchers' relationship with participants and the potential implications this may have had on the studies' findings.

What are the findings?

The findings from the three qualitative studies highlighted service user and staff perspectives of the integrated programmes. The main theme, which was present over all three studies, was non-judgemental approaches to care (Toner et al., 2007, Lefebvre et al., 2010 and Milligan et al., 2016). This was noted to be "fundamental" by the professionals and appreciated by the clients who felt supported by the service (Toner et al., 2007). Women reported a non-judgemental approach by professionals respected their dignity and saw the woman beyond her substance use (Milligan et al., 2016). Lefebvre et al. (2010) found a non-judgemental approach to women increased their likelihood of attending again as they felt they could disclose their drug use without judgement.

Team communication was highlighted by both professionals and women as a key element to integrated programmes (Toner et al., 2007 and Lefebvre et al., 2010). The opportunity for multi-professional meetings and forums improved communication within the team (Toner et al., 2007). Lefebvre et al., (2010) who compared urban and rural services found team communication was better in the urban setting than the

rural setting. To overcome this a nurse was introduced to the rural service to co-ordinate the team.

Communication between the practitioner and the woman was also found to be important as women expressed previous negative experiences of standard services who did not take the time to listen, educate or share information with them (Lefebvre et al., 2010). Communication in the form of contacting and reminding was an essential element of the service to support women's executive functioning (Milligan et al., 2016). Women were aware specialist practitioners had expert knowledge they could share with them, which was not evident in standard treatment (Toner et al., 2007). Empathetic listening was found to support women to openly disclose their challenges and concerns in order for services to be tailored to address their individual needs (Milligan et al., 2016).

One study which developed a model of therapeutic relationships to support emotional regulation and executive functioning recommends adoption of the model within integrated services for this population of pregnant women with substance use (Milligan et al., 2016). They found key therapeutic approaches such as empathetic listening, in the moment and pre-emptive support improved emotional regulation, whilst goal orientated plans and parent coaching, among other techniques, improved executive functioning.

Challenges and complexities of the service were increased due to different policies, philosophies and ethos between agencies (Toner et al., 2007) and approaches from child protection services (Lefebvre et al., 2010). Consistency and clarity in many areas including management, staffing levels, policies, information sharing, care pathways and referrals were noted to be lacking (Toner et al., 2007). This was a main concern for services covering two different hospitals (Toner et al., 2007).

Improvements to services were suggested including support groups with women who had similar experiences, drop-in sessions and further postnatal support (Lefebvre et al., 2010, Toner et al., 2007). Toner et al. (2007) also identified a need for improved training in referral and child protection and inclusion of partners and family members in the service.

Will the findings help locally?

Toner et al. (2007) is the only UK based study included in my literature review, which supports the consideration of study findings to my local setting while also highlighting the limited nature of UK based research. The majority of other publications in the UK are descriptive accounts of integrated services. Additionally the study highlights the importance of the perspectives of both practitioners and service users, which is the approach currently being advocated in global research practices (Gray-Burrows et al., 2018). Interestingly the challenges and concerns raised are at organisational level which may be applicable across integrated models situated in different sectors. Specifically when integrating different disciplines, Toner et al. (2007) found team ethos, philosophies and focus were not aligned and was evident in across agency working with police, criminal justice service and primary care. When considering the policies and guidelines in the UK and Scotland, it is possible these issues may also be present in the local setting.

The context in which the others studies were conducted must be considered. One study (Lefebvre et al., 2010) which looked at both rural and urban settings found differences in the population, frequency of service used, and challenges e.g. team communication. It is therefore fundamental to consider the Macro, Meso and Micro context in which an integrated service is set before assuming similar proximal and distal outcomes will be achieved.

Both Lefebvre et al. (2010) and Milligan et al. (2017) studies were conducted in Canada where substance use is approached in a harm reduction model to reduce health and social inequalities (Pauly, 2008). This is similar to the approach in the UK and Scotland and differs to the criminal justice and abstinence approach which dominates in the USA (Grant, 2009). Because of this harm reduction approach the findings from these two studies are more relevant and applicable to the UK setting, which aims to support harm reduction measures as well as promoting longer term recovery.

One study which considered the framework of integrated services focused on the core relational aspects of the intervention as part of a larger evaluation of integrated services. The study (Milligan et al., 2016) sampled 50 women from six different integrated services which gives a broad sense of the key aspects of care across

different geographical settings, size of service and length of time established. This study design enables the findings to be more generalizable and more transferable due to the sample size and number of research settings included in the study.

Summary of Phase Two

These three studies discuss the women-centred or person-centred approach to services which is a key policy and guideline focus in the UK. This is likely because these studies were conducted more recently than the studies in Phase One and again because of the harm reduction focus vs the criminalisation of drug use due to their geographical location. The authors of these studies were from mental health and drug treatment backgrounds whose philosophy of care may differ from Paediatric or Obstetric led services noted in the studies in Phase One. With this in mind these findings aid the development of my study design including the evaluation of a woman centred approach and the impact on outcomes.

Discussion

There is evidence that an integrated approach to maternity care for pregnant women with alcohol and drug use as per NICE recommendations (NICE, 2010) improves neonatal outcomes and engagement and retention in treatment, although the evidence which informed the recommendations were noted by NICE (2010) to be of low quality. My review of the literature reiterated that studies comparing different models of care were of low quality and all based in the USA. I did not identify any new studies since the NICE (2010) recommendation was published. Overall there was some evidence to suggest that integrated models may lead to better outcomes for babies. Furthermore qualitative studies indicate that women find such services to be accessible and acceptable. However methodological limitations of the published comparison studies highlight the need to conduct more robust evaluation of such services. Reviewing these studies emphasises the importance of considering the service and study context when evaluating or implementing such care pathways.

Despite the link between health outcomes and substance use during pregnancy, standardised measures and reporting were not used, meaning the outcomes of the studies are difficult to compare. Recommendations by the World Health Organisation (2014) suggest improvements were needed in standardised research design and outcomes to enable comparison across studies. Measurable outcomes in research

should include properties of reliability, validity and variability (Velentgas et al., 2013). Consistent definitions in line with a standard approach such as WHO ICD 11 criteria (World Health Organisation, 2018) or DSM 5 (Williams and First, 2013) is recommended in further studies to ensure there is consistent reporting and the opportunity to compare studies.

A limitation of the design of the studies in my review is the lack of discussion regarding any Behaviour Change Theories (BCT). As it is behaviours such as drug use that are a core element of integrated services, understanding how interventions theoretically change behaviour is a fundamental part of service design (Michie, 2012). BCTs are also relevant when considering the impact of services on behaviour outcomes. For example the majority of participants in the qualitative studies were engaging or had engaged with services. This may imply that participants are in some way motivated to change their behaviour and therefore their experience of services may be different to someone who is not yet motivated. There is more to BCT than individual motivation; understanding the impact of these factors could provide the theoretical underpinnings for an integrated service and improve understanding of how and why integrated services have different outcomes for different service users. Although this lack of BCT is acknowledged as a limitation within most experimental studies (Carroll et al., 1995, Sweeney et al., 2000 and Armstrong et al., 2003) none of the studies reported considering this within their design. This may reflect the time in which these studies were conducted as the volume of literature now available on BCTs demonstrates the growth in this area especially regarding substance use behaviour.

Whilst experimental designs have shown neonatal outcomes, including gestational age and birth weight, are influenced by attendance to integrated programmes, these studies lacked a greater understanding of how these outcomes were achieved. There was limited evidence to indicate either dose or quality of service were associated with improved pregnancy, birth or neonatal outcomes. However, increased antenatal care (which was reported in these studies) improves surveillance of the developing fetus and maternal wellbeing and can allow early detection of potential issues. The qualitative studies shed some light over how services engage and retain women in services and highlight the importance of the therapeutic relationship offered by practitioners and the non-judgemental approach to holistic woman-centred care.

Taking Phase One of the review alone would only show a narrow medicalised view of neonatal outcomes, however the addition of Phase Two (the qualitative findings) helped understand the proximal measures which lead to distal outcomes. As Milligan et al., (2016) moved towards a theoretical approach to understanding how one element (therapeutic relationships) functions within the integrated programme model, a deeper understanding of the nuanced mechanisms at work within the programme are presented.

How my review informed the design of my realist evaluation

My review highlights the importance of considering the political, cultural and geographical context in which services are placed when designing, implementing and evaluating such complex interventions. As clearly stated aetiology of drug use and zeitgeist of approach to treatment will influence the structure and ethos of integrated programmes. Applying these findings to a contemporary UK setting must be actioned with caution in light of these contextual factors.

Further research is required within the local health boards in the UK and Scotland in order to assess the needs of the local population. Retention in treatment was a frequently reported key finding, suggesting that integrated programmes are more acceptable to this population and result in better service engagement and retention, which in turn, can lead to better outcomes for mothers and babies. Although outcomes depend on the quality of the services and interventions delivered, a realist evaluation can help to find out how services can improve retention. Evaluation of these services should assess what elements of the integrated programme contribute to improved neonatal and maternal outcomes, to what extent, and for whom. Taking a realist approach would allow for depth to unearth the underlying mechanisms that are at play within specific contexts and contributing to specific outcomes.

Realist evaluation is a theory driven approach which borrows from positivism and constructivism (Pawson and Tilley, 1997). It involves an iterative style of theory testing and refining to unearth causal mechanisms to understand how programmes work, to what extent and for whom. Applying a realist approach to research design and execution would consider the different agendas each stakeholder prioritises which drive the treatment programmes in the local area. It would consider the importance of

women's context, which influences their engagement with services, and would encourage a multilevel evaluation of the service since the key point in realism is that programmes do not just work, people within programmes make programmes work.

Conclusion

The purpose of this review was to find out if integrated programmes, including antenatal care with drug services as a minimum, improve maternal, neonatal and service outcomes for pregnant women with alcohol and drug use. The first review of quantitative studies concluded that integrated programmes may help to improve neonatal outcomes and retention in treatment. However, a second review identified the importance of therapeutic relationships, organisational structure and non-judgemental approaches to enable better engagement with services. Limitations in study design and applicability of findings to the Scottish context suggest further research is required to explore how, in what way and to what extent, integrated services improve proximal and distal outcomes for women, babies and their families. The next chapter will outline the methodology of realist evaluation and the applied approach to test theories of how an integrated service produces outcomes in the local context.

Study aim

My study therefore aimed to explore how, in what way and to what extent, integrated services improve outcomes for women, babies and their families. I designed a three phase realist evaluation of the integrated multidisciplinary team (MDT) service for pregnant women and new mothers with problem alcohol and drug use in urban Scotland, to inform future policy, practice and research in relation to integrated programmes. The research question and objectives are outlined in Figure 4 and Chapter 3 Methodology will present and justify my methodological approach to the evaluation and Chapter 4 Methods, will outline and justify the methods I applied.

Figure 4. Research Question and Objectives

The main research question was:

- The service: What works, for whom, in what respects, to what extent, in what context and how?

The objectives of this study included:

- Identify initial programme theories which hypothesise how the programme works.
- Test these theories through an iterative process of data collection and analysis.
- Refine these programme theories to unearth a deeper understanding of how the programme works, or not.
- Identify middle range theories to explain how the programme works in a broader sense.

Chapter 3 Methodology

Chapter overview

In this chapter I will outline my chosen methodology and provide a rationale for why I chose Realist Evaluation (RE), the paradigm of scientific realism, describe the principles of realist methodology and how I applied realist methodology to my study. I will discuss the underpinning philosophy of scientific realism including the distinction between ontological and epistemological perspectives, the differences between scientific and critical realism, principles of generative causation and what is meant by theories. Finally, I will outline a stepwise approach to the application of realist methodology in my study.

Realist evaluation and my rationale for choosing this methodology

Realist Evaluation (RE) is valued for its explanatory focus to unearth *what works, for whom in what circumstances and how* (Pawson and Manzano-Santaella, 2012). This evaluation methodology has become widely used in health and social research to aid the development of evidence-based practice and inform policy (Pawson and Tilley, 1997, Wong et al., 2017). RE is principally applied to understand programmes (interventions) which produce intended (and unintended) outcomes. Although other methods of evaluation could be applied, complex interventions such as integrated services for women with drug and alcohol problems during pregnancy require acknowledgement of multiple constructs, such as social justice and gender, and various interacting influences rather than a single biomedical focus. Many evaluation methods favour the biomedical model, prioritising positivist approaches as identified in the review of Medical Research Council 2008 framework for evaluating complex interventions (Craig et al., 2008). However, randomised designs would not be appropriate in this evaluation as the process of the service is as much a contributing element to the outcome generation as the "programme" itself. Furthermore randomising women to take part in the pre-existing IPPSS would be both unethical, potentially unachievable and would unlikely provide the deeper understanding I wished to gain. Understanding the local application of the service is a key element informing my evaluation design, as highlighted by the literature review in Chapter 2 Literature Review, RE offers the method and perspective to address the complexity of

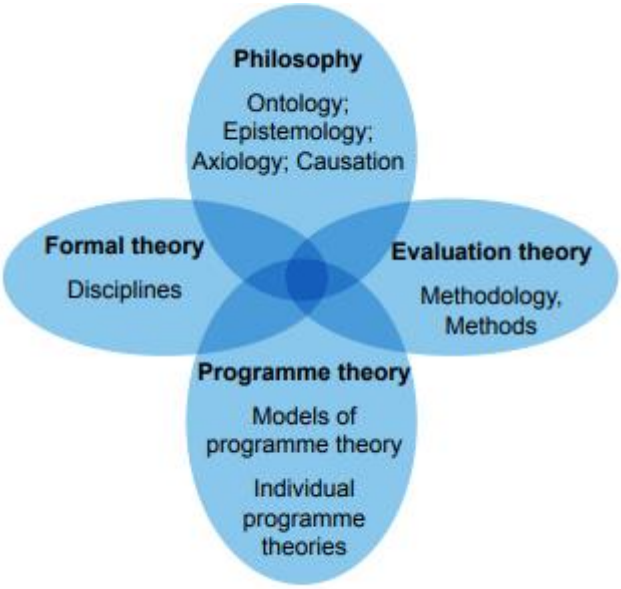
the intervention and would enable me to design the evaluation taking account for effectiveness, process, and outcome. In order to understand realist evaluation methodology a step back into the underpinning philosophy is necessary.

Underpinning philosophy

The principle text *Realistic Evaluation* by Pawson and Tilley (1997) presents the emerging methodology of realist evaluation and the importance of scientific realism to understand this depth-ontology. Pawson and Tilley (1997) explain realism is the philosophical perspective which "has sought to position itself as a model of scientific explanation which avoids the traditional epistemological poles of positivism and relativism", (Pawson and Tilley, 1997, p. 55).

Realist evaluation is a theory driven approach moving through three phases of theory building, theory testing and theory refinement. There are four main areas of "theory" in evaluation research: Philosophical, Evaluation, Programme and Formal (Greenhalgh et al., 2017a) (Figure 5). Each area will be discussed within this chapter with relevance to the study.

Figure 5. Main Areas of Theory in Evaluation Research



Note. From Greenhalgh et al. (2017a).

Commonalities and differences between scientific realism and critical realism

The main tenants of scientific realism are influenced by critical realism yet the similarities and differences between scientific realism and critical realism have been contested by many key players in the field of Realism (Porter, 2015, 2016, Pawson, 2016).

Pawson, (2018) outlines the evolution of RE through the key philosophers, sociologists, evaluators and others in the RE "Family Tree" and it is no surprise critical realist philosophers such as Harre, Bhaskar and Archer are noted. Critical realism is not identified as a separate oddity to positivist or constructivist positions but instead embraces aspects of both, applying an understanding of generative causation (Pawson and Tilley, 1997). Acknowledging these positions within this paradigm is required in order to achieve a realist perspective. Critical realism is not antithetical to scientific realism, in fact basic aspects of critical realist theory is evident in scientific realism. Whilst scientific realism and critical realism both accept a mind independent reality and seek ontological depth, they are different in their application to research. Scientific realism is concerned with scientific theory testing in a methodologically sound way (Pawson and Tilley, 1997), whilst critical realism is a more global or societal philosophical perspective (Archer et al., 2016). Fleetwood (2014) highlights the ontological perspective of critical realism goes beyond ontology as it influences the aetiology, epistemology, methodology and research methods and is therefore considered a meta-theoretical position. Archer et al. (2016) define critical realism as "a reflexive philosophical stance concerned with providing a philosophically informed account of science and social science which can in turn inform our empirical investigations". The fallibility of theory and application of methods is what differentiates scientific realism from critical realism (Sayer, 2000).

The paradigm of scientific realism

Scientific realism is the underlying paradigm of realist evaluation and is a theory driven methodological approach to research. The principle aim is to test theories through data gathering and evaluation in order to understand the reality. This is achieved through generative causation, which is explained further in the following section. Sayer (2000) in addition to Pawson and Tilley (1997) argue that the realist philosophical

approach is neither positivist nor constructivist in nature, rather a paradoxical approach incorporating elements of both. Whilst positivists focus on the observable empirical data, constructivists focus on meanings and interpretations (Greenhalgh et al., 2017b). To detail this further Westhorp (2018) states realist evaluation is a "type of applied realism" (Westhorp, 2018, p. 43) not a toolkit to apply to evaluation due to the ontological and epistemological positions assumed by realists.

Ontological and epistemological perspectives

Ontology refers to the perspective or view of the world from a philosophical perspective (Pesut, 2017). Whilst epistemology refers to the philosophical perspective of knowledge; what is known and how it is known (Westhorp, 2018). Ontological and epistemological views create a philosophical perspective which impact the methodology and methods applied in research. There are several differences between Positivist, Realist and Constructivists philosophies, which are summarised in Table 7.

Table 7. Philosophical Perspectives of Positivism, Realism and Constructivism.

	Positivism	**Realism**	**Constructivism**
Ontology	There is an objective reality	All material and social elements are "real"	Subjective reality
Epistemology	Identification of facts and truths through observation and theory	No final truths or knowledge but increased understanding of reality	Knowledge is socially and individually constructed and interpreted
Causation	Linear, secessionist causation	Generative patterns of causation	Co-constructed interpretation leads to outcomes
Implications for Evaluation	Identify facts and truths: Controlled closed systems e.g. Quantitative methods, RCT	Explain how and why interventions generate outcomes: open systems e.g. mixed methods	Describe and interpret open systems e.g. Qualitative methods.

Note. Adapted from Westhorp et al., (2011) and Greenhalgh et al. (2017b)

Realist ontological perspectives accepts that everything is real, independent of observation or knowledge (Archer et al., 2016). Although something may not be observed, this does not mean it is not real. For example, culture and trends affect the way we act or think about something, meaning it is real despite not being observable. This is often termed "mind-independent reality" (Greenhalgh et al., 2017b).

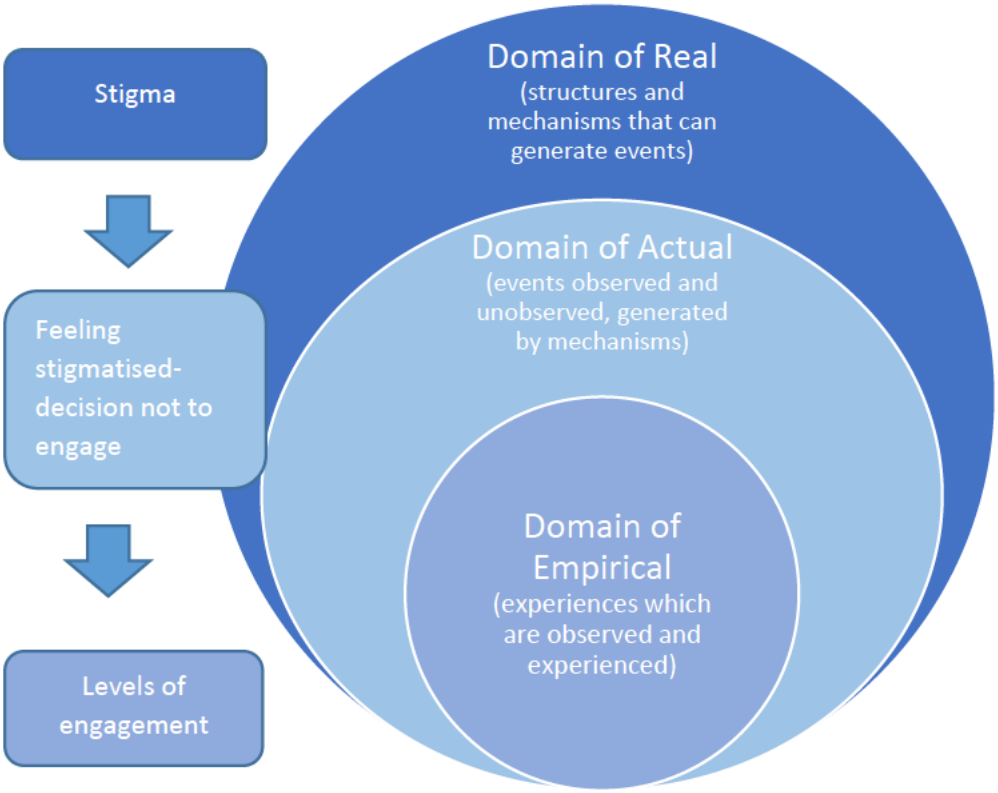
Realist epistemology is fundamentally grounded in the belief that mechanisms are generated and function to create outcomes through their actions within certain contexts. Through the evaluation process, mechanisms are unearthed to add to our explanations of reality. Causality is not viewed in a secessionist perspective, which outlines series of events; instead, realists view causality as generated through the behaviours of mechanisms when activated in contexts leading to outcomes (Williams, 2018). This action occurs at an ontological depth, positioning realist ontological perspectives at a deeper level of reality compared to positivist approaches.

Constructivists believe all realities are interpretive and individual, yet realists accept there is a reality, which may not be seen or captured in the empirical sense, but through theory testing, can be identified through plausible generative causal claims. Pawson and Tilley (1997) explain that generative forces, embedded in both Macro and Micro social forces, produce outcomes. This raises the importance of understanding attitudes, behaviours and individual's capacity, which may contribute to different observable outcomes.

Layers of reality

As highlighted, realists identify both material objects and social constructs as real as they both can have real effects (Westhorp, 2018). Scientific realism identifies that reality is stratified in layers: the empirical, the actual and the real (Sayer, 2000, Mingers, 2004) (Figure 6). In the case of maternity services for women with drug and alcohol problems, low levels of service user engagement may be due to an underpinning experience of stigma by the individual (Lefebvre et al., 2010). Service user engagement levels are real, yet they are influenced by a social construct of stigma, which is therefore also real. This example highlights the connection between the individual and the wider social system but also highlights the aim of realist methods, to uncover the *explanation* for the observable outcomes (Emmel et al., 2018).

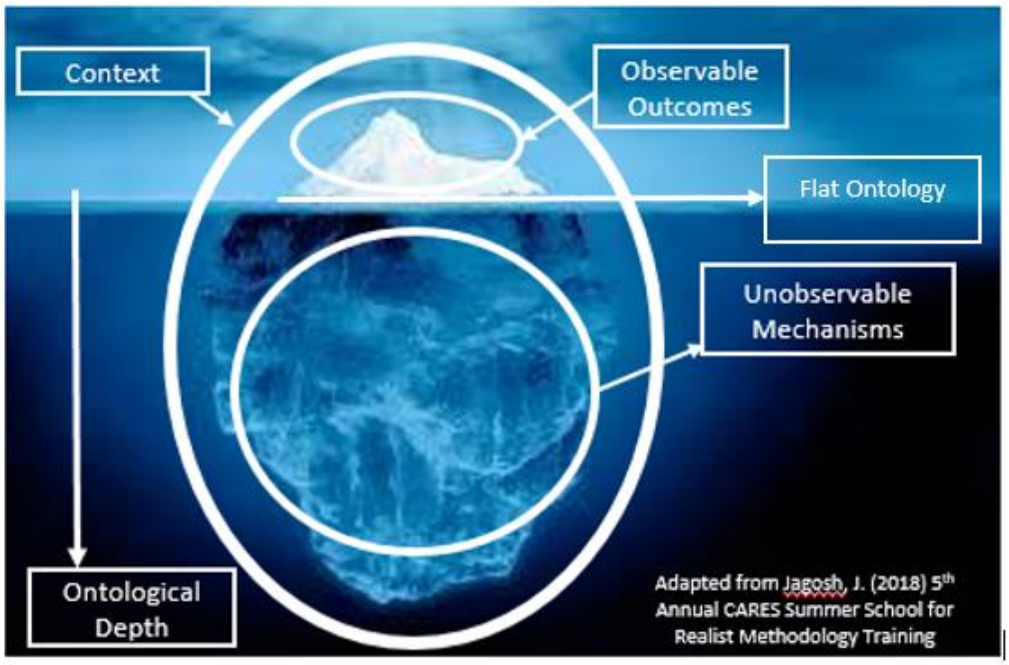
Figure 6. Levels of Reality in Scientific Realism



Note. Adapted from Mingers (2004)

Scientific realism moves from accepting a flat ontology evident when stopping at the empirical or actual and aims to reach ontological depth (Figure 7). Pawson & Tilley (1997) propose that realist philosophy sits between positivist and constructivist neither agreeing with nor disregarding either. Whilst positivism aims to test theory to gain generalizable knowledge, constructivism aims to build theory through experiential enquiry. Realism aims to align these principles (positivism and constructivism) to understand reality and to develop a greater understanding of a mind-independent reality; there is a reality beyond what we "know", beyond the actual, beyond the empirical. Sayer (2000) contends that by altering the status quo of accepting secessionist understanding of the social world, the tenets of scientific realism appreciate events are based on contingent conditions. For example, instead of calculating patterns and frequencies of occurrence of levels of engagement by service users, scientific realism aims to *explain* the occurrences based on the understanding of generative causation e.g. levels of engagement are influenced by women's experiences and perceptions of care, depending on their previous experiences or levels of support.

Figure 7. Depth Ontology vs Flat Ontology



Note. Adapted from Jagosh (2018) 5th Annual CARES Summer School for Realist Methodology Training. Aitken-Arbuckle, A. (2021, February 15th). *Realist Evaluation* Post Graduate Talk, Edinburgh Napier University.

Generative causation

Scientific realism is a theory driven methodological approach based on the logic of generative causation. Generative causation is produced through the unearthing of mechanisms which are causal forces generating outcomes within a specific context. The unearthing of these causal mechanisms is termed retroduction and can be described as going beneath or behind in order to reach ontological depth (Jagosh, 2020). From a realist evaluation perspective, one way to explain this is to say that all programmes have outcomes, which are based on the underpinning or hidden causal mechanisms which are at play when a programme element is placed within a specific context (Pawson, 2008). Generative causation is the unearthing of causal pathways which show the causal links between these contexts, mechanisms and outcomes (Pawson and Tilley, 1997). Outcomes are not produced alone but are directly influenced by the mechanisms in context. Generative causation allows the evaluator to

reach a depth ontology, understanding the workings of programmes and illuminating outcomes generated within the perceived reality.

Mechanisms

The key to generative causation is the explanatory mechanism (Pawson and Tilley, 1997) which in scientific realism is the response a person has to a social programme based on the context. Pawson and Tilley (1997) refer to these social mechanisms as a person's choice or capacity and describe this as a person's reasoning to the resources offered by the programme. Pawson and Tilley (1997) argue that social programmes are often based on social contingency and it is the introduction of social mechanisms within the fertile context which will result in an outcome. Whilst this is a brief definition of mechanisms at this stage, this concept will be expanded on in the subsequent section under the Principles of realist evaluation (Pawson and Tilley 1997) and Chapter 4 Methods.

Theory development, testing and accumulation

Scientific realism is a theory driven approach meaning theory development, theory testing and theory accumulation are all aspects of this methodology. Studies applying this methodology start from a theoretical perspective, as Pawson highlights, "The real starting point of science…lies in "theory", our ideas on the nature of the problem and on the nature of its solution" (Pawson, 2013, p. 7). It is through both inductive and deductive methods that these theories are tested in order to reach understanding of the theories at a depth ontology. Bearing in mind that scientific realism is somewhere between positivism and constructivism, this means both inductive and deductive methods of enquiry are used through a process of abduction in order to achieve retroduction. This process of generating causal claim results in refined theories. Testing of these theories is one of the commonly identified differences between scientific realism and other realist methodologies. Popper (1959) suggests that the falsifiability of a theory is what ensures the testing is scientific, if they are not fallible then they are not science and instead considered pseudo-science.

This theory driven approach of theory generation, testing and refinement leads to theory accumulation (Pawson and Tilley, 1997) which is essential in social sciences and evaluation research. The iterative approach builds further theories which can be

transferred and utilised in other settings. The tenets of scientific realism accept the importance of objectivity; aiming for objectivity through an accumulation of subjectivity. This accumulation of subjective views leads to a greater objective understanding of reality and supports the validity of findings (Jagosh, 2019).

Several realist philosophers lay value on theory accumulation; Merton (1968a) being the pioneer of middle range theories (MRT) as a form of developing cumulative abstract theories applicable to multiple social behaviours and structures (Merton, 1968a). However when considering the social world, there requires a cautious approach to the applicability of accumulated theories due to the permanent state of self-transformation. As Archer (2019) proposes through their explanation of morphogenesis, the social world is always developing and changing. Interventions themselves are also transient and context specific in space and time and therefore the unearthing of semi-predictable outcome patterns known as “demi-regularities” become the a priori focus and aim of realist evaluation methods (Pawson, 2013).

Open and closed systems

As stated previously, theory accumulation adds evidence to a theoretical perspective which may be transferable to other settings. Popper (1959) claimed accumulation of theories must be considered in realist terms as no repeat of a theory would be exact due to the nature of open systems in social science. The understanding of Bhaskar’s (1978) open and closed systems in critical realism is also relevant in scientific realism. Bhaskar (1978) argues that scientific enquiry in the term of laboratory experiments are considered closed systems. This means the theoretical principle being tested is controlled for stability and external conditions meaning the mechanism generating causal power is not altered. However the social world is an open system which cannot be controlled for, as previously outlined by Archer et al. (2016). This means different outcomes can be produced by the causal power (mechanism) depending on the altering context (Sayer, 2000). In scientific realism this view is taken further by Pawson (2013), who argues laboratory experiments are only partially closed and all theories/programmes/causal powers (mechanisms) are sensitive to external conditions. Therefore, theory accumulation aims to support generalisation of theories which have been context specific (Pawson and Tilley, 1997). This point has been

contested by Porter (2015) who argues against Pawson's interpretation of Bhaskar's open and closed systems. However, my interpretation is that a contextual understanding is essential in social science due to the nature of open systems. Additionally the concepts of structure and agency are also paramount in understanding such contexts and their interactions with mechanisms.

Social structures and human agency

Structure and Agency are two concepts broadly used in sociology relating to the interactions between individuals and their world around them. Structure refers to the governing principles of society which create rules, expectations and boundaries (Porter, 2017). Agency refers to the individuals' capacity to make choices within the boundaries of the social structures (Pawson and Tilley, 1997). There are several interpretations of these concepts which have been contested by sociologists who interpret aspects of structure and agency from different philosophical perspectives (Debelteau, 2008). This therefore has an impact on their application in social science research. Structure and agency are often described as "two sides of the same coin" (Kelinman and Cabaniss 2019 p. 124) as the identity of self is developed through an individual's interaction with society, which in turn contributes to the society as a whole. However, other interpretations such as Archer's social theory of Morphogenesis interprets these concepts as two distinct forces which develop in sequential patterns influenced by history, culture and time (Archer, 2019). As social structures interact with agency through providing "opportunities, limits…restraints…and influences" (Porter, 2017, p. 84) therefore enabling or constraining the actions (agency) of the individual, this concept is pertinent to the understanding of causal mechanisms. These concepts are vital in understanding how implementation of a service can generate outcomes depending on the structural factors in which it is placed and the consequences on individual agency. With regards to women with drug and alcohol problems during pregnancy, the myriad of complexities between structure and agency must be considered within the design and analysis of the evaluation in order to reach the "realities" of *how* services work. These concepts will be further explained in relation to their application to the study in Chapter 4 Methods.

Principles of realist evaluation

Pawson and Tilley (1997) developed realist evaluation and synthesis methodology in order to understand the underpinning processes and reasons in which programmes "work" in the real world. Programmes are the interventions or social processes which are put in place to support an outcome. In the case of this study the "programme" is the integrated approach to maternity services for women with drug and alcohol problems. Historically, evaluation research aimed to discover if interventions such as these worked, however realist evaluation research aims to discover *how* interventions work. Evaluation theory entails the decision and justification for the evaluation being conducted and is paramount to the understanding of generative causation as non-linear.

Realist evaluation requires the construction of programme theories, which are the outlined logic theories of what is happening within a specific programme. Programme theories are constructed of Context (C), Mechanism (M) and Outcome (O) (CMO) configurations (Pawson and Tilley, 1997) (see Figure 8), which are used to, "Hypothesize the causal and situational triggers for changes in behaviour or responses to the interventions." (Blamey and Mackenzie, 2007, p. 445)

Figure 8. Context Mechanism Outcome

Context (C) defines the fertile environment or background in which the programme will be placed.

Mechanism (M) refers to the response or reaction generated by the programme.

Outcome (O) also known as result or effect (often observable) from the combination of the Mechanism (M) firing within the Context (C).

Types of theory in realist evaluation

Firstly, the researcher develops initial programme theories (IPTs) which form hypotheses to be tested within the study. Through the testing, the researcher unearths a deeper understanding of the causation, further developing and refining these theories. Programme theory is the explanation of how a programme is expected to result in specified outcomes when placed in a stated context. The relationship between the context and outcome is only present when underlying mechanisms of

change are present. The Context Mechanism Outcome (CMO) heuristic (as presented further in section CMO configuration (CMOc)), is used to enable realist evaluators to theorise, clarify and present the theory being tested. Programme theories are specific statements which show generative causal claims about how a programme is working. These can be presented as positive or negative in terms of how a programme is theorised to work or not work. Programme theories can however be more theoretical about one aspect of the CMO. An example of programme theory relevant to this study is presented in Figure 9.

Figure 9. Programme Theory Example

When a woman has a positive **trusting** therapeutic relationship with their midwife whom also has a trusting relationship with their colleagues (C) and practitioners are open and honest with the woman (M), the woman feels respected, empowered and in control, alleviating her stress (M). The woman continues to trust the practitioner and is more likely to engage with the other practitioners (O).

Middle range *programme* theories are a step removed from the intervention under evaluation and may be more general to types of intervention or programme. This means the theory may be applied more generally to a programme which is targeting similar aspects of the programme under evaluation (see Figure 10).

Figure 10. Middle Range Programme Theory Example

When health professionals and service users have **trusting** therapeutic relationships (C) they are more open and honest in their communication and experience more rewarding interactions (M). This encourages further engagement of service users in meaningful exchanges with practitioners (O).

However, Middle Range Theories (MRT) (Merton, 1968a) are substantive theories which are overarching theories further explaining programme level theories on a broader scale. MRT may be discovered or drawn upon by the researcher at multiple points throughout realist evaluation as they provide a lens to apply to the retroductive process (Jagosh, 2019). Formal MRT is a theoretical perspectives of social programmes

and can be applied to many aspects of society rather than just models of programmes or specific interventions (see Figure 11). The principle of formal MRT were introduced by Merton to explain "all the observed uniformities of social behaviour, social organization and social change" (Merton, 1968b, p.39 in Pawson and Tilley, 1997, p.123). MRTs differ from programme theories due to their level of abstraction (Marchal et al., 2018). Whilst realist evaluation starts with initial theorising and works towards testing and refining these theories at the programme level, MRT are required to aid conceptualisation of the theory at the early stage (Shearn et al., 2017). In order to test a programme theory it needs to be conceptualised (e.g. holistic care), MRT and empirical data unearth mechanisms to better understand in what way holistic care works. This is the process of abstraction, digging down to a deeper level of theory generation through reflective, abductive approaches. Exploring MRT provides a lens to consider programme level theories further or in a wider or different context.

Figure 11. Middle Range Theory

Gibbs Trust Level Theory (1991) explains that open and honest communication between people supports the discovery process of the individual to disclose who they are and express how they feel to one another. Through the discovery process the individual develops a deeper level of **trust** and is able to participate fully in the relationship with others.

Theory accumulation from the programme level can provide evidence for middle range programme theories and formal middle range theories (Pawson and Tilley, 1997) as previously explained. Realist evaluation is used more widely in the evaluation of complex programmes. As the social world is a complex terrain, realist evaluation aims to test theories to generate causal claims to better understand the complexity of social programmes. Through theory accumulation, MRTs can be developed as discussed previously.

Theory development and testing

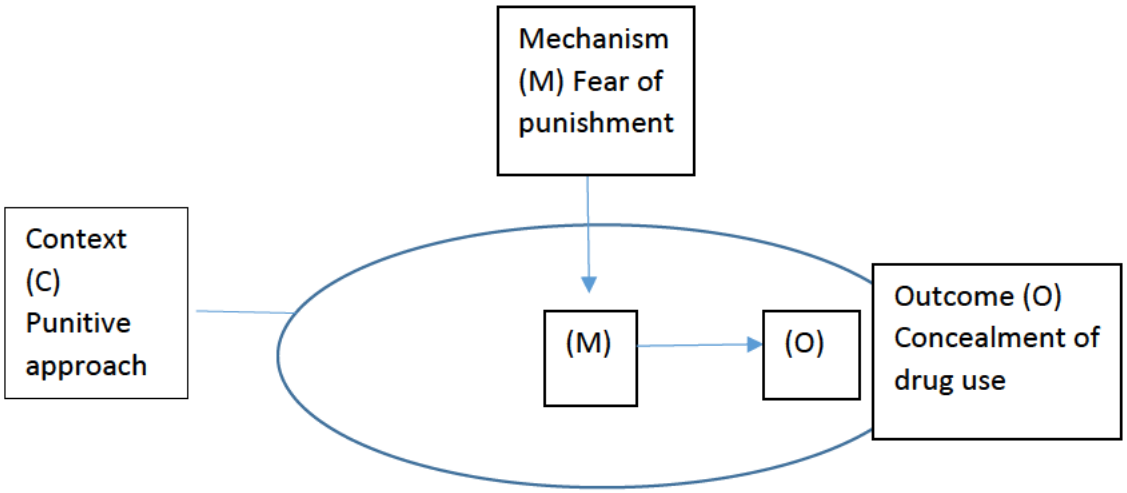
There are several approaches to developing initial programme theories (IPT) including exploring stakeholder assumptions, exploratory research or literature reviewing (Marchal et al., 2018). One form of developing the theories from the data is the use of

"If…then…because…" statements. These statements are used to form logical lines of enquiry by stating "If X, then Y, because Z". Whilst this may appear as secessionist causation, the process can uncover missing aspects of the theory development and the Z (mechanism) gives opportunities to consider several opposing theories. Opposing theories are often termed "Rival Theories" (Pawson, 2013, p.21.) and are essential in theory development and testing as they allow for alternative lines of enquiry to be pursued. By using rival theories, the realist researcher can focus on specific contextual factors which may give rise to different outcomes due to their interactions with causal mechanisms (Pawson, 2013).

CMO configuration (CMOc)

Bearing in mind the scientific realism principles of generative causation, Pawson and Tilley (1997) advocate the use of stratifying causal claims by using the heuristic tool of Context, Mechanism, Outcome configuration. Known broadly in realist evaluation literature as CMOc; these heuristics are used to outline the components of each theory or multiple theories. As highlighted in Figure 7 and further illustrated in Figure 12, context can be identified as the back drop of the programme and is differentiated from the programme itself e.g. punitive approaches to drug use. Mechanisms have been identified as an individual's choices which are triggered by capacities derived from "group membership" (Pawson and Tilley, 1997, p. 66) e.g. fear of punishment. Outcomes are the intended and unintended results of a programme when mechanisms are triggered within specific contexts e.g. concealment of drug use. The use and presentation of CMO configurations have evolved since Pawson and Tilley's seminal work, such as the development of the heuristic by Dalkin et al. (2015) who further disaggregated Mechanism by separating it into "Resource" from the programme and the individuals "Reasoning". Further adaptations include identifying the actor's interaction with the intervention, which have been included in Mukumbang et al. (2017) papers where the heuristic is presented as Intervention (I) Context (C) Actor (A) Mechanism (M) Outcome (O) (ICAMO). In addition, Jagosh et al. (2015, p.3) also presents the "ripple effect" identifying when one CMO configuration triggers a sequence e.g. an outcome from one configuration becomes the context of the next.

Figure 12. CMO Configuration



Note. Adapted from Pawson and Tilley (1997).

The actions of generative mechanisms have been described by many realists in different ways such as "triggers" (Pawson and Tilley, 1997, p.66) or "dimmer-switch" (Dalkin et al., 2015, p.10), however, the explanation offered by Westhorp (2018) extends these descriptions of the actions of mechanisms and explains how the constructs of mechanisms differ depending on the level of system at which they act e.g. material, cognitive, social group or institution. An example of this may be gravity which is seen in the material system or peer pressure in the social system which are both constructed as "force mechanisms" due to their actions (Westhorp, 2018, p. 49). Further discussion of how alternate constructs of mechanisms have been used in this study will be outlined in Chapter 4, Core mechanisms – new understanding of mechanisms.

The most important principles when using CMO configurations is understanding its purpose of identifying generative causation. Some authors fail to reach generative causation as they present their findings in disaggregated C, M, and Os and do not use the heuristic in the way it was intended.

Use of qualitative, quantitative and mixed methods

Pawson and Tilley (1997) promote the use of mixed methods in realist evaluation. The design of a study needs careful consideration in order to test programme theories and unearth causality. Strategies, such as including qualitative and quantitative data,

support triangulation of research findings (Flick, 2018). Realist approaches to literature searching can support unearthing mechanisms and aiding programme development despite the quality of the primary data (Pawson, 2006). The principles of realist methods as outlined through the ontological and epistemological stand points are applied to the research at every stage, i.e. design, data collection and analysis (Maxwell, 2012). Despite the testing of theories in realist evaluation, alluding to a scientific and positivist paradigm, objectivity can be sought through accumulative subjectivity and approximation (Jagosh, 2020). Williams (2018) describes realist researchers as "detectives" highlighting the importance of effective research skills to ensure the quality of evidence and conclusions drawn. Therefore, an appreciation that data collection is affected by ethical implications, access to participants and sample size guided the methodological design of my study. The justification for the research methods employed in my study are included in Chapter 4 Methods.

Applying realist evaluation methodology in my study

Theory development, testing and refinement

In order to evaluate a complex intervention within a complex system, a three-phase theory driven approach was applied. The phases included theory development, theory testing and theory refining. The theory gleaning phase was the first step to develop initial programme theories. This used an iterative approach of data collection and analysis to glean initial theories of how the programme worked. A series of stakeholder interviews, non-participatory observations, overview of policy documents and scoping of literature generated theoretical statements on how the programme was expected to work. An architectural outline of the programme was constructed to direct theory building across all aspects of the programme. Cataloguing of disaggregated context, mechanism, outcomes was initially carried out followed by "if…then…because…" statements to aid stratification of CMO configurations into programme theory statements.

The second phase involved testing the theories to find out if these falsifiable theories were true. Stakeholder interviews with women who were receiving the service and practitioners providing the service were carried out. Realist interviewing technique (Manzano, 2016) was used in order to test and build theory throughout the interview

series. A review of the current annual reports and participant case studies were also conducted.

Phase three involved analysis of the data collected and produced refined theories of how the programme works in certain circumstances. Several middle range theories (MRTs) were utilised during the analysis process to aid refinement of the theories.

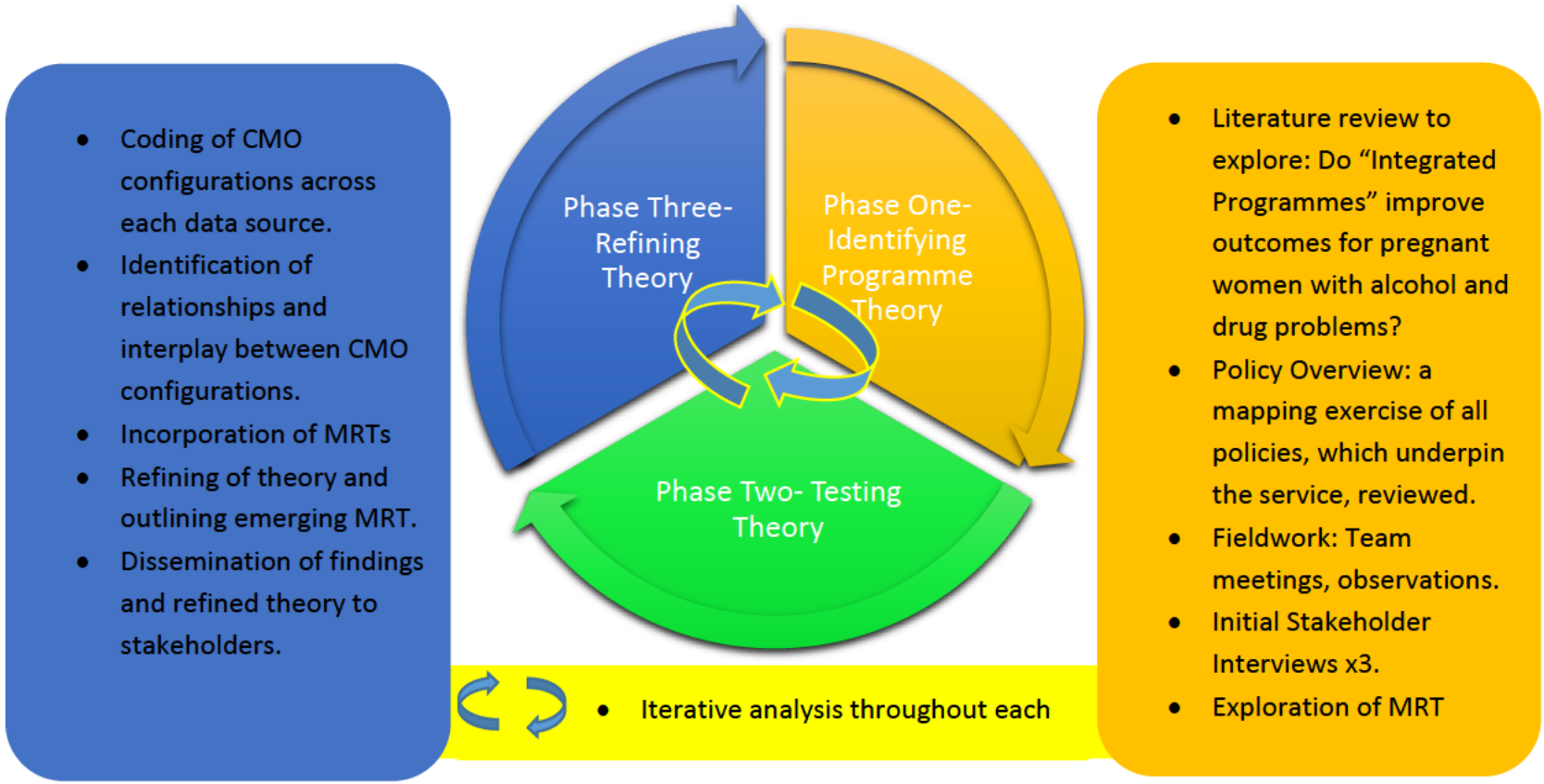
Realist evaluation is an iterative process and analysis therefore takes place throughout each phase of the theory building, testing and refining phases. The following Chapter 4 Methods, details a full description of how the methods were applied to the three phases of the study.

Chapter 4 Methods

Chapter overview

This chapter will outline the three-phase approach applied to develop, test and refine theories of how the IPPSS works (see Figure 13). Each phase involved data collection and analysis in an iterative approach, building on each phase in turn. Firstly, I will outline the Ethical considerations and implications of my study as they apply to data collection, analysis and dissemination. Secondly, the research methods applied are briefly outlined in Realist evaluation methods in relation to sampling, recruitment and data collection. Finally the main section of this chapter will outline each phase of the study in turn with relation to all the data collection and analysis methods I applied in Phase One methods– Identifying programme theories, Phase Two methods– Testing programme theories, and Phase Three methods – Refine programme theories. The subsequent Chapter 5 Phase One Findings, will outline the findings from theory development, Chapter 6 Findings Phase Two, will outline findings from theory testing, and Chapter 7 Phase Three, will outline findings from the final phase.

Figure 13. Three Phase Realist Evaluation Outlining Data Collection and Analysis



Ethical considerations

The sensitive nature of the topic of parental substance use and the potential vulnerability of participants required a carefully considered approach to my research protocol and ethics application. For example, how to ensure confidentiality, providing opt out at any stage, managing the provision of incentives to participate and researcher personal safety, were all explored. The study protocol was reviewed and approved by Edinburgh Napier University, School of Health and Social Care Ethics Committee (18013) (Appendix 4. Ethics Approval Received from Edinburgh Napier University on 18.02.19) and NHS South East Scotland Research Ethics Committee No.2. (19/SS/0045) (Appendix 5. Ethics Approval Received by NHS South East on 02.04.19) Integrated Research Application System (IRAS) form and Research and Development (R&D) applications were completed and then authorised by the above committees. A minor amendment was approved on 11th December 2019 to allow audio recordings to be professionally transcribed (Appendix 6. Amendment Approval Request Form submitted to Edinburgh Napier University on 19.03.20). The ethical considerations are detailed in the next subsections (Study sample – Authorship policy). The methods themselves are outlined from section Realist evaluation methods.

Study sample

My study included two different samples of participants: practitioners who worked within the service being evaluated and service users receiving the service. I aimed to recruit at least one practitioner from each disciplinary background working within the service of which there were six, however, I could not assume all would participate despite their involvement with the service. Practitioners were informed at every interaction (e.g. study meeting, recruitment, and observations) that their participation was voluntary and consent was an ongoing process. I planned to stop any group observations where all practitioners had not agreed to participate, however, this situation never arose. From the pool of service users receiving the service, I aimed to recruit up to 20 of which 2-3 would be case studies.

Recruitment

The recruitment process was underpinned as voluntary and non-coercive with careful consideration of the power imbalances between me and the participants (see section Power dynamics) as well as risk of coercion. All participants were given a Participant

Information Sheet (PIS), (Appendix 7. Participant Information Sheets (PIS)), detailing the purpose and scope of the study and expectations of participants. These were distributed by both the service practitioners during routine appointments, or by me during interactions with service users and practitioners. PIS were used in conjunction with conversations about the study allowing potential participants time to ask questions about the implications of their involvement. All potential participants were given at least 48 hours from noting interest and being contacted to confirm their interest, as recommended by the Health Research Authority (2019).

Consent

Informed consent is a vitally important aspect of any research to ensure voluntary involvement from all participants (Sanjari et al., 2014). In particular, this study faced additional challenges concerning consent due to the potential intoxication of service users. It was also essential to ensure participants had the capacity to consent to taking part in the study (Baedorf Kassis and Roth, 2012). To assess this a few measures were taken: consent was an ongoing process throughout the study, consent was obtained in a private environment, and plain English language was used (Baedorf Kassis and Roth, 2012). The consent process took place face to face in a private space within a local community health centre prior to data collection. A consent form (Appendix 8. Consent Forms) was read through with the participant using a "teach back" method (Klingbeil and Gibson, 2018) to ensure the participant understood the purpose and requirements of the study and supported assessment of the individuals' capacity to consent. This offered the participant an opportunity to ask any questions during the consent process. If the participant appeared to be intoxicated or withdrawing from drugs (slurring speech, agitated behaviour, inability to communicate, incoherent) at the time consent or data collection was due to take place, and therefore not able to engage in the "teach-back" method, then I planned to politely re-arrange the appointment for another day, however this was not required in any case.

Power dynamics

Power relations between the researcher and participants are widely discussed in qualitative research and have many ethical and methodological implications. (Karnieli-Miller et al., 2009). Particularly, concerning recruitment, I required to acknowledge the

power dynamics which were present between me, the practitioners as participants and the service users as participants. This also required specific attention to the power relations between the service users and the practitioners they worked with. As I was holding relative power in terms of the aims, objectives and methods of the study, it was essential for me to balance this with an overt awareness that the practitioners and service users were experts within the field of study. Through using realist interviewing techniques (Pawson and Tilley, 1997), participant's power increased as I presented concepts from Initial Programme Theories (IPTs) to the discussions and asked them to expand further and reflect on their opinion. I also encouraged participants to reflect on their role as an "expert", through their lived experiences as practitioners and service users which could enhance my theoretical understanding.

Throughout recruitment, consent and data collection, I continually presented myself to gatekeepers (managers and practitioners) as a researcher with theoretical perspective and disciplinary experience yet reliant on the participants for their expert contribution (Lavrakas, 2008). In the case of service user interactions, I presented myself as a researcher but chose not to disclose my disciplinary background as a midwife. I made this decision to not fully disclose my background in order to focus the data collection on the particular service being evaluated and to avoid multiple power dynamics within the relationship between service users and myself. As all service users who participated in the study were currently or recently pregnant, I considered it inappropriate to lead with this disclosure of my midwifery background in case participants became expectant of me assuming this role within our interactions. I planned to disclose my clinical background if I was asked by service users however this situation did not arise.

Confidentiality

All participants were interviewed on their own to ensure privacy with the exception of one woman whose husband was present during part of the interview to care for their newborn. During the consent process, I assured all participants that every effort would be made to ensure their confidentiality during data collection, analysis and dissemination. Ensuring confidentiality in qualitative research can be challenging due to the nuanced detailed data which is produced by qualitative methods which could

also risk identification of participants. However at several stages throughout the research process I made decisions to protect the confidentiality of participants to avoid deductive disclosure (Kaiser, 2009).

All participants were made aware that if they disclosed information which I perceived to be putting a child or adult at significant risk of harm, then I had a duty to report this information to the appropriate service as per NHS Child Protection and Adult Protection Procedures. This was discussed during the consent process and appeared as an item on the consent form.

Anonymity

All service users were given pseudonyms and practitioners given participant numbers to protect their identity. I ensured that all transcripts were fully anonymised so that no participants could be identified. As the service was a small, specialist team of practitioners this led to practitioners' roles being more easily identified. To mitigate this, all practitioners reviewed their own interview transcripts prior to data analysis and commented on parts of their data they thought could identify them due to their discipline.

Sensitive topics

As service users and practitioners would be discussing their experiences which included substance use, domestic abuse, child protection and other experiences of trauma, ethical considerations were taken into account regarding the discussion of sensitive topics. As an experienced midwife I aimed to approach such topics in a compassionate and considerate way, gauging the responses from participants. Discussing sensitive topics would be vital to the research data however not to the detriment of the participant and measures were taken to prevent re-traumatising experiences when discussing such topics. A debrief letter (Appendix 9. Participant Debrief Letter) was given to and discussed with all service user participants following interview which included resources for support.

Participant expenses

There are differences of opinion across research practice as to the ethics of reimbursement, payment or incentives during research participation. However I decided to offer reimbursement for time involved in the research and to ensure

participants were not “out-of-pocket” due to participation. The population from which participants were being recruited are disadvantaged and from a low socio-economical background, therefore measures were taken to ensure that participants were not excluded due to financial barriers.

Service user participants were given £20 “Love2Shop” vouchers which can be spent in many high street retailers, to cover any out-of-pocket expenses for attending an interview (Health Research Authority, 2014). Those participants who chose to participate in a series of interviews as part of a case study, received a £20 voucher for each interview.

Researcher safety and wellbeing

NHS lone worker policy was adhered to and risk assessment completed, whilst I attended any fieldwork and several measures were taken to ensure safety (Given, 2008) (Appendix 10. Lone Worker Risk Assessment Completed 14.02.19). I informed my supervisory team of the date, time and location of any one to one interviews. I checked in and out with reception staff at the location in which data collection took place if it was a public setting and I carried personal alarm and mobile phone. Practitioners from the service conduct risk assessments for routine home visiting and to ensure my safety shared the details of this with me when referring participants.

Reflection and regular supervision meetings allowed for debrief following difficult conversations and supported me, by monitoring and addressing any issues relating to my wellbeing.

Data protection

Participants were issued with a Privacy Notice (Appendix 11. Privacy Notice) which outlined data protection, confidentiality and data management processes. All anonymised data was stored securely on a password protected computer on the University’s secure research data V: Drive on Edinburgh Napier University Campus. All documents with personal identifiable data (consent forms and socio-demographic data, genograms and eco-maps) were stored in a locked drawer in a locked room on campus which only I and my supervisor had access to. An encrypted voice recorder was used for interviews and audio files were uploaded to the secure V: Drive as soon as practical. All study data (excluding audio files) will be kept for 10 years from the end

of the study, on the university's secure network, in accordance with the university's data management policy. After this time, the data will be destroyed. Audio files and all personal identifiable information (e.g. consent forms) will be deleted or destroyed within 12 months of end of study.

Insurance and indemnity

Edinburgh Napier University has insurance in place (which includes no-fault compensation) for negligent harm caused by poor protocol design by the Chief Investigator and researchers employed by the University. Sites which are part of the United Kingdom's National Health Service have the benefit of NHS Indemnity, (Appendix 12. Professional Indemnity and Liability Certificates).

Authorship policy

Ownership of the data arising from this study resides with the PhD student and Director of Studies.

Realist evaluation methods

The service

The background and context of the IPPSS being evaluated has been outlined in Chapter 1 The service. The service had already been identified by the local NHS clinical researchers and managers during the development of the funding application for this doctoral study. As previously stated the service was established in 2006 and had not been independently evaluated. As the service was unique in its approach across the NHS Health Board and had been identified as an example of good practice it was thought essential to evaluate the service.

Steering group

A steering group comprising clinicians, academics and lay members oversaw the governance and conduct of this evaluation and provided valuable insight and guidance. The manager from the service was included in the study steering group and led the involvement of the service in the study. The steering group met biannually, providing opportunities for guidance in study design and theory development.

Sample and sampling methods

RE encourages recruiting participants who can provide a range of perspectives and experiences of the programme to be evaluated. Because I was considering the

programme interactions at Micro-Meso-Macro levels I decided it was important to recruit participants from these different levels. Service users were they key informants and I wanted to privilege their voices by identifying and recruiting them first. However, as I also needed to understand the purpose and structure of the programme and identify how the programme was intended to work, I needed to recruit key stakeholders at managerial level who could provide this insight. In order to sample service users, I initially decided to recruit women who had used the IPPSS during their pregnancy and into the postnatal period. I considered that this would give greater insight into how the programme worked. In particular being able to explore their experiences in pregnancy and follow this up after their baby's birth could potentially elucidate different priorities at different time. As I anticipated recruitment and retention difficulties with the study sample I decided to recruit 'case studies' who would provide this pre and post birth perspective. This was to allow for deeper understanding of the experiences of service users and to add to the contextual background of the families. At the time of my research there were around 30 service users actively involved in the IPPSS. Following discussions with the steering group and the IPPSS and in line with an acceptable sample for RE, I aimed to recruit a sample of 10 women and 3 case studies.

The practitioners sampled for the study were drawn from population of health care providers who had a role in the IPPSS during the time of my research. I aimed to sample practitioners from the different disciplines to capture the different perspectives of the multidisciplinary team. There were 11 practitioners representing 6 different disciplines.

Identification and recruitment of key stakeholders

Three key managerial level stakeholders from the three core disciplines (maternity, social work and mental health/addictions), were identified by members of the steering group committee. These managers were chosen because of their immediate involvement with the IPPSS and their role which provided practice, managerial and strategic perspectives on the IPPSS. Two of the managers were involved in the IPPSS on a daily basis whilst one was more peripheral, overseeing the provision of maternity services. I emailed these three stakeholders and informally invited them to take part in

a one to one discussions. All three agreed and participated in informal discussions within their clinical setting between January and February 2018. These discussions supported the "theory gleaning" of programme theories as discussed further in section Stakeholder interviews.

Recruitment of service users

I initially planned to recruit women from antenatal groups however, at the time of recruitment this was no longer feasible because funding issues and poor uptake of the groups had caused the antenatal groups to be suspended. The recruitment process was therefore adapted to involve practitioners, who would distribute participant information sheets to women at routine appointments and invite them to contact me if interested in participating or requiring further information. Women could also provide their contact details and agree to be contacted directly by me. Efforts were taken to avoid women receiving multiple invitations to participate; for example practitioners asked women if they knew about the study prior to issuing leaflets; the IPPSS team leader discussed recruitment at the weekly team meetings to keep track of who had been invited to participate. This latter also ensured all service users were approached about the study and given information, thus avoiding recruitment bias by practitioners choosing who to approach. In most cases practitioners passed on service users details to me and I contacted women. I found it challenging to reach service users on the phone, which may have been due to previous clinical experiences. I adopted a proactive approach, contacting service users more than once and at different times of the day. I recorded all telephone interactions e.g. unsuccessful, voicemail etc. to keep track of the attempts and record outcomes e.g. service user requested further call tomorrow at 2pm. In doing this I aimed to give service users the opportunity to participate whilst remaining non-coercive in my approach.

However, after several weeks only one service user had agreed to take part. Despite several service users showing interest and passing their contact details on to me, most were uncontactable by phone or non-responsive to planned follow-up. Following discussions with IPPSS practitioners, we identified two practitioners to act as key contacts for recruitment. These practitioners engaged with women in both the antenatal and postnatal periods which supported dissemination of study information

to service users across the duration of the service. This allowed me to keep in close contact with the team about service users I had not yet managed to contact and to check contact details and get feedback about women who were still keen to participate in the study that I had not been able to contact. Insider information such as preferred times of day for contact and method, e.g. text vs phone call, all supported the recruitment of service users. We also agreed it may help service users to meet me informally as previously planned through my original recruitment plan via antenatal groups. The practitioners arranged for me to observe various team members as they interacted with women to understand the workings of the team and the service user's experiences as well as informally introduce myself and the study to service users.

I participated in five observational sessions, shadowing practitioners to their meetings and interactions with service users. During this time I was introduced as a researcher to any service users I met and PIS were issued to anyone expressing an interest. This familiarity between myself and service users helped recruit three of the nine women who participated in the study. Continued interactions with the key practitioners also helped motivate practitioners to continue attempting to recruit service users to the study. The final strategy required to reach optimum recruitment was for practitioners themselves to arrange the time and location of the interview and for me to confirm this and attend. As many women within the service have mental health issues including anxiety and depression it was important to plan recruitment and data collection to suit their needs to ensure they had equal opportunity to participate. For some women who were especially anxious, it was easier and more comfortable for them to arrange details with someone whom they knew from the service. In total I recruited nine service users, (two pregnant and seven postnatal), over 10 months from 19 who were approached as they were interested. The 10 who did not participate were either uncontactable or further declined to take part after initial contact.

Recruitment of case studies

Women who were pregnant at the time of their first interview were also invited to be a longitudinal case study which involved a series of interviews over their time with the service. Three women were recruited as case studies to be followed up during the time of their involvement with the service. All three antenatal women who had agreed to

participate in the study were offered to be included as a case study. Of these women, two agreed to be case studies and consented to follow up. Of these two only one further participated. One participant was lost to follow up as she did not respond to my phone calls, text or letter correspondence. The second case study participant was in her third trimester by the time the initial interview was conducted, therefore only two interviews took place (one antenatal period, one postnatal period) due to the time frame of data collection. A third participant was invited to be included as a case study however it was not possible to arrange an interview during the time she was pregnant. I therefore conducted two interviews in the postnatal period.

Recruitment of practitioners

Multiple strategies were used to enable and enhance practitioner recruitment. These included attending team meetings, observing practice and running study recruitment information sessions. At a team meeting attended by the majority of practitioners I disseminated the PIS and invited all practitioners to contact me if they would like to take part. Despite all practitioners informally indicating they would like to participate no one contacted me. Following discussion with my two key practitioners (see above), I emailed all practitioners individually with an invitation to participate. This resulted in 10 out of a possible 11 practitioners agreeing to take part.

Data collection

A wide range of data sources were used in an iterative manner as recommended in RE methodology. Each source is described in detail in either Phase One methods– Identifying programme theories, Phase Two methods– Testing programme theories or Phase Three methods – Refine programme theories of the study methods, in the following section. Figure 14, Figure 17, and Figure 19 provide an overview of each data source used in each phase. The next section will describe the data collection and analyses used in Phase One to identify IPT.

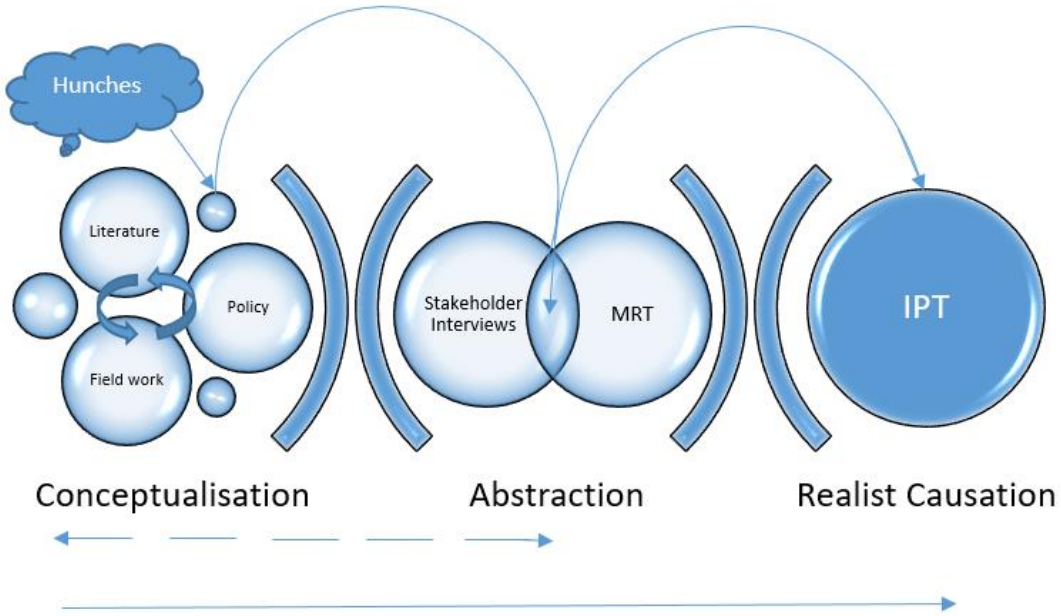
Phase One methods– Identifying programme theories

Objective – Identify initial programme theories which hypothesise how the programme works

This section outlines Phase One of this Realist Evaluation, which involves the development of Initial Programme Theories (IPT). IPTs are the prior assumptions or "folk theories" (Pawson and Tilley, 1997, p. 88) which explain how the programme or intervention is expected to "work". In my research these theories proposed how an integrated multidisciplinary service for pregnant women with alcohol and drug problems expected to improve the health and social outcomes for both mother and baby within an urban setting in central Scotland. These IPTs were then tested through single interviews and case studies in Phase Two of the study as discussed in section Phase Two methods– Testing programme theories, below and Chapter 6 Phase Two Findings.

There have been many different approaches to IPT development across realist evaluation methods (Marchal et al., 2018 and Mukumbang et al., 2016). I used multiple methods in Phase One to construct the IPTs working through a process of Conceptualisation, Abstraction and Realist Causation. Figure 14 demonstrates these steps taken to build IPT. The methods employed in each of these processes is described below with examples of theory development outlined in Figure 16, Figure 18 and Figure 20.

Figure 14. Phase One: Identifying Programme Theories



Key:

MRT- Middle Range Theory

IPT- Initial Programme Theory

Iterative approach-

Conceptualisation informed my "hunches" through an exploration of the literature, policy, and fieldwork including observations of team meetings and participant-practitioner interactions (Figure 15). I visited and revisited these data sources using an iterative approach, comparing and contrasting concepts, to inform my thinking and build my knowledge around potential IPTs. Stakeholder interviews were conducted to further conceptualise these hunches and a snowballing technique as described by Greenhalgh and Peacock (2005) was applied to explore the literature of relevant emerging theories to enable abstraction of theories. This abductive process, informed by my hunches, is described by Jagosh, (2020) as "theoretical re-description" which directs the design and execution of the study to scientifically test the mechanisms. Conceptualisation and Abstraction were approached iteratively, continually reflecting and reviewing the theories.

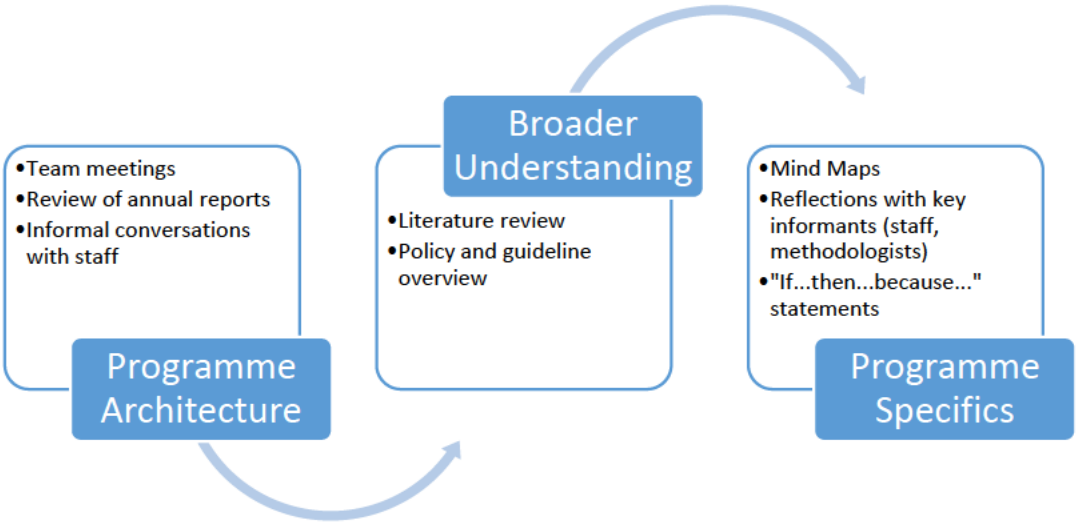
At this early stage of developing the IPT, the aim is to use different data sources and methods to "glean" many theories about how the service might work or not to achieve its proposed aims. This requires the net to be cast widely, incorporating data from different angles, before narrowing down the scope of the evaluation (Shearn et al., 2017). This has been argued by several methodologists as key to IPT development as single data-driven approaches to theorising lack broad and diverse perspectives (Shearn et al., 2017), produce vast quantities of theories (Pawson, 2013) and miss opportunities to consider influences of wider social structures (Pawson, 2006). Both stages of Conceptualisation and Abstraction over time supported the development of IPTs in the final stage of Realist Causation. Input from the wider supervision team and experts in both realist methods and maternal substance use aided the development of three IPTs and prevented a single lens approach. To help the reader I have added an example at the end of each section of the chapter to demonstrate Conceptualisation, Abstraction and Realist Causation.

Data collection and analysis

Conceptualisation

The conceptualisation process (Figure 15) aimed to generate programme specific understanding of the intervention. This required both a specific understanding of the local service and a broader understanding of the service's approach to maternity care for women with drug and alcohol problems. This process helped to develop "hunches" which then informed the stakeholder interviews and reflections on observations.

Figure 15. Process of Conceptualisation



Outlining programme architecture

The first stage of conceptualisation requires an outline of the programme architecture or blueprint of the programme (Jagosh, 2018) in order to assess what the service consisted of and what was being evaluated (Appendix 13. Programme Architecture). This architectural depiction was informed by discussions with the staff members from the service and reviewing the service annual reports. Attendance at a staff team meeting gave insight into the roles, intentions and interventions each practitioner contributed to the service. From this architecture, a complex intervention can be broken down into specific components (Jagosh, 2019). Formal and informal meetings with the service practitioners allowed for this architecture to be refined and enabled me to identify what underpinning policy frameworks, guidelines and legislations formed the foundations of the multidisciplinary service. The outcomes presented in Figure 16 are broad outcomes for each discipline which were gleaned when outlining the programme architecture from different data sources. Some of the disciplines who informed the architecture had a very narrow focus on outcomes e.g., toxicology, while others had a broader range of outcomes that they considered important. This is discussed further in the findings section Phase One, Identifying programme theories. The outcomes focused on in my IPT development were more intermediate e.g., relationship building and engagement, as demonstrated in Chapter 5 Phase One Findings. As the study was conducted over several years this process was repeated at

multiple time points to ensure at the point of data collection the programme architecture was accurate. This was important as certain disciplines in the service were funded for short periods of time and when this funding stopped the construct of the team changed.

Policy overview

Discussions with practitioners highlighted the key policies and guidelines they followed during their practice and informed their selection for exploration. Due to the interdisciplinary structure of the programme, the policy frameworks included: Maternity, Drug and Alcohol, Early Years and Child Protection and more specifically Early Years within Drug and Alcohol. Each policy was reviewed and noted to focus on certain core principles (child protection, family centred, person centred, and woman centred) varying in ethos and focus depending on discipline area, Appendix 14. Policy Documents Included in Review

In addition to the sequential systematic literature reviews presented in Chapter 2 Literature Review, I also read other relevant published literature which I identified from citation lists from papers reviewed and policy documents. The literature and policy overview allowed me to start exploring what context, mechanisms and outcomes were perceived to be at play in MDT services for pregnant women with substance use. Comparing and contrasting context e.g., USA based programmes vs UK based programmes raised questions about the local barriers to services and local policy background. Concept maps (Figure 33) facilitated the development of key factors and from these I outlined 22 “If…then…because…” statements based on six components of the service. These six components were identified through discussions with the IPPSS manager who identified these as core aspects of the service including: the MDT working approach; co-location of the practitioners; holistic service; midwifery care; mental health services (CPN); and parenting officer. These covered diverse aspects of the service and are included as key components of the NICE (2010) guidelines for women with complex social factors. These “If…then…because…” statements (Table 13), formed the initial step in conceptualising IPT by outlining what elements of the intervention led to what outcomes and have been used widely in realist studies to elicit initial programme theories (Jagosh, 2018, Mukumbang et al.,

2016). I presented these statements at a Centre for Advancement in Realist Evaluation and Synthesis (CARES) summer school where further direction towards MRTs was advised in line with Pawson and Tilley's seminal work and the abductive process of theory development.

Figure 16. Example of Conceptualisation

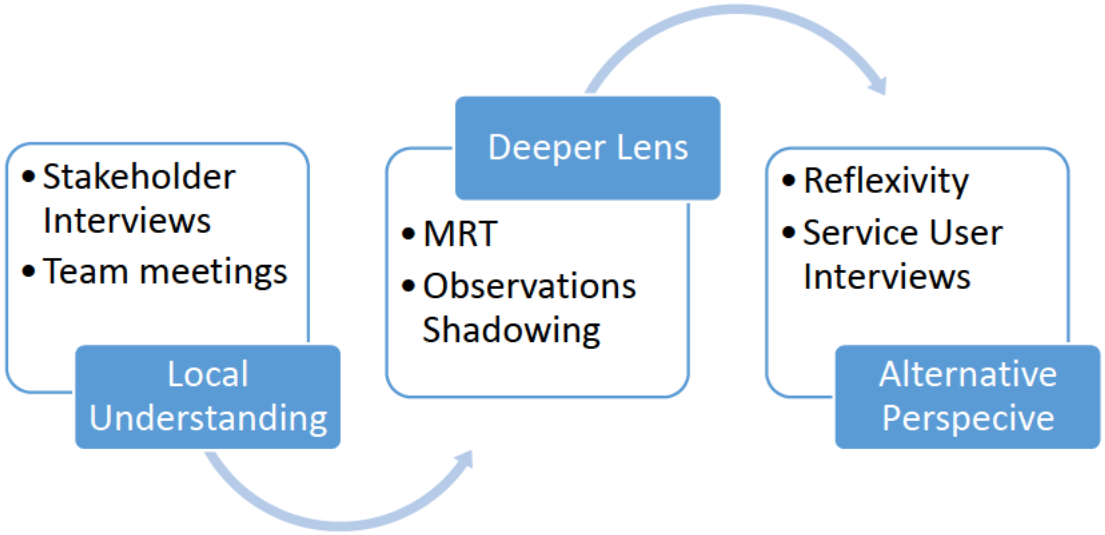
Component 3. Holistic approach	If a service is holistic (Intervention) then… all aspects of the service users' needs can be addressed (outcome), this in turn can build relationships/trust (outcome) as women feel the service is interested/investing (mechanism) in them and by addressing issues this may increase engagement, self-efficacy and executive functioning (outcome).
	If a service is holistic and non-stigmatizing then (Intervention)… women will feel welcome, safe, not judged and are more likely to engage (outcome).
	If a service is not holistic and is judgemental then (intervention)…women will feel scared, resentful, disempowered, unwelcome (mechanism) and will not engage (outcome) with services potentially leading to continued risk taking behaviour and poor birth outcomes (outcome).

The holistic approach to the service is conceptualised as an element of the intervention which can lead to engagement, through the way it makes women feel e.g. safe, welcome, invested in. What this concept is missing at this stage is contextual factors which may influence the way it makes women feel and a greater understanding of the causal mechanisms which trigger the outcomes associated with engagement.

Abstraction

The process of Abstraction involved primary data collection in the form of interviews and observations and exploring MRTs. Additionally reflexive practices were employed to gain deeper insights and alternative perspectives.

Figure 17. Process of Abstraction



Stakeholder interviews

Stakeholder interviewed were conducted to understand the expected "workings" of the service from service design perspectives from three key disciplinary backgrounds involved in the service: maternity, social work and mental health. The discussions were conducted as exploratory conversations, opening with scoping questions (Appendix 15. Stakeholder Interview Topic Guide) e.g. What is it about the service do you think works and does not work? These questions helped me understand the workings of the service from the three key disciplines in this "theory gleaning phase" as described by Manzano (2016). Realist interviewing techniques (Pawson and Tilley, 1997, Manzano, 2016) were used to unearth the presumed causal mechanisms as discussed by the stakeholders. This technique required me to conduct the interview in a "teacher-learner style" (Pawson and Tilley, 1997) whereby I brought my own knowledge to the interview, presented these concepts and built on this with the response from the stakeholder. Stakeholders brought their expertise and experience, responding and contributing to the development of theoretical components. This is common in realist methods as the purpose of realist enquiry is to build and develop theory in a theory driven way. Further description of the employment of realist interviewing techniques are described in Phase Two methods– Testing programme theories, of this chapter.

The “If…then…because…” statements previously outlined during conceptualisation, informed the direction of my enquiry however, the scoping style of the interview allowed for an exploratory, inductive approach in this early stage of programme theory development. The main areas identified by the stakeholders included: what works, what does not work, short and long-term aims, successes and main identified outcomes. The responses to each question were collated into one of two categories: Service structure or Individual staff. From these interviews a further 20 “If…then…because…” statements were developed, which are presented in Chapter 5 Phase One Findings.

The role of middle range theory in IPT development.

Personal reflection and discussions with supervisors and the wider realist network led me to explore more abstract theories. Middle range theories (MRT) described in Chapter 3, Types of theory in realist evaluation, are overarching theories which further explain programme theories on a broader scale. MRT may be discovered or drawn upon at multiple points throughout realist evaluation as they provide a lens to apply to the retroductive process (Jagosh, 2018). This part of the retroductive process is termed “Abduction” and refers to the re-description of theories (Jagosh, 2020).

At the stage of theory gleaning it was necessary to explore potential MRTs as they were presented or emerging from the data in the form of researcher hunches. Jagosh et al. (2013) explains how researcher hunches are a valid part of the theorising process enabling conceptualisation through abductive methods and increases external validity through reflective research approaches. Several MRTs which influenced the development of IPTs are outlined in Table 8. As theory development is an iterative process, further MRTs became utilised later and will be discussed in Phase Two and Three, to detail the different stages of the process with in the application of RE in this study.

Table 8. Middle Range Theory Explored During Phase One.

MRT	**Relevance to the theory development**	**Reference**
Partnership synergy	Identifying factors to support collaborative working across partnerships	Lasker, Weiss and Miller (2001)
Inter-professional collaborative relationship building process	Focused theory in the direction of: ethos, leadership, communication, collaboration and co-location.	D'Amour et al., (2005), San Martin Rodriguez et al., (2005), Wener and Woodgate (2016).
Woman Centred Care	Feminist approach supporting the understanding of holistic needs and relationship based practices to improve empowerment of women during their involvement with maternity services.	Hamner and Daphne (1999), Leap (2009), Fahy (2012)
Trust Level Theory	Appreciation of the wider contextual influences which direct fear and trust in individuals and their ability to form trusting relationships and self-growth.	Gibb (1991)

These MRTs outlined in Table 8, expanded my thinking and therefore focused my theorising in the direction of relational based practices for disempowered populations, the importance of ethos, leadership, communication, and co-location for interagency working (San Martin Rodriguez et al., 2005, D'Amour et al., 2005) and the wider Macro contextual factors which influence trust building (Gibb 1991).

Observations of practice

As previously highlighted, theory development was an iterative process. Whilst exploring the MRTs I attended a team meeting to further present my thinking and

invite feedback on the process and components of the service with the staff, to gain greater insight into the local workings of the service. This highlighted the practitioners' own perceptions of the service and what they believed contributed to outcomes. As this took place within the team meeting, I acknowledged that some responses to my thoughts may have been influenced by the presence of work colleagues and managers. To enhance my understanding, I shadowed a member from each discipline over the course of a few weeks to familiarise myself with each role within the service. This also offered practitioners the opportunity to discuss the service without colleagues present. Shadowing each practitioner in turn gave me insight into their working schedules, the content of their appointments and helped me understand how their roles supported and complemented one another.

Observations such as practitioner-women interactions, built on the examples practitioners had shared with me about the importance of building relationships. These observations added value to my understanding of the workings of the service and were a valuable data source in addition to the stakeholder interviews (Manzano, 2016). Observing the woman's part within the interaction with the practitioner aided conceptualisation of the contextual factors which may influence their experience of the service. Travelling between appointments with practitioners offered opportunities to informally discuss the service and explore individuals' perspectives without the influence or pressure of other team members. Following each observation I documented written reflective accounts, highlighting changes or developments in my understanding and key questions to take forward to my next observation or informal discussion. This iterative approach of observing and reflecting supported the development of the initial programme theories.

Ongoing reflexivity throughout the iterative deductive approach

Following the stakeholder interviews, observations and further consideration of MRTs, I viewed theory development as part of a deeper reflexive approach. Reflexivity is "an awareness that the researcher and the object of study exist in a mutual relationship" (Whitaker and Atkinson, 2019, p.1). The researcher must remain vigilant of this relationship and the influences each have on the research. Reflexivity is a vital element in realist evaluation with many highlighting its importance to ensure rigour (Ebenso et

al., 2017) and conduct ethical research (Karnieli-Miller and Pessach, 2009). Acknowledging my own influences and perspectives from the outset of the study brought awareness to the view I have and the decisions I made (Nayar and Stanley 2014). Throughout the iterative process of IPT development I continually reflected on each aspect and content of data collection whilst acknowledging the lens in which I viewed the theory development as well as the wider research process as demonstrated in section The role of written reflections.

An example of this is the transparent approach to decision making throughout this study. With a wealth of diverse viewpoints within one service, the scope and direction of the study could have been vast. However, pragmatic decision making such as setting boundaries to enable the study to be manageable within my PhD capacity, time frame and funding was key. Acknowledging the policy context in which this study was set and presented as an example of good practice (NICE, 2010) also guided the direction of the study to explore tensions between woman centred care within child protection services. Further descriptions of the transparent decision-making process are detailed through the methods section Phase Two methods– Testing programme theories and Phase Three methods – Refine programme theories as well as throughout the findings presented in Chapter 5 Phase One Findings, Chapter 6 Phase Two Findings and Chapter 7 Phase Three Findings.

Significant reflexivity throughout the iterative process of theory development helped conceptualise the theories from multiple perspectives. To support this I kept written notes, diagrams and mind maps on the development of specific theories to refer to when required and kept a chronological record of developing thoughts. My background in midwifery also brought a practical lens giving me insight to clinical practice and a disciplinary lens, as I had previous experience of providing services for vulnerable pregnant women as well as caring for newborns with Neonatal Abstinence Syndrome (NAS)**.** Whilst my perspective was from a midwifery lens, I broadened my scope of understanding through multiple data collection methods and sources.

Through these reflexive approaches outlined, I reviewed the 42 “If…then…because…” statements and categorised them into six overarching themes: MDT, Co-locations,

Service structure, Individual Staff, Therapeutic Relationships and Policy. Through constructing the "If…then...because…" statements I began outlining context, mechanism and outcomes to explain how each element of the service led to specific outcomes. Cataloguing individual context, mechanism and outcome was one element of the process however building interactions of context, mechanism and outcome to show causation was the desired aim.

Under each theme the "If…then…because…" statements were refined as several were similar or alluded to the same theory resulting in 19 "If…then…because…" statements (as outlined in Chapter 5, Table 16). After refining these I presented the "If…then…because…" statements to my supervision team and we discussed the refining process ensuring consensus with the decisions made. This practice highlighted to me that at this stage most of the theory development was from practitioners' perspectives (e.g., stakeholder interviews, informal discussions, team meetings, observations) and the research required further insight from the lived experiences of service users.

Service user perspective

During reflection with my supervision team, we discussed the IPTs which were mainly constructed from the viewpoint and assumptions of the practitioners. Whilst this is important to identify how in theory the intervention is expected to work, I felt it was essential to know the service users' perspective at this early stage to conceptualise the intervention from both perspectives. Inclusion of service users was planned to be during Phase Two Testing Programme Theories. However, I decided to bring these interviews forward into Phase One Developing Initial Programme Theories. One of the main reasons for this was the key role service users' play in how interventions work. Understanding the intervention in a realist perspective requires acknowledgement that no one is a passive recipient within an intervention (Pawson and Tilley, 1997). Therefore, the service users have as much influence if not more than practitioners in how outcomes are achieved.

Secondly, the service users participating in the IPPSS are a marginalised group, disempowered by their position within society. Marginalised groups including drug

users, sex workers and the homeless population, have been identified as rarely having opportunities to voice their opinion and make changes to services (O'Donnell et al., 2016). Women within IPPSS were pregnant and parenting, but also belonged to these marginalised groups. Pressured by the risk-averse nature of services, with regards to the child protection agenda, their voices hold little clout against the decisions and actions of social services. Within the IPPSS, feedback is encouraged by practitioners at the point of discharge through a questionnaire, however this process lacks impartiality as the practitioners themselves conduct the questionnaires. In addition, this process would rarely capture the views of those disengaging with service and may overly present positive responses.

Finally, another driver for including service users' perspectives to support the direction of the study was the practice of woman-centred principles. As described in Chapter 1, Woman-centred care, woman-centred principles aim to empower women to make choices, collaborate with women to meet their needs, focus on the woman's aspirations and expectations (Fahy, 2012). As this service is based within maternity care, which, in theory portrays a woman centred approach, it was essential to include the woman's perspective to shape the theory development and design of the study. For these reasons, interviews were conducted with women who were using IPPSS to further support IPT development. As theory development, testing, and refinement is an iterative process, testing of some theories began before other theories had been conceptualised. Detail of service user interviews will be outlined in Phase Two methods– Testing programme theories and the findings in Chapter 6 Phase Two Findings

Figure 18. Example of Abstraction

Interviews with stakeholders identified "hunches" they had about what worked and didn't work. Building on the concept of holistic approaches stakeholders identified that Practitioners who were **Direct** and **Honest** and practiced **Continuity of Carer** made the service work. **However, Missed opportunities to build relationships** cause the service not to work**.**

This highlighted both individual staff level and overall service structure elements which influence building relationships within a holistic approach. These elements were constructed into "if…then…because…" statements.

Individual Staff	If **staff are honest** then this will build more trusting relationships with women and encourage good communication.
Service Structure	If there is **continuity of staff** then **therapeutic relationships** will be built and staff can provide the most appropriate service for the woman.
Service Structure	If there **is no opportunity for staff to build relationships** with clients then communication will be lacking, trust will not be built.

Attending team meetings to discuss their roles and processes highlighted the value practitioners assigned to "building trusting relationships". As each team member described their part in the service, they emphasised the importance of **building a therapeutic relationship** to **improve trust** between themselves and the service user as well as trust in other members of the team. Practitioners described the process of introducing the service to a woman starting with the midwife and the CPN to aid gradual introduction of all elements of the service. The midwife's role was seen as essential for ensuring the health and wellbeing of the woman and fetus. The midwife was also presumed by practitioners as a welcomed service as women were assumed to want to have their pregnancy assessed. Practitioners also described the **importance of sharing information** about child protection concerns with the service user to ensure they were fully informed. This information sharing was seen by practitioners as a **way to build trust** with service users and encourage honesty from them. I recorded these thoughts in meeting notes and further reflected on these to develop the concept of holistic approaches further introducing the element of **therapeutic relationships** and **trust building**.

Figure 18 continued

Through the initial interviews with service users' **therapeutic relationships and trust building** were explored further with women highlighting the importance of **being and feeling informed** about child protection processes, as well as **barriers to trust building** e.g. previous experiences with social work.

Individual Staff	If staff are honest, dedicated, assertive and persistent then this will build more trusting relationships with women encouraging good communication, increase commitment to work with women to reach the best outcome for them even when women continue to disengage.
	If staff withhold Child Protection information from women (family) then honesty and transparency will be lost and communication will break down as women are not included in decision-making and will therefore withhold information which they consider could be used against them.
(Continuity Of Carer) Therapeutic Relationships	If there is continuity of carer (CMW, HV, CPN, EYO) then this will enhance therapeutic relationships which improve communication, build trust, encourage disclosure, and anticipate issues.
	If continuity of carer is achieved, the practitioner will be able to work with the woman (family) to prepare them for the arrival of baby (e.g. parenting skills, capacity, labour prep, breastfeeding, bonding, support, recovery, family planning, assess safety for baby), practitioners will also feel more invested in the family due to time and effort spent with them.
	If there is no opportunity for continuity of carer then there is no opportunity for building therapeutic relationships causing a lack of trust.

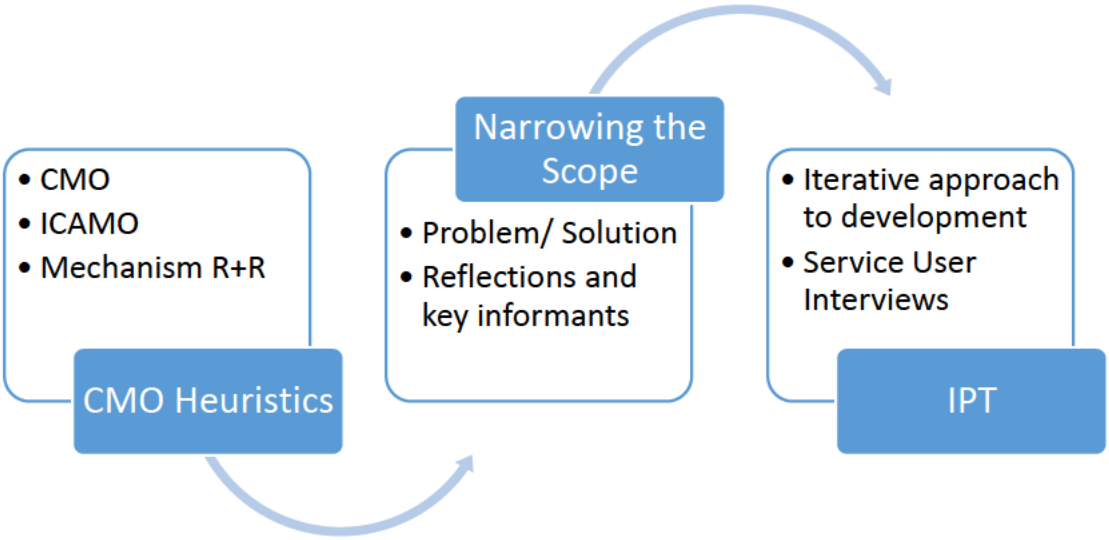
I then turned to the literature on trust and explored MRT of trust which helped expand my thinking around why someone trusts, how trust is built and what trust might manifest as. Thinking about these questions helped unearth mechanisms of trust as well as explore in what context trust can be built. Some of the key literature which informed my thinking includes The Empowering Theory of Trust (McGeer and Pettit, 2016) and TORI Theory and Practice (Gibb 1972). This iterative approach of empirical data collection, theory explorations and reflection aided the development of IPT and informed the interview schedules for Phase Two (theory testing).

Realist causation

Finally, the analytical process of Phase One was completed through identifying Realist Causation (Figure 19), constructing Context (C) Mechanism (M) Outcome (O) heuristics

(CMO), focusing the aim and objectives of the study and incorporating service user perspectives at the theory development phase.

Figure 19. Process of realist causation



Context Mechanism Outcome (CMO) heuristics

The final stage of the initial phase was to explain these conceptualised "If…then…because…" statements as Context Mechanism Outcome (CMO) heuristics, to further identify the causal link. Many different approaches to CMO construction have been exemplified in realist studies (Mukumbang et al., 2016, Emmel et al., 2018, Dalkin et al., 2015) as described in Chapter 3 CMO configuration (CMOc). I used a combination of Mukumbang et al's (2016) ICAMO which involved identifying the Intervention element (I), Context (C), Actors role (A), Mechanism (M), Outcome (O), and Dalkin et al's (2015) breakdown of Mechanism into Resource and Reasoning or Response. I found the combination enabled me to identify gaps in the causal links as well as refine my identification of mechanisms. The use of Rival Theories was also important to question elements of the theories which may identify different components such as specific contexts which could change a mechanism response (Pawson, 2013, Jagosh, 2020). Building CMO Heuristics over time allowed me to identify which programme theories were impacting the service across all disciplines.

Some theories were specific to discipline area and others spanned the whole service. Decisions regarding the pragmatic decision to progress with certain theories, and not with others, is detailed further below and in Chapter 5, Narrowing the scope of theories. It was necessary to identify specific core theories that worked across the service, as I would not be able to evaluate the service using all 19 potential "If…then…because…" statements.

Figure 20. Example of Realist Causation

Continuing the example previously highlighted in conceptualisation and abstraction the table below shows one element of broader IPT 2. By focusing on the intervention element of **building therapeutic relationships** this CMOc aims to show the causal link between context, mechanism and outcome. When therapeutic relationships continued to be discussed in observations and interviews I returned to the literature to explore this further. Studies involving pregnant women with substance use also highlighted the importance of therapeutic relationships and how these were built and how they influenced outcomes (Milligan et al 2017 and Rayment-Jones et al 2019). Elements of services as presented in "Resource" influenced women's feelings "Response". As I continued to explore these mechanisms in the literature and the interviews, key context e.g., previous experience of social work, were clearly influencing factors in how mechanism's played out. Testing this element further in Phase Two helped to refute and refine this IPT further.

I3. Part of the intervention is to build therapeutic relationships with the woman.	C4. Woman with previous experience of social work leading to fear and distrust of social work services.	M4. **Resource:** Practitioners are open, honest and share info, are non-judgemental. Offer flexible service e.g. attend social work meetings, **Response**: Woman has increased knowledge, trust, alleviated stress and anxiety and feels respected and considered.	O4. Woman builds therapeutic relationship based on trust and feels empowered resulting in *motivation* to engage with service.	Date source: Milligan et al., (2017), Rayment-Jones et al., (2019) Interviews with stakeholders, interviews with service users.

This one element which is part of IPT 2 also influences IPT 3 .The therapeutic relationship built between practitioner and service user becomes the context essential to the workings of IPT 3. This became clear through interviews with the service users and observations of practice. If a woman had not built therapeutic relationships and began engaging with the service, she would not know of the potential flexible nature of the service. This relates back to initial assumptions made by the stakeholders who identified a reason for the service not working as "Missed opportunities to build relationships".

Narrowing the scope

I presented the nine core theories covering the six themes (MDT, Co-location, Service Structure, Individual Staff, Therapeutic Relationships and Policy) (Table 17 in Chapter 5) at both the steering group committee biannual meeting and local NHS midwifery research meeting to involve the thoughts and opinions of both clinical practitioners, academics and service developers. This engaged different perspectives and aided development of rival theories, consolidation and prioritisation of programme theories. With a wealth of interconnected theories covering various elements of the intervention the prospect of testing all nine was beyond the capacity of my study. Realist researchers have previously highlighted the importance of narrowing the focus of realist studies: "In the face of this abundance, RAMESES guidance stresses the importance of prioritizing or focusing the research." (Shearn et al., 2017. p.4).

At this point I went back to examples of realist evaluation and constructed an over-arching programme theory (see Narrowing the scope of theories) in a problem-solution frame as previously done by Adams et al., (2015). In their study Adams et al., (2015) outline the "problem" the intervention is trying to address, and the "solution" programme designers assume will improve outcomes. In my approach I aimed to conceptualise the whole intervention outlining the key Intervention elements, Context, Mechanism, Outcomes, essentially illustrating the service as a sum of its parts. This helped outline the service and re tabulate the CMOs I was examining (see Chapter 5 Figure 34 and Table 18).

I reviewed the nine theories and decided to proceed with the three most prominent from the interviews, observations, and those, which involved the mechanisms identified in the overall theory. These three theories focused on an intermediate outcome of engagement, a key outcome to meet, in order to reach short and longer-term outcomes as proposed by the service. At this time, I was also conducting interviews with service users, to explore women's assumptions of how the intervention worked. However, as expected with iterative approaches to data collection and analysis, there became a point where I was beginning to enquire about certain areas of the service, and it was becoming clear I was proceeding to test certain theories. These theories were interesting to me and continually presented themselves

in the interviews with the women which demonstrated their significance to them. Wong et al., (2013) highlights the vast and complex nature of theorising programmes and acknowledges the importance of justified priorities and pragmatic decisions, in order to narrow the scope of the study.

The three IPTs developed in this initial phase of this realist evaluation are presented in Figure 21, Figure 22 and Figure 23.

Figure 21. Initial Programme Theory 1

Initial Programme Theory 1

The service model for pregnant women with problem alcohol and drug use works because specialist practitioners work as a multidisciplinary team in a co-located service, and the range of specialist expertise in combination with daily staff interaction serves to strengthen coordination, understanding of roles and problem solving.

Within a challenging and "gruelling" practice area (Context) the service (MDT, Co-located, specialist service) (Intervention) with mutual goals and team ethos (Context) introduces…

1. the opportunity for (formal and informal) communication (resource) which builds respectful, trusting inter-professional relationships (response) leading to improved communication about cases (outcome).
2. the opportunity for (formal and informal) communication (resource) improving practitioners understanding of responsibility and accountability (response) resulting in timely action (outcome).
3. skilled staff (resource) who bring an understanding of responsibility and accountability (response) and motivation and dedication (response) resulting in improved staff morale and retention, reduced burn out and timely action (outcome).
4. peer supervision (resource) which improves motivation and dedication (response) and an understanding of responsibility and accountability (response) resulting in improved staff morale and retention, reduced burn out, improved communication about cases and timely action (outcome).
5. a case co-ordinator (resource) which improves each practitioners understanding of responsibility and accountability (response) leading to improved communication about cases (outcome) and timely action (outcome).

Figure 22. ***Initial Programme Theory 2***

Initial Programme Theory 2.

The service model for pregnant women with problem alcohol and drug use works as the practitioners use open, honest, non-judgemental approaches to encourage trust building with women who are often distrusting and fearful of services due to previous experiences. This approach helps to make women feel respected, considered and more trusting of the service.

If the service aims to build therapeutic relationships (intervention) with a woman who has previous experience of social work (who have fear and distrust of services) (context)

1. Then a non-judgemental approach and flexible service (resource) makes the woman feel respected and considered (response) and therefore more encouraged to engage (outcome).
2. The flexibility of the service (resource) offers practical alternatives (resource) alleviating stress and anxiety (response) (because of "hand holding", "takes pressure off") enabling women to engage (outcome).
3. Then offering open and honest communication (resource) the woman begins to trust the practitioner (response) leading to therapeutic relationships (outcome).
4. Then the practitioner sharing information (resource) with the woman will inform the woman and will lead to trust building (response) and strengthening the therapeutic relationship (outcome).

Figure 23. Initial Programme Theory 3

Initial Programme Theory 3.

The service model for pregnant women with problem alcohol and drug use works as it offers a flexible service (home visits, transport, informal communication, advice, practical support) (intervention) to a woman who has a therapeutic relationship with a practitioner and is engaging with the service (context)

1. then the tailoring of the service (resource) makes the woman feel more valued (response) as it meets her needs (outcome) leading to satisfaction and positive experiences with the service (outcome) and longer-term engagement (outcome).
2. then the tailoring of the service (resource) offers choice (resource) strengthening woman's autonomy and improving her self-efficacy and empowerment (response) leading to satisfaction and positive experiences with the service (outcome) and longer-term engagement (outcome).
3. then goal setting or laying out of expectations (resource) gives women a sense of hope (response) leading to motivation and behaviour change (outcome).

Phase Two methods– Testing programme theories

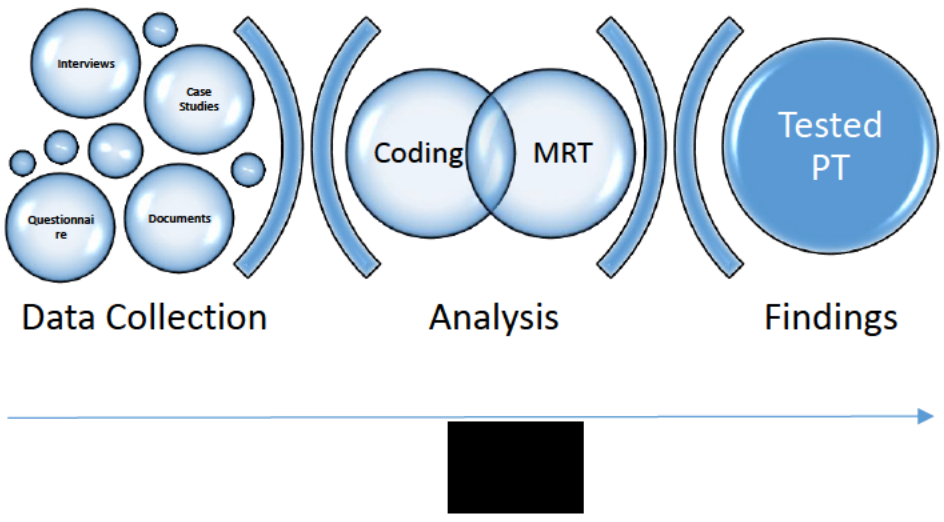
Objective – Test these theories through an iterative process of data collection and analysis.

Overview

This section describes the data collection methods and analysis employed during phase two of the study, testing of the three IPTs presented above, the aim of which was to refute, refine or defer the theories.

In their description of the Realist Evaluation Cycle, Pawson and Tilley (1997) explain "Hypotheses are tested through observations of various kinds" (p. 84). These observations can be any appropriate method, as realist researchers follow a *Pluralist* approach to data collection (Pawson and Tilley, 1997, p. 85). Data collection methods are chosen in a pragmatic way to ensure the most appropriate method of data analysis can be applied to "test" each theory as described in Chapter 3 Methodology. The three IPTs were tested through interviews with service users and practitioners, questionnaires, secondary analysis of routinely collected data and longitudinal case studies. An iterative approach to data collection and analysis was taken and resulted in three refined programme theories. Figure 24 illustrates an overview of the process taken in Phase Two.

Figure 24. Phase Two: Testing Programme Theories



Data collection

Interviews

Realist interviewing technique was employed in a "teacher-learner" (Pawson and Tilley, 1997) style with participants to support the testing of theory elements. This interviewing approach as previously described in Phase One, has been widely used in realist methods as it aids the testing and development of specific theories. During theory testing, realist interviewing technique differs to the theory gleaning phase through the more direct and specific enquiry (Manzano, 2016). For example, during theory testing of the mechanisms of co-location I enquired broadly about the benefits of co-location versus disparate locations.

> *Do you find working in a co-located sight is giving you benefits that you might not have if you worked you know [in different offices and locations]?*
>
> (Practitioner Interview 1.)

However, in the final practitioner interview my questioning was more specifically focusing on the contextual factors, which may drive utility of co-location such as practitioners experiencing "difficult" times, relating to the "gruelling" context of practice in IPT1.

> *Okay, and what about on a day to day basis, coming into the office, some members of staff have said that that's really good if you've had a really difficult time they can come in and see somebody, maybe not had a chance to have lunch or sit with just...how do you see that on a day to day basis is working, is that hypothetical that it should work that way or is it a reality?*
>
> (Practitioner Interview 10.)

This difference in interview questioning also supports the validation of analysis and the refinement of theories through "follow up" interviews. Although practitioner interviews were only conducted with practitioners once, the analysis process commenced during data collection, therefore, the theories were being tested and refined as an ongoing process and subsequent interviews were utilised to "follow up" and refine theories.

Prior to the interviews I outlined key concept areas (developed during Phase One) to test in the interview and included these in interview schedules (Appendix 16. Interview Schedules (Service Users) and Appendix 17. Interview Schedules (Practitioners). All participants were offered a revised and simplified version of the interview schedule to put them at ease during the interview and as a tactical resource to help them connect with the interview. The use of interview schedules structured the conceptual areas being explored in the theories and were explicitly testing certain aspects of the IPTs. However, the interviews were also directed by participant narratives as in most cases the interviews followed a natural conversational interaction. In cases where participants stories took over, I would offer time and space to allow participants to share and then redirect them to the concept being discussed by paraphrasing their description to ensure the main response was captured and clarified during the interview.

In total 21 interviews were conducted, 10 practitioners and nine service users (two participated in two interviews each). Practitioner interviews took place in private meeting rooms in either the University setting (n=1) or the health and social care setting (n=9). Women's interviews took place either at their own private home (n=8) or in a community health and social care setting (n=3). Fifteen interviews were transcribed verbatim by me and six were transcribed by a professional transcription company due to time limitations.

Following each interview, I wrote reflections on the concepts which presented during the interview and how these were contributing to the theories being tested. These reflections led me to update the interview schedules prior to the next interview and informed the direction of the theory testing.

Questionnaire

Practitioners and service users completed questionnaires (Appendix 18. Participant Questionnaire (Practitioner) and Appendix 19. Participant Questionnaire (Service User)), at the time of their interview which collected demographic data (presented in Chapter 6 Sample). Practitioners' questions included length of time qualified in their discipline role, whilst service users' included substance use history, medical history and obstetric history. Similar questionnaires had previously been developed for a study

with the same service and service user population and was known to be acceptable to participants. These descriptive statistics were collected to provide contextual data of the service and support triangulation of the findings. In most cases questionnaires were completed by participants confidentially prior to the interview being conducted and were not discussed with the researcher. However, a couple of service users did not have the literacy skills to complete the questionnaire independently and in these cases I supported them to complete the questionnaire by reading the questions and filling out the responses. Although this may have influenced the responses from the service users, it was considered more ethical and considerate to ensure the participant could fully participate in the study. On balance any participant could have falsely recorded their response, however this was at their discretion.

Case studies

Three service user participants agreed to be case studies. This meant that they took part in the first one to one interviews, as per the other participants, and follow up interviews to examine their experiences over time. One participant was interviewed during the antenatal and postnatal period, the second participated in two interviews during the postnatal period and the third participated in one interview during the antenatal period. The initial plan for antenatal and postnatal interviews, aimed to test how services may change in their focus and approach during these two contrasting periods, however case study interviews did not provide this perspective due to recruitment issues previously highlighted in section on recruitment. Despite this limitation in recruiting for antenatal and postnatal interviews, case study interviews remained valuable to allow further testing and refinement of IPT especially towards the end of data collection when concepts had been tested through service user and practitioner interviews.

Genograms and ecomaps

I included two data collection tools in my case study interviews to support contextual exploration and trigger conversations to unearth examples of mechanisms functioning through service user and service interactions. Genograms and ecomaps were initially utilised in therapeutic settings (counselling, social work, health); however they have become more popular in qualitative research to explore intergenerational

phenomenon, sensitive topics and to support reflexivity (Alexander et al., 2018). The process of creating the diagrams were positively received by participants and were relatively easy to use. Although case studies are few, extensive data collection through several methods allowed for testing and generalization of theories, which supported theory refinement (Wynn and Williams, 2012). I trialled the tools with my peers before introducing them to my participants. The benefits of this were I was confident in the use of the tools and my peers supported me to consider and address potential barriers to their use. Examples of genograms and ecomaps created during data collection are included in Appendix 20. Ecomap Example from Case Study Participant and Appendix 21. Genogram Example from Case Study Participant.

Towards the end of the case study interview the participant was invited to work on two activities to explore their own contextual background. With consideration of the transgenerational impact of substance use and trauma, historical context was considered highly relevant to understand the service users' position within the wider service. Genograms were used to support discussion of the participants' family background, substance use history and emotional relationships. Ecomaps aided discussion of current support which could be reflected on at subsequent interviews to explore how social support changed during the time the women were involved with the IPPSS. The participant and I jointly created these interactive illustrations e.g., she described the family connections to me and I illustrated the diagram, however the conversations which arose from the task were of most interest.

Secondary analysis of routine data

The IPPSS collect its own routine data annually to compare and contrast the extent of the service. These reports supported continued funding of the service and allowed for outcomes to be reviewed with considerations of changes in the service structure. During the period of the study, annual reports were reviewed to support theory development as described in section Phase One methods– Identifying programme theories. I planned to collate three reports covering 2017-2021 to provide descriptive statistics to illustrate the service and to support theory testing through triangulation of mixed methods data (Flick, 2018). This would have included the average number of women who were referred to the service on an annual basis, types of substance use

history and length of substance use, percentage of children at point of discharge who remained in parental custody, were placed in kindship care or were fostered/adopted. However due to the COVID-19 Pandemic this was not possible and secondary analysis was not conducted, the limitations of which are described in Chapter 8, Secondary analysis. Instead the service-level data aided theory development and provided summary statistics of the IPPSS as outlined in Chapter 1, The service. I was able to note changes in annual data (e.g. location of child at point of discharge) to provide a description of the service and aid theory testing (e.g. women's fear of their children being removed was noted as a potential reality as seen in the annual reports).

Analysis

Phase Two required an iterative approach to data collection and analysis to test the programme theories and build on the development of theories. Taking a cyclical approach back and forth to the data collection allowed for aspects of the theories to be tested over time with the addition of new data. The following process of analysis took place during and after data collection.

The role of written reflections

Following each interview, reflections were completed on the interview content, experience and potential developing theories. These supported the theory testing over time, helped to develop my skills as a qualitative researcher and ensured my data collection was appropriate for my line of enquiry.

Reflections on the theory development included comments on how aspects of the theories may have changed during the interview, what new concepts may have presented and why certain participants had different perceptions or experiences of the service. This reflective process allowed me to identify areas of the theories that required more testing in subsequent interviews and aided the development of the interview schedule. For each interview, a modified interview schedule was outlined to include these developments of the theory testing and as theories changed, further exploration into appropriate middle range theories was conducted. In this extract from Reflection on Interview 4 my understanding of women's experiences of domestic violence is changing, I begin to question the women's role as victims and how services

perceive and support women in domestic violence situations when there is a child at risk.

> *Domestic violence is not a choice, this woman is a victim but at some point she is no longer seen as a victim by the service as she is not "choosing" to leave her partner. Initially I thought women in domestic abuse situations would be more supported by the service but where does the balance shift to being seen as "staying" with or "choosing" partner over safety of the child? Why are women again put into this position to choose to protect or sacrifice? Why are women seen as the ones to "control" their partner?*
>
> (Research diary: Reflection on Interview 4.)

Reflecting on concepts such as these in the interviews with service users altered my line of enquiry and focused subsequent interviews with practitioners allowing me to explore concepts from their point of view. Table 9 below illustrates the line of questioning for practitioners from an interview schedule developed after the majority of service user interviews had taken place.

Table 9. Extract from Practitioner Interview Schedule

Question for Practitioner	**Logic of theory**
If the service is portrayed to or perceived by the woman to be focused on **child protection** how do you think this changes your practice? the team? makes women feel? Prompt: some thoughts are this could make women feel they have to prove themselves, not respected, no privacy, no autonomy. (Disengagement)	Testing context and mechanism of child centred approaches which lead to disengagement.

The use of prompts was helpful to "teach" the participant elements of the theory, in this case focusing on the mechanisms at play in the theory component of child centred

approaches. Prompts were also used in service user interviews to allow participants to reflect on their experiences and how these may have been different to those previously expressed by other participants.

Allowing myself time to reflect immediately after the interview was also important to identify how adequately, data collection processes met the purpose of testing the theories and how my interviewing technique could be improved. Specifically I had been cautious in my approach with service users, as I was aware from discussing with practitioners that many women had social anxiety and struggled to engage. Pacing the interview was important to ease participants into a natural conversation and building rapport was essential to support participants to be open about their experiences.

> *The flow of the interview went well starting with the participant's experience of the service. Despite being nervous and anxious (participant) did really well talking to me. I think starting the interview asking about experience of the services gave her confidence because she was the expert.*
>
> (Research Diary: Reflection on Interview 5).

Realist enquiry assumes participants to be experts in their domain and through the process of realist interviewing at times each individual takes on the role of "teacher" or "learner" (Pawson and Tilley, 1997, Manzano, 2016). This "teacher-learner" style supports the development of theory under testing as together the researcher and participant build on their own expertise, shedding light on areas of the theory which may not have been previously uncovered. To deter further power imbalances between the participant, and myself, I felt it appropriate not to disclose my professional background as this may have further disempowered participants from considering themselves as the "expert" in their experiences with the service.

Finally, written reflections supported the justification and appropriateness of the data collection methods, allowing me to consider if any changes needed to be made in the study process. This was particularly helpful during interviews with case studies who participated in a series of interviews during their involvement with the service. The use of Eco-Maps and Genograms had been justified during study design as they were considered interactive yet simple in their approach to aid discussion of potentially

distressing topics. When reflecting on the use of the tools in the first case study interview, I was surprised by their utility, practicality and effectiveness.

> *This worked well as the participant was on board and engaged well. I was honest and said I hadn't really done this before and presented the key as something for me to use and not for her to worry herself too much with it. However, once we got going with it – it was easy to use and she engaged really well- actively held the key and used it to point to "emotional relationships". This was especially helpful if she felt she couldn't talk about them out loud because her partner was in the next room. She was very confident using it.*
>
> (Research diary: Reflection on Interview 5.)

Although I had trialled the tools with my peers it wasn't until I used them with the participants that the extent of their use came to light and the contextual factors I was trying to explore were illustrated.

> *Previously I had thought about just minimising the key down to positive and negative relationships after some feedback from peers, however it was clear in these relationships it's much more important to be able to elaborate on the meaning by having the other options. Distinguishing between a relationship which was hostile or abusive, was important and meant very different things to the participant.*
>
> (Research diary: Reflection on Interview 5.)

Reflecting on the interview process was useful at the time to be able to progress with subsequent data collection, in addition it helped track my developing thoughts, allowing me to reference back many months later.

Transcribing

I initially transcribed each audio recording, which allowed me to reflect again on the content of the interviews and on the development of the theories. At the start it was possible to transcribe each interview prior to the next interview, however as recruitment improved there were on occasion multiple interviews in a week which did not allow me time to fully transcribe in between interviews. In these cases the written

reflections and listening to the audio recording gave sufficient opportunities for theory reflection and development. Although transcribing was time consuming and arduous, it allowed me to remain close to the data, listen and re listen to the content and begin the analysis. Being present at the interviews meant I had a better understanding of the direct meaning and tone used during the conversations and I could make notes on these in the margin during the transcribing process. However, towards the end of the study the time taken to transcribe was impacting on the study deadline, therefore six of the 21 interviews were transcribed by a professional transcription company.

Computer Assisted Qualitative Data Analysis Software (CAQDAS)

Interview transcripts were uploaded to NVivo 12 software to store and support data analysis. The use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) has been demonstrated within the realist literature (Dalkin et al., 2020, Douglas et al., 2010; Gilmore et al., 2019; Maluka et al., 2011; Marchal et al., 2010) to support the complex analysis process in realist methods and encourage transparency through multiple utility of software components. A pragmatic decision to collate all data sources in one secure location was the initial reason for choosing to use a CAQDAS. As I had used NVivo in a prior study (McInnes et al., 2015), I felt it appropriate to utilise and build on these skills. Finally the study supervision team were geographically dispersed which meant online collaboration could be facilitated. Three key functions (Nodes, Memos and Concept Maps), of the software were utilised to support theory development and allow for collaborative working within the supervisory team.

Nodes

The first seven transcripts were coded line by line in an open coding approach. This involved reading each line of the transcript and inductively coding the data. Whilst this approach implies theory development as opposed to testing, the interviews had been semi-structured by the initial programme theories included in the interview schedule. Therefore this open coding approach was aligned to the previous outlined initial programme theories. Codes were created as “Nodes” on NVivo 12 software and where appropriate assigned to Context (C), Mechanism (M), Outcome (O) or Intervention (I) which constructed the main coding framework (Figure 25 and Figure 26). A member of

my supervision team independently coded a transcript at this time to compare, contrast and confirm the coding was trustworthy (Maher et al., 2018).

Figure 25. Nodes — Realist Coding Framework

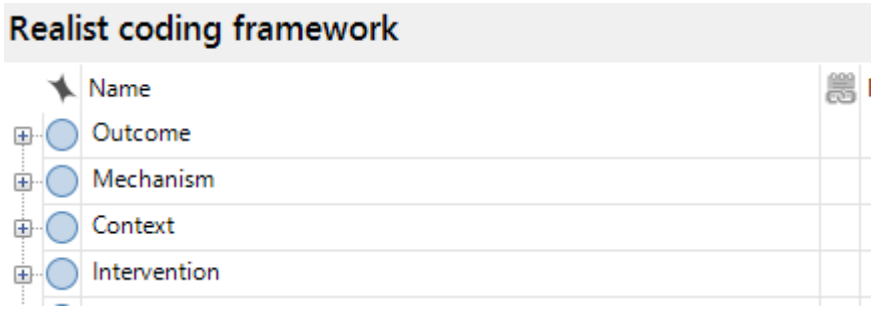
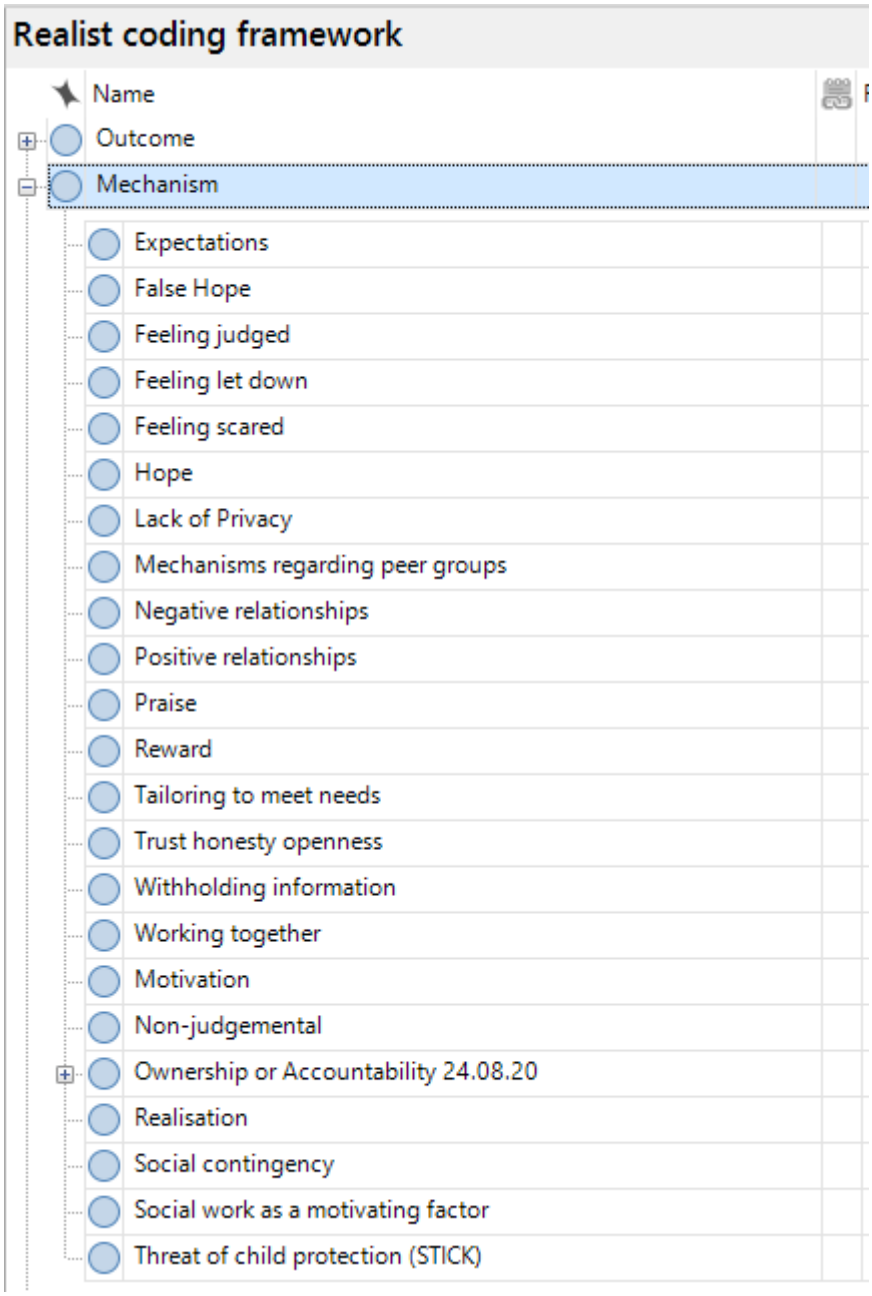


Figure 26. Extended Nodes — Realist Coding Framework

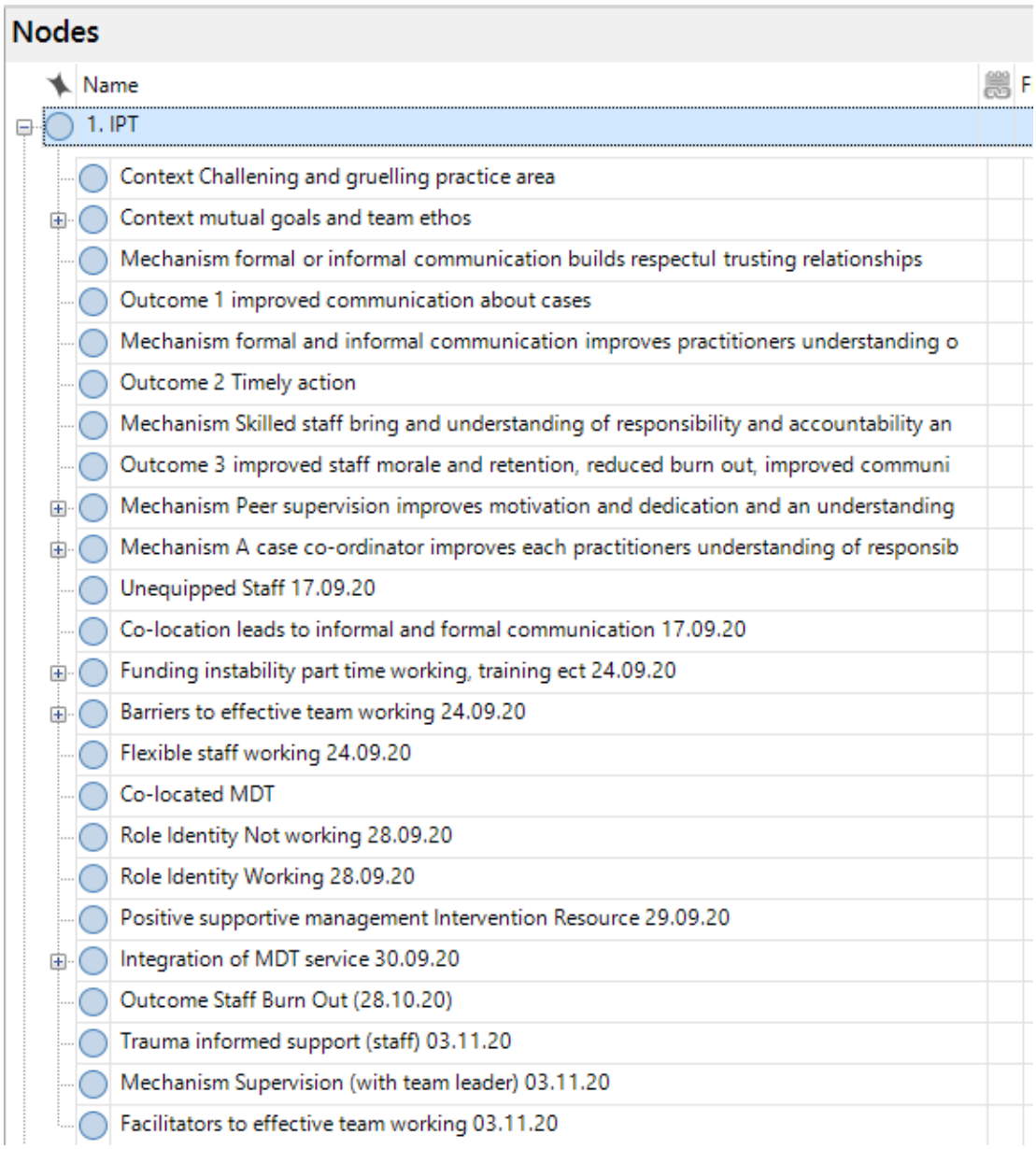


Coding to CMO

Once the coding framework was established the remaining 14 transcripts were coded line by line to the C, M, O and I components of the three initial programme theories being tested through data collection (Figure 27 and Figure 28). This deductive approach to coding supported the testing of the theory components as data was interpreted to refute, refine or defer the programme theory.

Figure 27. Nodes — Initial Programme Theory Framework

Figure 28. Extended Nodes — Initial Programme Theory Framework



Memos

When data was interpreted which did not align with the initial programme theory components of C, M, O, I, a memo was created. These memos were used to construct reflections on data analysis, collate data sources and refine programme theory components. Memos were also vital to configure C, M, O, I components to bring the analysis into a retroductive frame, testing causality of the programme theories. These memos contributed to what I have termed Emergent Components. These are newly refined programme theory components which emerged during the theory testing phase. These are not refined theories themselves but illustrate the beginning of causal links during this analysis stage.

Concept maps

Concept maps were constructed for each IPT during Phase One to outline the theory components which would be tested in Phase Two. During analysis in Phase Two, I constructed concept maps on NVivo 12 to map out the connections between C, M, O, I, (Figure 29). This demonstrated the flow of interactions between the components and supported theory testing and refinement by identifying gaps (new concepts) in the configurations. When these gaps raised more questions, I turned to more substantive theory for evidence and explanations for what I was identifying as described further in Phase Three Abstraction.

Figure 29. Concept Map IPT 2 During Phase Two.

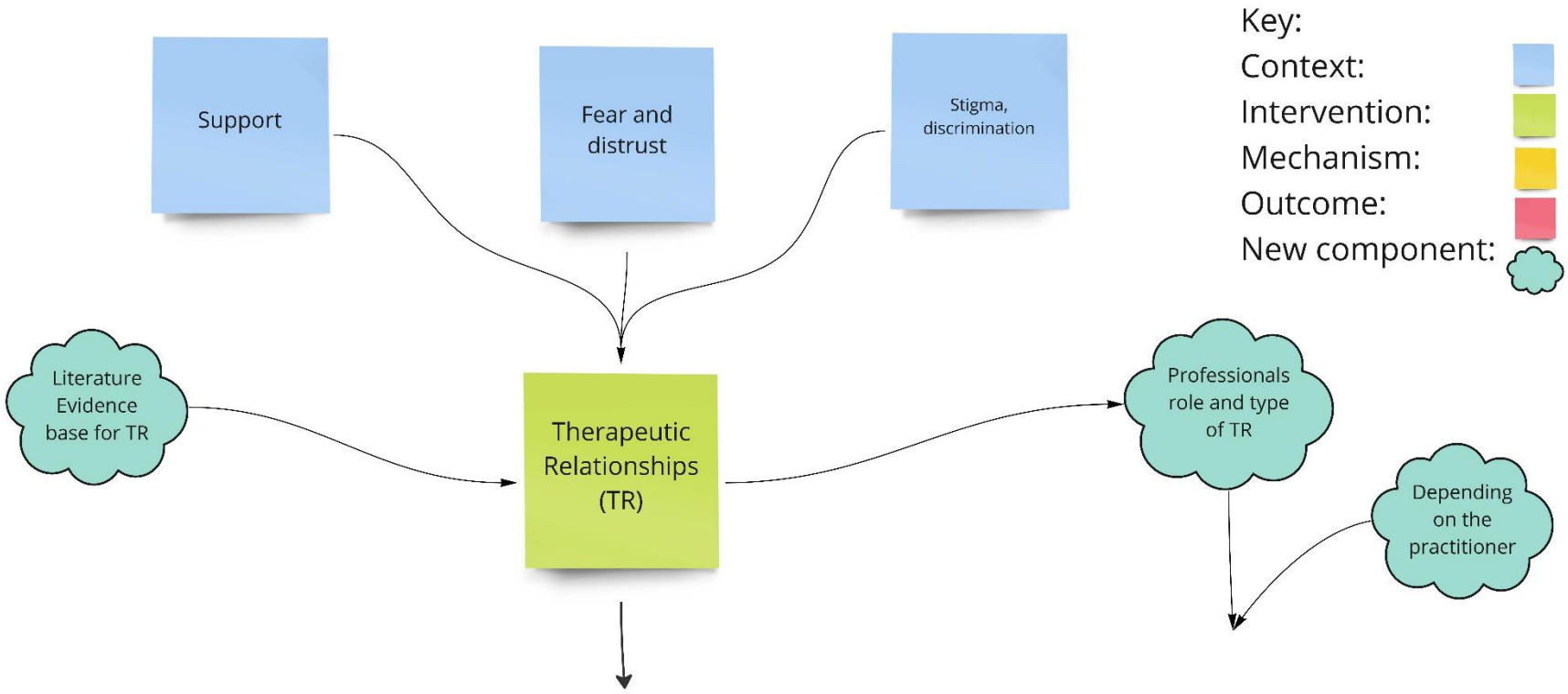
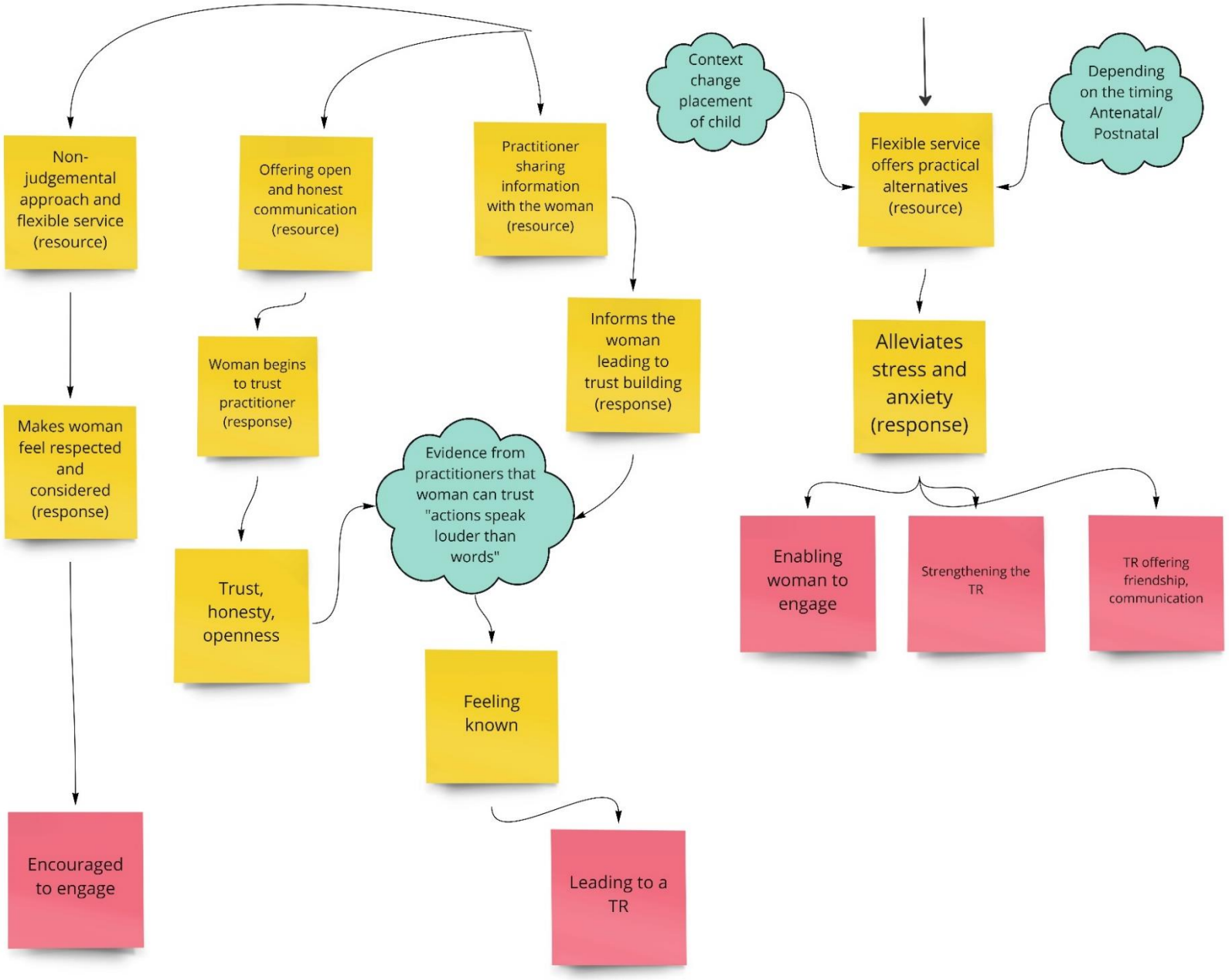


Figure 29 continued



Middle range theories (MRT)

Middle range theory (MRT) as termed by Merton (1968a) are vital to support theory development, testing and refinement. The use of formal theory in addition to primary data collection from stakeholders has been called “dual theorising” (Chen, 1990). This approach broadens the scope of theory testing and prevents the researcher naively considering stakeholders experiences as the only true explanation. Dual theorising can be used to explore mechanisms present in the programme theory which are more clearly outlined by substantive theories (Astbury, 2018). However, Astbury (2018) explains that in some studies these mechanism or theoretical perspectives do not present until the study is well in progress.

MRTs were initially explored in Phase One of the study to inform theory development, however MRT were also essential during theory testing. Further exploration of the principles of the four key MRTs previously outlined (Partnership Synergy, Inter-professional Collaborative Relationship Building Process, Woman Centred Care and Trust Level Theory) were conducted during the analysis stage. This involved comparing and contrasting elements of primary data (e.g. interview transcripts, case studies) with theory principles, to further identify elements of the programme theory. Two main theory components which were presenting strongly through the data analysis was the relationship between practitioners and service users, and between practitioners and other team members. Both practitioners and service users highlighted the importance of relationship building in order to engage the service user. However barriers to relationship building such as fear of child protection services and distrust in practitioners, were outlined in the interviews by both practitioners and service users forming a contextual backdrop. Service users were distrusting of the wider service and practitioners were tasked with preventing risk and managing trust with service users. This trust fear paradigm became a key component across the IPTs which required a more detailed analytical lens. I explored theories of trust which could support my analysis of the theory at the programme level as well as understand the interactions of context, mechanism and outcome. Incorporating these MRT lenses during analysis supported the testing and refinement of the theories. Further description of this dual theorising approach, incorporating MRT in the data analysis is explained in Phase three

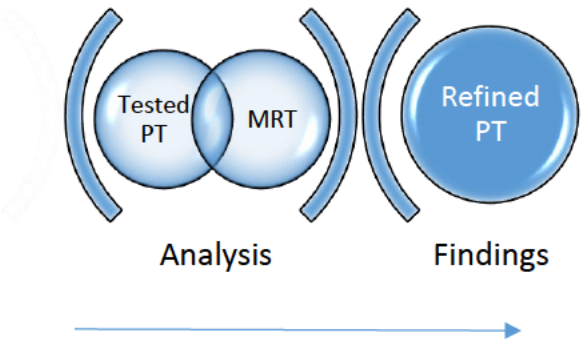
in this chapter. The three tested theories are presented in chapter five with evidence of findings from Phase One and Phase Two.

Phase Three methods – Refine programme theories

Objectives – Refine these programme theories to unearth a deeper understanding of how the programme works and identify middle range theories to explain how the programme works in a broader sense.

In this section, I will provide a description of the analysis, which I employed during phase three – refining programme theories (Figure 30). This iterative and abstractive process took many approaches to reach the findings presented in Chapter 7 Phase Three Findings. A specific and directive exploration of MRTs was required to refine the tested PT. However, firstly I will review the literature base of mechanisms as termed in realist methods to underpin my description of how mechanisms function.

Figure 30. Phase Three: Refining Programme Theories



Core mechanisms – new understanding of mechanisms

My initial understanding of mechanisms was firmly aligned with the "resource and reasoning" action described by Dalkin et al., (2015, p.8) who separate mechanisms into 'programme resource' and 'individual's reasoning or response' to the resource. This was helpful in my initial programme theorising to decipher what was part of the intervention and how this differed from mechanisms, which triggered responses.

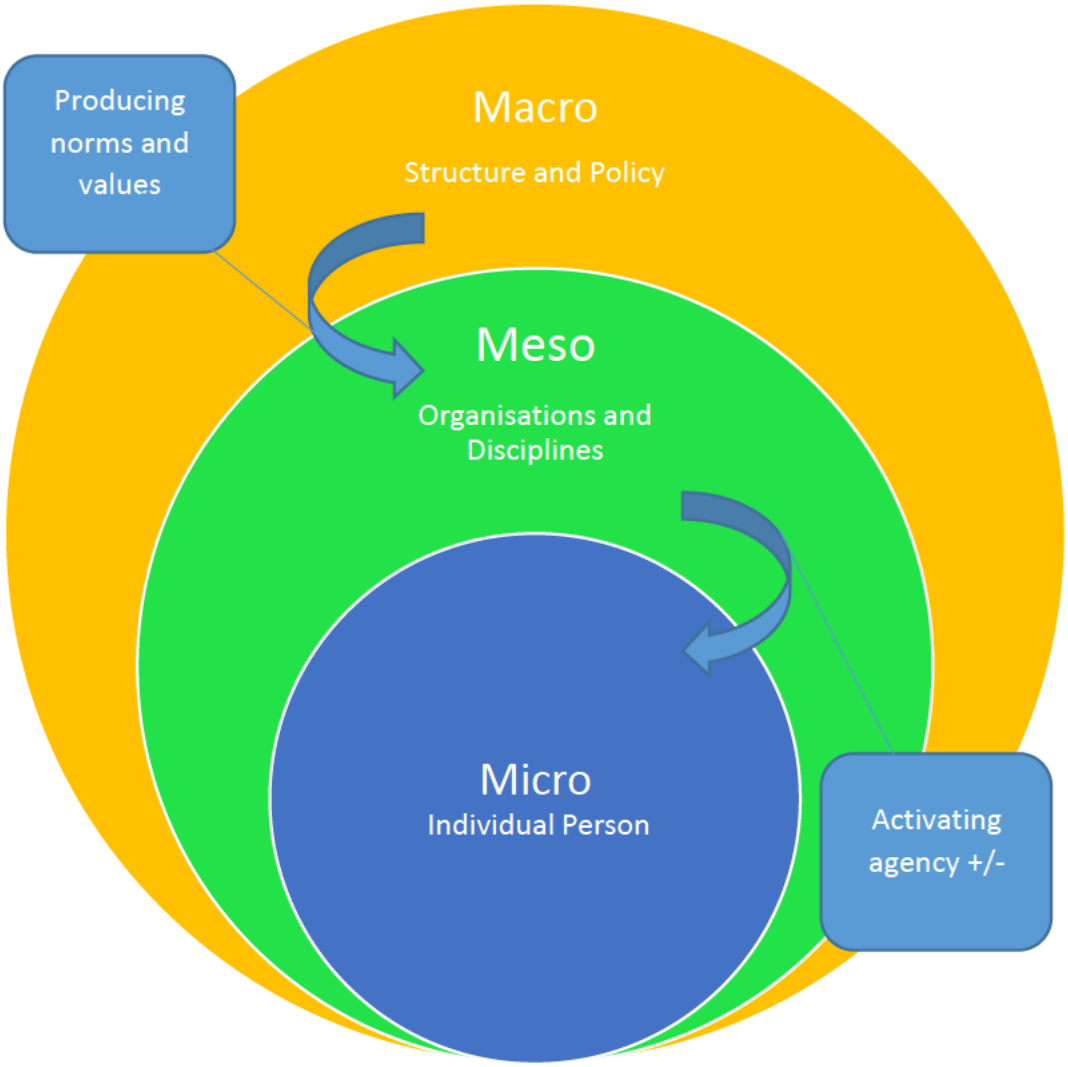
However, during testing of the initial programme theories I found it challenging to abstract meaningful connections without creating lengthy maps which described the processes but never quite identifying the causal mechanisms.

In speaking to, key researchers, attending a Realist 2021 conference, Gill Westhorp and Geoff Wong, allowed me to reflect on and question my approach to mechanisms in my analysis. Westhorp (2018) describes mechanisms' actions in different ways to the "triggering" (Pawson and Tilley, 1997, p66) or "dimmer-switch" (Dalkin et al., 2015, p10). By describing mechanisms as "forces", "interactions", "feedback and feedforward process", "powers and liabilities" as well as "reasoning and resources". These constructs of mechanisms broadened my perspective of mechanisms and their role within programme theories. This allowed me to examine on what level mechanisms may be working whereas "resource and reasoning" had restricted my focus to the individual (Micro) level. As Westhorp (2018) explains, "Mechanisms…are causal forces or processes which operate at a *different level* of the system than the outcome that they generate" (Westhorp, 2018, p.53, my emphasis).

This new perspective on the construct of mechanisms, whilst testing the ITP's gave new insight into relationships between the Macro, Meso and Micro levels. These terms are used to describe different levels of society and are defined differently depending on the perspective taken by the researcher (Serpa and Ferreira, 2019). However, a broad interpretation utilised in this study is described by Harman (2017), whose perspective suggests; "Macro level perspectives on sociality and culture, the Meso level of organizations and groups and the Micro level of individual identity" (Hartman 2017, p.1)

Through the new knowledge about the functionality of mechanisms I re-analysed my data to incorporate the three levels. Westhorp (2018) demonstrates the potential differences between contextual and mechanistic functions depending on the level at which they interact to produce outcomes. In my study the levels were defined by their presentation as well as their interactions with parallel levels (Figure 31) which sought to expand my thinking regarding mechanisms "functions".

Figure 31. Macro, Meso and Micro Levels in Analysis



Viewing mechanisms as a more multi-dimensional process than a linear step in the CMOc, I began exploring MRTs further. Combining the system level and the mechanism functions I identified a concept of trust and the three levels of interactions. I explored theories of trust and applied the principles from Trust Level Theory (Gibb 1991) which are discussed in more detail in Trust Level Theory section. Drawing on the concepts of "Environmental Quality" (EQ) (Gibb, 1991, p.41) scale which were considered Macro level dynamics and "Discovery" and "Defending" processes (Gibb, 1991, p.17) considered Micro level, (as described below in section on Trust Level

Theory) I began to conceptualise the programme level interactions emerging from the data.

In conjunction, adding the lenses of critical interactionism (Burbank and Martins, 2019) and feminist symbolic interactionism (Kleinman and Cabaniss 2019) (the justification for which is described further below), brought a greater understanding of the interactions between context, mechanisms and outcomes.

Analysis

The tested Programme Theories were presented to the supervision team, methodology experts and clinical experts in a series of presentations, and formal and informal discussions. Demonstrating the links between evidence from the interview transcripts and areas of the programme theories identified components that aligned with or refuted the findings or needed further refinement. Through this process, I reflected that the findings were not detailing the complexity of the interconnected components playing out in the service. I could visualise the complexity when I followed the narratives in the data but demonstrating the conceptualisation of the service was challenging. As outlined by Astbury (2018) sometimes it is not until the study is in progress that certain theoretical bases become evident. I required a further round of abstraction to review wider social theories to connect the main components. This abstraction process of dual theorising, going back and forward to the data and wider literature, is essential in realist evaluation and "entails (the researcher) simultaneously working upwards from local data and downwards from formal theory to provide a pincer movement on mechanisms," (Astbury, 2018 p. 74).

Therefore, I began reviewing the tested theories by applying the lenses identified from previous exploration of the MRTs in Phases One and Two, i.e. Trust Level Theory and additional MRTs identified in Phase Three i.e. Symbolic Interactionism.

Abstraction

Several MRTs had been explored as previously outlined in Phase One and Two. At this refinement phase, a further, yet more specific, exploration of MRT was applied. This required identification and review of similar yet opposing theories exploring social contingency through specifically targeted literature searching and conversations with

my supervisors. Theoretical bases of organisational learning (Popper and Lipschitz 1998) and policy instrument choice (Howlett 2009, Capano and Lippi 2017), were initially explored to broaden my understanding of service structure especially relating to integration of multiple agencies. These theoretical perspectives, in addition to partnership synergy (Lasker, Weiss and Miller, 2001) and inter-professional collaborative relationship building process (D'Amour et al., 2005, San Martin Rodriguez et al., 2005 and Wener and Woodgate, 2016) as explored in Phase One and Two, considered the Macro and Meso processes evident in the tested theories. However overarching all three tested theories was a focused perspective on relationship building. The principles of Trust Level Theory (Gibb, 1991) strongly aligned with the individual (Micro) and structural (Macro) concepts, which were evident in the tested theories. Additionally a closer examination of theoretical perspectives of relational interactions, as considered in Symbolic Interactionism (Blumer 1969, Goffman 1963, Mead, 1934) were appropriate as they closely observe relationships at the intrapersonal and interpersonal levels as well as between the individual and the wider social world. Through Phase Three, the tested theories were examined through the theoretical lenses of Trust Level Theory (Gibb 1991), and Symbolic Interactionism (Jacobsen, 2019).

Trust Level Theory

Broadening my understanding of Gibb's (1991) Trust Level Theory was my initial step, as their theory conceptualises trust building through an understanding of fear and trust, interacting with each other, due to wider contextual factors. This perspective aimed to address the connection between the Macro, Meso and Micro aspects of the service. It was clear from the data that women entering the service had considerable distrust in The IPPSS and wider Child Protection process, however, building trusting relationships with individual practitioners was the main strategy pursued by practitioners and welcomed by women.

Gibb's (1991) Trust Level Theory is based on the behaviours and interactions between people, which create environments to nurture trust. On the flipside Trust Level Theory (Gibb, 1991) outlines the contributors which encourage defensive behaviours and practices as people lose trust and exert fear. Trust Level Theory uses a scale of

Environmental Quality (EQ) to outline the structural components which affect the trust and fear interaction, interpreted during analysis as Macro level dynamics (Table 10). Those applying the Trust Level Theory (Gibb 1991) have used this framework to assess, diagnose and improve environments, be it a business, care setting or relationship. The EQ phases are described as an evolutionary process and describe only a point in time. Each "Environmental Phase" outlined in column 1 Table 10, are labelled to describe the main process in the setting, whilst "Focus of Energy" describes the contributing response fostered by the environment. Gibb (1991) describes an example of the environmental phase of autocratic and focus of energy of obedience by stating: "Those who need to obey and those who need to be obeyed create a dynamic tension that sustains autocracy, provides a visible need for power and thus sanctions the feeding of power," (Gibb, 1991, p. 50).

Table 10. Dynamics of the Environmental-Quality (EQ) States

Environmental Phase		Focus of Energy
I.	Punitive	Survival/retribution
II.	Autocratic	Power/control/obedience
III.	Benevolent	Reward/punishment
IV.	Advisory	Communication
V.	Participatory	Influence/choosing/resolving conflict
VI.	Emergent	Being/freedom/searching
VII.	Organic	Expression/integration/sensing
VIII.	Holistic	Creativity/spontaneity
IX.	Transcendent	Transcending sensory and body states
X.	Cosmic	Cosmic being

Note. Adapted from Gibb (1991, p. 48)

This demonstrates the relationship and interaction individuals on the Micro level have with the broader Macro forces or dynamics. Gibb's theory explains that as people or organisations work from EQ I. to EQ X., trust increases and fear reduces. According to Gibb, this evolves through the TORI (Trust Opening Realising Interdepending) Discovering Process (Table 11), a process of self-discovery which allows the person to trust themselves, others and the system around them. This process is described in Chapter 6 Phase Two Findings and Chapter 7 Phase Three Findings through the development of trusting relationships.

Table 11. The TORI Discovery Process

Discovering Processes	**Orientation of the person**
Trusting (Being, Personing, Centering, Accepting, Warming)	**Being me:** discovering who I am.
Opening (Showing, Letting in, Listening, Disclosing, Empathising)	**Showing me:** discovering how to reveal myself to others.
Realizing (Actualising, Asserting, Exploring, Evolving, Wanting)	**Doing what I want:** discovering my wants and how to realise them.
Interdepending (Inter-being, Integrating, Joining Sharing, Synergising)	**Being with others:** discovering how to live and work with others.

Note. Adapted from Gibb (1991, p. 13)

Table 12. The TORI Defending Process

Defending Processes	**Orientation of the person**
De-personing (Coding, Role-ing, Detaching, Appraising, Observing)	**Finding a role:** discovering and creating a role
Masking (Closing up, Distancing, Filtering, Strategizing, Covering)	**Building a façade:** discovering a strategy.
Oughting (Influencing, Persuading, Parenting, Coercing, Manipulation)	**Finding my needs:** discovering your demands and expectations.
Depending (Controlling, Submitting, Leading, Dominating, Rebelling)	**Controlling me and you:** discovering rules, boundaries, and contracts.

Note. Adapted from Gibb (1991, p. 19)

Opposing the TORI Discovery Process is the TORI Defending Process (Table 12) which exerts defensive behaviours and attitudes, resulting in distrust and fear of themselves, others and the system around them. If the Defending Process is activated, then this is evidence of people or organisations retracting through the EQ scale from EQ X to EQ I. Gibb (1991) presented this theory as a tool for improving relationships between individuals and wider organisations. However, the theory is just that, a social *theory* of relationships and Gibb (1991) does explain that the EQ of Transcendence and Cosmic are both speculative states based on "mystic events" and "out-of-body" experiences. Whilst I am not suggesting that a trusting relationship can only be met with an environmental state offering "out-of-body" experiences, the root of the trust, fear, concepts are clearly embedded within the wider environmental forces as seen in the experiences of women receiving the IPPSS.

This understanding of the interactions between Discovering or Defending Processes at the level of the individual (Micro) being underpinned by the actions, forces or "mechanisms" at the environmental, or structural level (Macro) is the foundations for capturing the complexity of the interactions within the service. These Discovering and Defending Processes provide possible explanations for the behaviours and actions of women and practitioners outlined in the data. For example, in the quote below Emma was 'Masking' by not being truthful with practitioners about her current drug use as she was fearful she would not regain custody of her child. Her experience of losing custody of previous children and being in care as a child herself had contributed to this fear.

> *I was finding it hard to be honest with them sort of thing… cause I was scared of telling them if I used [substances] then I would never get him home… I have had bad experiences in the past with social work, I've been in care myself so I know this.*
>
> (Emma.)

It was widely expected by practitioners and stakeholders interviewed that most women would be entering the service with fear and reservations, because of experiences of childhood trauma, domestic abuse and poor mental health, which

would bring defensive behaviours, heightened because of a lifetime filled with survival strategies.

Initially, Trust Level Theory (Gibb, 1991) was incorporated into the coding of tested theories allowing for examples of CMOs to be considered in relation to the "Discovery" and "Defending" processes described in Table 11 and Table 12 (Gibb 1991). Mapping these processes allowed me to identify the connections between contextual factors, and the outcomes of women and practitioners' actions or behaviours. However, I had insufficient depth to present causal mechanisms which would explain the patterns I had identified. Pawson (2006) refer to the practice of "digging for nuggets" (p. 134), whilst Astbury and Leeuw, (2010) suggest realist researchers aim to open up "the black box", (p.371), I was trying to uncover the mechanisms but was lacking breadth of social theory knowledge to do so.

Relational based practice

I decided to focus on the main area of trust building in the Meso layer between practitioner and woman as it aligned with both my professional and theoretical knowledge at this stage in the evaluation. Having worked as a midwife I knew the theoretical and practical basis for relational based practices. Stakeholders and practitioners discussed, during data collection, the importance of relational based practices to engage women in the service.

> *If you don't ever get an opportunity [to build relationships] how are you ever going to engage them? I think we are really good at like, if they don't turn up, sending a text to say: "look I know today was really difficult for you, and you weren't in a place to come and meet me but, I will be there next week at the same time if you want to come along"… hopefully after the sixth or seventh time they think "ok maybe this person is wanting to help me" and they will come along and meet you.*
>
> (Practitioner Interview 3.)

Discussions about relationships with women and their experiences of therapeutic relationships with practitioners led me to narrow my scope in this area to identify further theories and broaden my understanding and application of relational based

practices. Relational based practices have different meanings and goals depending on the literature base. However, they have been widely evidenced as essential in maternity services, recovery and social work.

Maternity services

Continuity of carer is at the heart of high-quality maternity care (e.g. Renfrew et al., 2014) and is evidenced in the current Scottish Government Maternity Plan "The Best Start" (Scottish Government, 2017a) and the England and Wales maternity plan "Better Births" (NHS England, 2016). Maternity care places relational based practice at the centre of its model and the continuity approach has been shown to positively affect maternity outcomes including breastfeeding, health status and maternal mental health (Rayment-Jones et al., 2015, D'Haenens et al., 2020).

Recovery

Within the recovery literature, there are several frameworks, which are embedded with relational based practices. For example, CHIME (Connectedness, Hope, Identity, Meaning in life and Empowerment) is a framework of personal recovery in mental health, which requires development of relationships both new and withstanding to support recovery through the steps outlined in the acronym (Leamy et al., 2011). The Senses Framework (Orr, Elliott and Barbour, 2014) also promotes "relationship-centred" approaches to recovery services at the interpersonal level as well as organisation level.

Social work

Social work and child protection practices are similar in their focus on relational-based practice in order to support a whole-family approach (Scottish Government, 2013b, McGhee and Hunter, 2010). Ingram and Smith (2018) call for relationships to be at the "heart" of social work practice in their review whilst acknowledging the barriers that power and agency hold. Relationship-centred care is recommended to promote continuity of practitioners, and build and sustain therapeutic relationships.

It was clear to me that the basis of these therapeutic relationships was the interaction between practitioners and service users. However, I could not discern the motives and

intentions, and how fully service users and practitioners embraced the process of relationship building. Further exploration of other services, which aimed to build interventions around the relationships and interactions of their participants, highlighted that compassionate relationships are the crux of all interventions (Choi and Kiesner 2007). This prompted me to revise my thinking about embedding the importance of the Trust Level Theory framework and the Discovery versus Defensive processes into my analysis. It was not just what created a positive trusting relationship that was of importance, but what could cause distrust or a resistance to relationship building, which was essential to uncover. I began exploring social theories of interaction to further my understandings and application to my study. Drawing on different lenses from these social theories, gave me a broader collective perspective from multiple theories to apply to my analysis.

Interactionism

Interactionist theories are sociological perspectives often considered as "Microsociological perspective" (Jacobsen, 2019) due to their focus on constructing meaning through daily in-person interactions. Broadly, Symbolic Interactionism is a collection of theories concerned primarily with the interaction between two people at the individual level as seen in relational-based practice (Ingram and Smith, 2018). Philosophers including Blumer (1969), Mead (1934) and Goffman (1983) constructed elements of interactionist principles, which have been used in many research areas (Burbank and Martins, 2019). Blumer's theory (1969) accepts that there is meaning through interaction however, it makes no attempt to account for predictable patterns of outcomes as explained by Azarian (2015) in their critique of the theory:

"What is particularly missing from Blumer's treatment are specified accounts of the questions about how the fitting of the participants' individual lines of action occurs or through which mechanisms the participants jointly produce the alignment of their behaviour" (Azarian, 2015, p.4).

This questioning is aligned with realist ontology and concerns the missing perspective of generative causality and retroductive theorising, thus aligning with my realist approach to this study. To appreciate the principles of Symbolic Interactionism the

mains tenets are described including: Joint Action, Interaction Orders, Structure and Agency:

- *Joint Action* is based on the interactions between two people which are underpinned by the meanings those people bring to the interaction and are dependent on the context surrounding both the interaction and the meaning (Azarian, 2015).
- *Interaction Orders* are Goffman's (1983) interpretation of Joint Action and are based on one to one interactions. Broadly interpreted, Schwalbe (2019) describes Interaction Orders as patterned or regularities in interactions, which are predictable due to the underlying shared knowledge between those interacting. Schalwbe (2019) uses the metaphor of a "game" (p.35) to describe how interactions can be seen as moves and countermoves. Additionally these could also be considered as programme level demi-regularities as observed in realist methodology.
- *Structure* is another common metaphor used in interactionist theories and is considered to be the product and producer of "Interaction". Not only do Joint Actions create structure through meaning, the meaning brought into these Joint Actions are influenced by "structure". As Schwalbe (2019) explains: "To invoke structure as a cause is to march in a circle", (Schwalbe, 2019, p. 31).

  Meaning there is more to the picture than resting all issues on the problem of "structure". This approach would allow for an understanding of the connection between behaviours of women and practitioners and the structural contexts but would continue to miss the causal explanations required in realist evaluation to explain the patterns.

- *Agency* as previously outlined in Chapter 3 (Social structures and human agency), is a malleable term in sociology and is interpreted by many in different ways (Lamsal, 2012). Agency is the individual's ability to make choices and therefore exert actions within the interaction. However depending on which school of interactionism you are aligned, agency's role with Structure may be interpreted differently (Lamsal, 2012, Jacobsen, 2019). For me agency is an

> essential role in understanding the interactions between individuals' actions and behaviours within the structural environment interactions take place. This raises questions such as: what motivates behaviour change in women who are restricted by the powers and controls of child protection practices?

Concept maps were constructed using interactionist lenses to identify Macro, Meso and Micro levels of interactions. Exploring these concepts of symbolic interaction above (Joint action, Interaction Orders, Structure and Agency) allowed me to consider the interactions between individuals. However further reading led me to consider how interactions between the Macro, Meso and Micro levels may contribute to the patterns noted in the data. Whilst Symbolic Interactionism was a useful lens to analyse the interactions on the individual level, it did not allow for further exploration of Macro, Meso, Micro interactions. Branches of Interactionist perspectives have taken many directions and forms, and a growth in Critical and Cultural Interactionism has become evident (Jacobsen, 2019). S*tructural* interactions have been theorised in many interpretations of interactionist theories (neo-structural interactionism, Schwalbe, 2019, critical interpretive interactionism, Denzin, 2019,) to develop the utility of interactionist approaches on the Macro level.

Critical Interactionism

Critical Interactionism (Burbank and Martins, 2019) is a sub section of interactionist social theory, constructed by combining Symbolic Interactionism and Critical Social Theory (Burbank and Martins, 2019). These two interactionist perspectives allow for addressing complexity at the Macro and Micro levels through their individualist and structuralist lenses. Burbank and Martin (2019) argue:

"By viewing complex human conditions with a critical interactionist lens, both Micro and Macro perspectives can be studied and innovative strategies for change across individual and larger system levels can be developed" (Burbank and Martin, p. 80 in Jacobsen, 2019).

This Critical Interactionist lens allowed me to critically analyse the relationships between the individual and the wider contextual factors and specifically address interactions. This shed light on the mechanisms at play within these interactions, thus

explaining the complexities found in my initial testing of programme theories. Critical Interactionism has previously been used to understand health inequalities and social justice (Waitzkin, 1989, Habermas, 1984) suggesting its plausible utility in this evaluation.

Most important to my study was the understanding of power, and how agency is evoked within interactions when certain structures hold more power. The relevance is clear when I consider Gibb's (1991) EQ Scale which outlines the forces, which may be present, affecting the individual's behaviours or actions. Using Critical Interactionism accounted for the structural impacts within my understanding of interactionism, however the importance of power and agency were still to be addressed. Considering the gender specific nature of the service (maternity), the wider social context (motherhood and addiction) and individuals' contextual factors (domestic abuse, sexual trauma), the most appropriate critique to address power and agency was with a feminist lens.

Feminist Symbolic Interactionism

Feminist Symbolic Interactionism (Kleinman and Cabaniss 2019) considers the gendered approach to inequalities at the centre of all these interactions. Addressing the issue of power and agency is not a new concept when considering women's interactions with services including maternity, recovery and social work (Hanmer and Statham, 1999). However, this lens enabled a critical approach to understanding the realist framed research questions "why and for whom" services work.

Considering this sociological perspective through a gendered lens, allowed me to identify the causal patterns between context, mechanism and outcomes. Appreciating the influence gender has at a Macro, Meso and Micro level, I considered how this implicated individual's agency. I identified agency as working in two directions on a spectrum, either being activated through positive interactions or constrained through negative interactions. Visualising agency as a component affected by mechanisms, whilst affecting outcomes, helped me understand the triggering response created by a mechanism.

Applying these lenses (i.e. Trust Level Theory, Symbolic Interactionism, Critical Interactionism and Feminist Symbolic Interactionism) to my analysis of the data supported my understanding of the interactions between individual's behaviours and the wider experience of the service. This generated four key mechanisms (Ethos, Transparency, Stigma and Inter-being), which are presented in Chapter 7 Phase Three Findings.

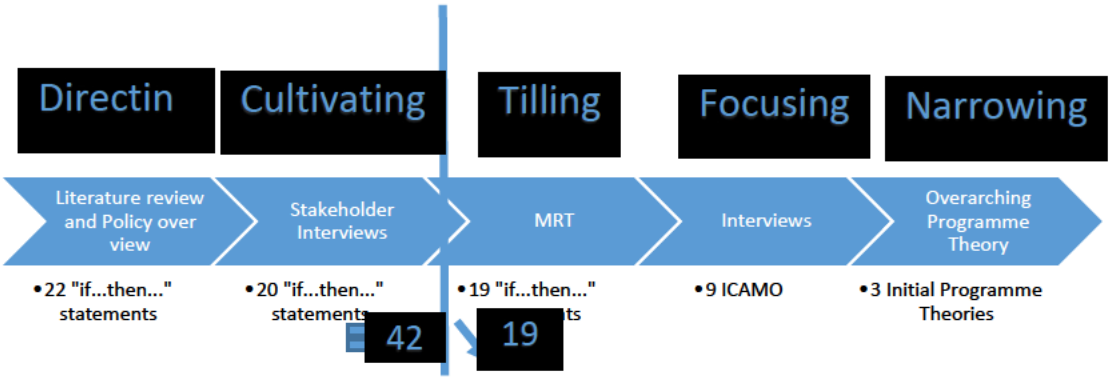
Chapter 5 Phase One Findings

Phase One, Identifying programme theories

Objective – Identify initial programme theories which hypothesise how the programme works

This chapter will present the findings of the processes I used to identify programme theories. The methods are discussed in chapter 4 and comprise concept mapping, developing "if… then…" statements, stakeholder interviews and exploration of middle range theories (MRT). This overall process is outlined in Figure 32, to show how each stage supported the development of the IPTs. I used literature and policy to develop concept maps, which I then developed into 22 "if…then…" statements. This was then followed by stakeholder interviews to explore their perceptions on what works and what outcomes are of importance, which were analysed to provide further 20 "if…then…" statements. I then analysed all 42 "if…then…" statements through the lens of middle range theories to reduce the statements down to 19. Through discussions with the supervision team and the beginning of primary data collection and analysis of interviews with service users, I developed nine Intervention Context Actor Mechanism Outcome (ICAMO) statements. I then narrowed the scope of the study to focus on testing three theories in phase two.

Figure 32. Developing "if…then…" Statements to Develop Initial Programme Theories



Directing theory development through literature and policy scoping

The literature review presented in Chapter 2 Literature Review directed the design of the study towards realist evaluation. The studies examined (MacGregor et al., 1990, Chang et al., 1992, Carrol et al., 1995, Egelko et al., 1998, Sweeney et al., 2000 and Armstrong et al., 2003), identified that integrated services for pregnant women with drug and alcohol problems could improve outcomes for women and infants. Review of qualitative studies (Toner et al., 2008, Lefebvre et al., 2010, Milligan et al., 2017) seeking to understand the experiences of women and practitioners, receiving and delivering these services, identified therapeutic relationships, organisational structure and non-judgemental practices as key concepts contributing to the success of services. With a lack of UK or Scottish evaluations of services for pregnant women with drug and alcohol problems, there was a dearth of knowledge of how integrated programmes function within the local context and the impact this has on outcomes. The findings of my literature review supported the design of the study including the initial theory concepts of therapeutic relationships, organisational structure and non-judgemental practices.

My policy overview sought to understand the ethos and direction of current guidelines, which underpinned the service being evaluated. As outlined in Chapter 4 Phase One, practitioners from the service directed the selection of the policies and

guidelines reviewed (Appendix 13. Programme Architecture and Appendix 14. Policy Documents Included in Review). Review of these guidelines and policies indicated differences in whether they promoted a woman, child or family centred approach. This is further emphasised in the literature, which focused mainly on neonatal outcomes and highlighted tensions between differing philosophies between disciplines (Toner et al., 2007 and Lefebvre et al., 2010).

Concept mapping (Figure 33) initially supported the visualisation of the service and the overlay of concepts from the literature and policy background. This introduced me to the concepts of Context (C), Mechanism (M) and Outcome (O) as framed by realist methods. Working with CMOs aligned my realist philosophy with the application of the methodology. Whilst some labels were assigned at this early stage, these were not fixed at this theory generation phase.

Concept mapping helped me explore potential tensions between the ethos and philosophies of disciplines and what impact they may have on service delivery and reciprocity. For example, the specialist multiagency service brought different guidelines and policies and therefore differing approaches to practice. Examining the relationships between the clinical and cultural Context, Mechanisms and Outcomes sought to identify what works for whom, to what extent and in what circumstances (Pawson and Tilley, 1997).

Architectural depiction of the service as described in Chapter 4, Outlining programme architecture, contributed to my understanding of the service. By dividing the service into six components, (MDT working approach, Co-location of the practitioners, Holistic service, Midwifery care, Mental health services (CPN) and Early Years Officer) theories could be outlined covering the whole service. As previously described, these components were identified by the practitioners during project meetings and aligned with the NICE (2010) guidelines. Twenty two "If…then…because" statements as described in Chapter 3 Methodology and Chapter 4 Methods, were constructed from the findings of the literature review and policy overview in line with the service architecture (Table 13).

Figure 33. Concept Map From IPT Development

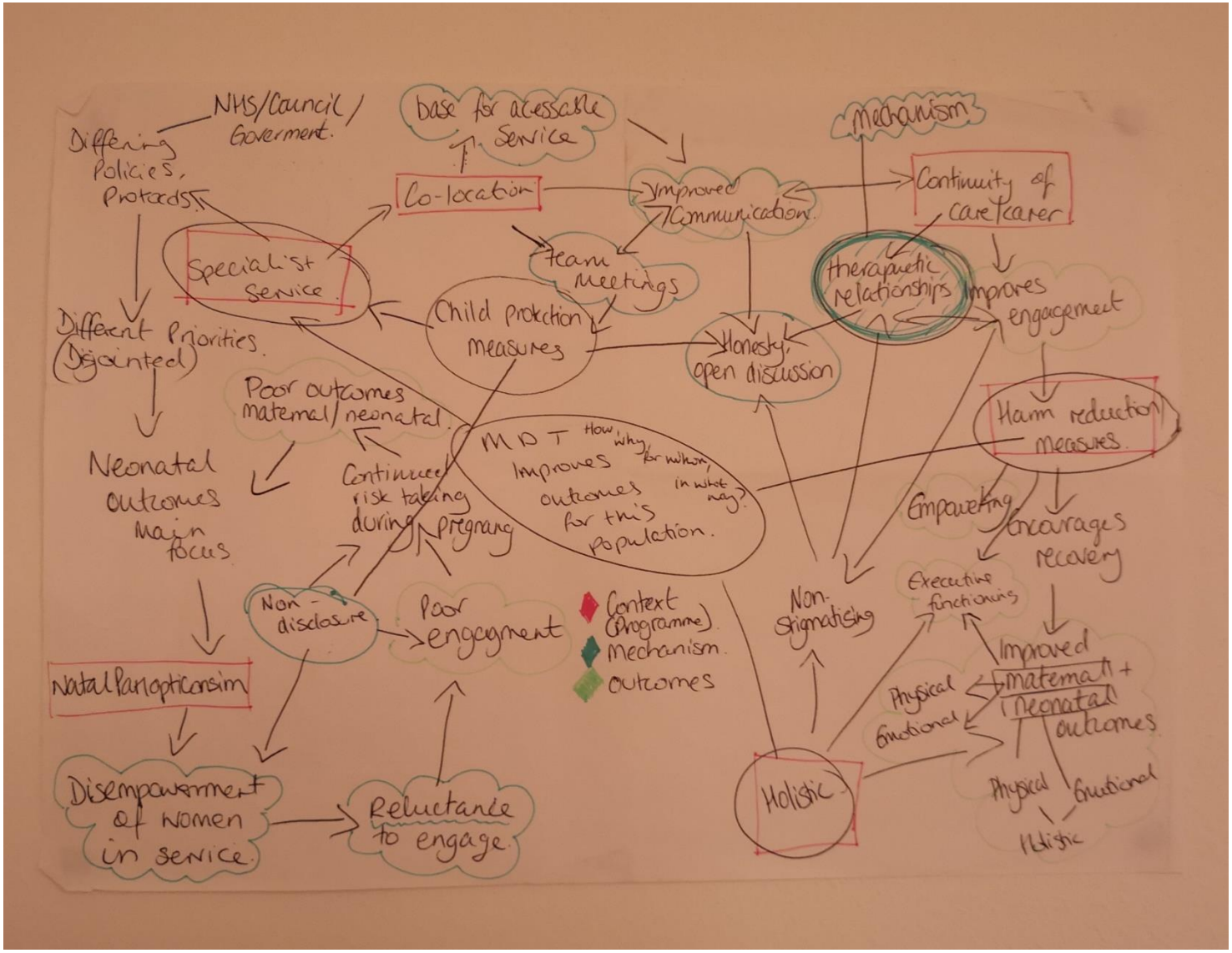


Table 13. "If… then…because" Statements from Literature and Policy Overview Developed at CARES Realist Workshop July 2018

Theme	**If then statement**
Component 1. MDT approach	If an MDT approach is in place then…highly skilled specialist services are able to case load the complex pregnancy, meaning quicker referrals, improved communication, shared decision making and elements of the care are not missed.
	If an MDT approach is in place then…different policies, practice and priorities are being used, documentation is on different platforms and communication and collaborative working is superficial.
Component 2. Co-location	If a service is co-located then… weekly team meetings are held, team members engage on a daily basis and communication is improved.
	If a service is co-located then…service users can access all services in one place at one time reducing the amount of time/travel they have to make encouraging engagement.
	If a service is co-located then…service users are aware that practitioners work together which aids communication and shared decision making in a practical and holistic way.

Theme	**If then statement**
Component 3. Holistic approach	If a service is holistic then…all aspects of the service users' needs can be addressed, this in turn can build relationships/trust, as women feel the service is interested/investing in them and by addressing issues this may increase engagement, self-efficacy and executive functioning.
	If a service is holistic and non-stigmatizing then… women will feel welcome, safe, not judged and are more likely to engage.
	If a service is not holistic and is judgemental then…women will feel scared, resentful, disempowered, and unwelcome and will not engage with services potentially leading to continued risk taking behaviour and poor birth outcomes.
Component 4. Midwifery care	If a service is providing midwifery care then…there will be continuity of carer which builds trust and therapeutic relationships leading to open and honest discussions improving engagement.
	If a service has a midwife then…through improved/building of therapeutic relationships women may disclose more about their social situation which can then be supported.
	If a service has a midwife then…deeper discussion can take place to ensure women make informed choices about labour/ birth/ their care and women will feel empowered to engage in shared decision making…this may lead to further engagement with other services e.g. attending obstetric appointments, sonography, Drug Treatment and Testing Order.

Theme	If then statement
	If a woman attends a service offering antenatal group education then…women will share their lived experiences, support each other, learn from each other, and feel encouraged to change and improve executive functioning skills.
Component 5. CPN (mental health)	If a service has a mental health nurse then…women's needs/mental health assessment/ addiction could be assessed promptly and referral/ prescription commenced quickly.
	If a service has a mental health nurse then…they can make regular/timely appointments to be seen in the community setting which is convenient for the women, encouraging engagement through flexible service.
	If harm reduction measures are in place then…women will reduce the risk taking behaviour as they will not need to find money for street drugs through risky sexual behaviours, this then will improve pregnancy outcomes, build self-efficacy/self-esteem, empower women and encourage engagement.
Component 6. Early Years Officer (social care)	If a service has an early years officer (EYO) then…women's parenting capacity can be assessed and child protection recommendations can be made.

Theme	If then statement
	If a service has an early years officer then…transparent discussions and expectations can be outlined through the supportive relationship built between the practitioner and woman/family.
	If a service EYO's offer Parents Under Pressure Programme (PUP) then…couples are given the opportunity to build resilience, improve communication, work through scenarios and improve parenting capacity, in turn this may improve child protection outcomes.
	If a dad's worker is provided then… the programme will work more holistically improving executive functioning/skills, encouraging engagement and treatment through a supportive one-to-one or group setting specifically for dads.
Rival theories	If a service takes its policy lead from child protection then…the service will be focused on the pregnancy and child outcomes, safety of the baby first, this will lead to less focused discussion around support for the woman leading to disempowerment, lack of engagement, resistance against services that seem to be focusing on/at risk of removing child from parent.
	If a service acknowledges the woman as the main focus (who is therefore protecting the fetus) then holistic approaches can enable engagement to prioritise harm reduction, stability and long term recovery.

Theme	If then statement
	If a service acknowledged the root cause of the woman's problem e.g. Adverse Childhood Experiences (ACE), trauma, domestic abuse, lack of support then… recovery and support can be provided in an appropriate and holistic approach.

Cultivating theory development through stakeholder interviews

As described in Chapter 4, Phase One, three key stakeholders from Maternity, Social work and Mental Health services were recruited to participate in a one to one scoping interview. Stakeholder interviews identified main components of the service and explicitly identified outcomes, which were considered successful for the service. Table 14, outlines what stakeholders believed contributed to the service working or not working. Three components (Individual, Team and Service) of the service were identified which contributed to the service achieving its outcomes.

At the individual level, interactions between practitioners' and service users were considered to impact outcomes. Being direct and honest in their approaches such as overtly addressing child protection concerns was highlighted as well as offering continuity of practitioner.

As a team, providing a multidisciplinary team approach ensured several aspects of holistic care could be addressed and the team could work collectively with the same ethos to support the service user. Dynamics such as assertiveness, persistence and adaptable approaches to team work were considered to address challenges faced when working with this vulnerable and disengaged cohort of service users.

From a service perspective, the co-location structure was thought to facilitate opportunities to co-ordinate services and improve team working. The service made every effort to be accessible to service users and the team worked together in multiple ways to support each other.

However, there were aspects of the service, which prevented the achievement of main service outcomes. Covert approaches to child protection prevented trust building between service users and practitioners. Lack of engagement then prevented opportunities for the team to build relationships with service users and provide adequate services. Overall, uncertainty of funding put a strain on the service and the local scope of the service prevented collaboration with neighbouring health and social care partnerships.

While these aspects of the service alluded to mechanistic functions of the service as being crucial to contributing to outcomes, stakeholder interviews merely cultivated the

soil in terms of “digging for nuggets” (Pawson 2006, p. 134). However, discussions with stakeholders highlighted a different focus depending on their professional role within the service, suggesting potential tension between maternal and child centred approaches possibly affecting service focus and outcomes. This was similar to that identified in the scoping literature and policy overview.

Stakeholder interviews provided a broad exploration of general service outcomes as considered by stakeholders as successes and measurable outcomes. These outcomes were compared with the outcomes reported in the service annual reports and the World Health Organisation (2014) to see what scope the service was aiming to achieve in terms of public health aims. A combination of outcomes for mother, infant and other (family or partner), were identified as proximal (measurable within the time frame of service delivery) and distal (measurable or anticipated sometime after delivery of the service). However, with some evidence already identified, which suggested integrated programmes do improve maternal and neonatal outcomes (Chapter 2 Literature Review), I decided to focus on how programmes work by considering what role possible “outcomes” such as engagement had on longer term health outcomes.

Following the stakeholder interviews a further 20 “If…then…because” statements were developed across individual and service structure themes (Table 15).

Table 14. Findings from Stakeholder Interviews February 2018

What Works	**What Does Not Work**
Individual — Continuity, Direct, Honest, Skilled practitioners. Team — MDT, Adaptable, Same Ethos, Assertive, Persistent. Service — Co-located, Accessible, Team Support.	Individual— Holding back child protection issues. Team— Missed opportunities to build relationships. Service — Uncertainty of funding and budget constraints, Movement between geographical areas causing disjointed care/service.
Short-Term Aims	**Long-Term Aims**
Healthy live birth Stability and engagement with services Attendance Prescription (Methadone — Harm reduction)	Treatment for substance use Thriving mum and baby Engagement of father Bonding Contraception/ Family Planning Signposting to long-term support services Disseminating knowledge, experiences and training for other professionals in Edinburgh

Success	**Measurable Outcomes**
Live birth	Breastfeeding rates
Healthy baby	Long Acting Reversible Contraception (LARC)
Loving supportive environment for baby to thrive	Smoking cessation
Appropriate environment	In drug treatment
Healthy mum	Reduced substance use
Mum caring for baby	Safe environment
Prescription (Harm reduction)	Reduced SCBU admission
In drug treatment	Reduced NAS
Vitamins	Engagement
Roof over their head — stable living	
“Life style changes”	
Reduced criminality	
Contraception	

Table 15. "If… then…because" Statements from Initial Stakeholder Interviews

Theme	**If then statement**
Individual staff	If **staff are dedicated** then they will be committed to doing the best they can for their clients and will continue to work with them to reach the best outcomes.
	If **staff are honest** then this will build more trusting relationships with women and encourage good communication.
	If **staff are skilled and experienced** then they will have the abilities to provide evidenced based care, anticipate potential issues and prevent problems arising.
	If **staff are assertive and persistent** then they will continue to work towards providing care for women even when women continue to disengage.
	If there is **continuity of staff** then staff might feel more invested and dedicated to the women because they have been involved with all aspects of their care over time.
	If **staff withhold CP** info then honesty and transparency is lost and women will feel they are not being kept involved in decisions about their child.
	If **staff withhold CP** info then women may withhold info they feel will be used against them and therefore communication breaks down and therapeutic relationships are lost.

Theme	If then statement
Service structure	If the service has a low threshold to prescribing then women will be offered **harm reduction** measures in a timely response to encourage stability.
	If there is **continuity of staff** then **therapeutic relationships** will be built and staff can provide the most appropriate service for the woman.
	If the services takes an **MDT approach** then all aspects of the woman's care can be addressed by one team.
	If the service takes an **MDT approach** then specialists can be contacted by other members of the team to discuss and work toward the best options for the woman.
	If the service is **co-located** then all members of the team will be visible and communication within the team will be improved.
	If the service is **co-located** then the women attending the service only have to attend one location to see most services
	If the service is easily **accessible t**hen women are more likely to attend.
	If staff have a **good knowledge** of the individual then they can anticipate issues, build on the knowledge they have, build relationships easier.
Rival Theory	If staff have **a good knowledge** of the individual then they may have preconceived ideas/ perceptions of them and this may deter from building relationships.

Theme	If then statement
	If there **is no opportunity for staff to build relationships** with clients then communication will be lacking, trust will not be built.
	If **funding is uncertain** and budgets are cut then the service will not be sustainable and uncertainty may lead to practitioners not staying in the service
	If **women move** out of the area then care is disjointed women are lost to other service and it is difficult for services to keep providing all aspects of care therefore women disengage.
	If staff are **not well supported** in the difficult working environment then they will become more stressed and affected by the experiences and will not be resilient to continue in the role long term.

Tilling middle range theory landscape

Following stakeholder interviews I returned to explore MRT's (as described in Chapter 4 Methods) to gain a deeper lens of the potential theories I was developing. Tilling is an agriculture terminology used to describe preparing the ground for growing crops which digs deeper than merely cultivation. This next step in developing IPTs required a deeper approach to abstract core concepts, which would explain the perceptions and experiences expressed by the stakeholders.

As with complex interventions, there are multiple aspects to the service, which are involved to address the complexity of maternal substance use. By reviewing the underlying policy documents there were clear competing needs from maternity services, child health and protection and drug and alcohol services. This drove a hunch that there may be tensions within the MDT when addressing different aspects of this complex issue. For instance I questioned how do maternity services embrace a "woman centred approach" as recommended in the NICE guidelines (2010) when the fundamental principle of the GIRFEC framework (Scottish Government, 2018c) is to ensure the child is at the centre of care planning. This line of questioning led me to explore the literature and history of "woman centred approaches," (Hamner and Statham, 1999, Fahy, 2012, Leap, 2009), consider the mechanisms which support interagency working (Partnership Synergy, (Lasker, Weiss and Miller 2001), Interprofessional Collaborative Relationship Building Process (D'Amour et al., 2005, San Martin Rodriguez et al., 2005 and Wener and Woodgate, 2016), and explore theories of trust to help explain what might support some service users to engage in services despite their fear of child protection implications (Trust Level Theory, Gibb, 1991).

A further return to primary data collection through the method of practice observations allowed me to reflect on the MRTs and how they apply in practice. All 42 "If…then…because" theory statements were reviewed and reconstructed to cover the main six components of the service as outlined in Phase One, reducing the statements to 19 (Table 16).

Table 16. "If… then…because" Statements Following MRT Exploration

Theme	**If then statement**
MDT	If an MDT approach is applied to this service then service users will receive input from skilled specialist practitioners who can manage cases in a timely manner, sharing decision making, anticipate issues and prevent problems by communicating concerns early.
	If an MDT approach is applied to this service then service focus and ethos will cover many aspects of the service users' needs e.g. maternity, addiction, mental health and child health. This can ensure all aspects are managed, however this might cause tension within the service as multiple agendas are addressed.
Rival Theory	If an MDT does not have a mutual goal or focus then the practitioners might focus on their own areas of discipline leading to breakdown in communication and siloed working.
Co-location	If this service is co-located then, communication will improve between practitioners as opportunities for formal and informal communication will arise and practitioners will be visible and known to each other.
	If the service is co-located this improves accessibility for service users as most aspects of the service can be seen in one place/at one time improving engagement with service.

Theme	**If then statement**
Rival Theory	If the co-location of services is purely for working base and *not* service user contact (because most women are seen at home or hubs) collaborative inter/intra professional relationships within the team will lead to trust building between patients and other practitioners due to the practitioners "knowing" each other through co-location of service.
Service Structure	If funding is uncertain and budgets are cut then the service will not be sustainable and uncertainty, reduced team members may lead to practitioners stress/ case load increasing, if staff do not feel well supported in the difficult working environment then this stress and pressure may lead to reduction in resilience and they may choose to leave their current role.
	If women move out of the area (occasionally on temporary basis for housing, family support) then their care is disjointed and women are lost to other services and it is difficult for services to keep providing all aspects of care meaning things get missed, aspects of social and health care are not provided and women do not receive the services they need.
Individual Staff	If staff are honest dedicated, assertive and persistent then this will build more trusting relationships with women, encouraging good communication, increase commitment to work with women to reach the best outcome for them even when women continue to disengage.

Theme	**If then statement**
	If staff withhold Child Protection information from women (family) then honesty and transparency will be lost and communication will break down as women are not included in decision making and will therefore withhold information which they consider could be used against them.
(COC) Therapeutic Relationships	If there is continuity of carer (CMW, HV, CPN, EYO) then this will enhance therapeutic relationships which improve communication, build trust, encourage disclosure and anticipate issues.
	If continuity of carer is achieved, the practitioner will be able to work with the woman (family) to XXXX them for the arrival of baby (e.g. parenting skills, capacity, labour preparations, breastfeeding, bonding, support, recovery, family planning, assess safety for baby) and practitioners will also feel more invested in the family due to time and effort spent with them.
	If there is no opportunity for continuity of carer then there is no opportunity for building therapeutic relationships causing a lack of trust.
Policy	If the service take a harm reduction approach then there will be a low threshold to prescribing allowing for timely prescriptions to be provided, encouragement of stability, reduction of risk taking behaviour and improved pregnancy outcomes.

Theme	If then statement
	If services are informed by Scottish Government 2018, EADP 2015-2018, Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) the services will take a human rights based, public health, family centred approach focusing on holistic services with MDT, interagency, harm reduction, outcome led, informed by ACE, addressing co-existing physical, mental and social issues.
	If the service are informed by NICE guidelines 2010, Scottish Government 2017 the service will be co-located, non-judgmental, accessible, high quality, empathetic, MDT, holistic, woman, family, person-centred, involving family and friend as the woman choses, and having the woman at the centre of decision making, with joint care plans across agencies.
	If the service takes a GIRFEC approach then the child (and their family) will be at the centre of the service ensuring child safety, protection from abuse and neglect is achieved through joined up working and building of a network of support for the child.
	If the service follows recommendations for early years and drug and alcohol policies then the service will be non-judgemental, recovery-orientated, relationships centred, outcome focused, involve father (and wider family) child centred focusing on safety and wellbeing, reduce barriers to services, aim for effective parenting and address health and social inequalities.

Theme	If then statement
	If an early years officer is involved in the service then a parenting capacity assessment will be conducted for each "parent" to allow for child protection measures to be taken into account and to offer support to improve parenting capacity to enable women (parents) to care for their baby (improving chance of baby being discharged home with birth parents).

Focusing the direction of theories

These 19 "If…then…because" statements were presented to my supervision team. It was at this stage the decision was made to include service user perspectives through interviews as explained in Chapter 4. Following open coding and written reflections on the first four interview transcripts, ICMO configurations were developed (Table 17). These statements were used as a platform for exploration, deductive reasoning and abstraction during the programme theory development. In Table 17, each colour refers to a new Intervention element as described in the first column. These are numbered 1-7, however Context, Mechanism and Outcomes are numbered 1-9 as there are rival theories included within the same Interventions.

Table 17. ICMO Configurations

Intervention	Context	Mechanism	Outcome	Evidence
I1. The service offers- MDT, specialist co-located service	C1. Mutual goals and clear ethos.	M1. **Resource**: Formal and informal communication, skilled staff, peer supervision within the team, case co-ordinator (changes) **Response**: Inter-professional trusting relationships are built, mutual respect for co-workers, motivation and dedication to team and work, understanding of responsibility and accountability.	01. Improved communication about cases, improved staff morale, retention of staff, and low staff burn out, timely action, successful collaborative team working across health and social care.	Wener and Woodgate (2016), San Martin-Rodregez et al (2005), Initial scoping interviews and observations.

Intervention	Context	Mechanism	Outcome	Evidence
I2. Referral into service	C2. Service ethos of woman-centred care: The service is portrayed to/perceived by the woman to be focused on her recovery, including her baby (but not purely child protection)	M2. **Resource:** There is less perception of surveillance on baby alone **Response**: There is less fear that baby will be removed and woman feels more respected and included in the intervention for her own benefit and investment in recovery.	O2. Woman has increased self-esteem, increased motivation, is more likely to engage.	NICE (2010), Rival Theory
I2. Referral into service	C3. Service ethos Child- centred: The service is portrayed	M3. **Resource:** Antenatal (surveillance), Drug tests, case conference, home visits,	O3. Continued fear and distrust of service and reluctance to engage with service.	Roberts and Nuru-Jeter (2010), Roberts and Pies (2011), Rayment-

Intervention	Context	Mechanism	Outcome	Evidence
	to/perceived by the woman to be focused on child protection outcomes	Parenting Capacity Assessment, **Response:** The woman feels powerless, and out of control of the situation, feels as though she has no say or decision about her baby.		Jones et al., (2019) Interviews with service users.
I3. The service build therapeutic relationships with the woman.	C4. Woman with previous (negative or poor) experiences of social work leads to fear and distrust of social work services.	M4. **Resource:** Practitioners are open, honest and share info, are non-judgemental. Offer flexible service e.g. attend social work meetings to advocate for woman. **Response**: Woman has increased knowledge, trust,	O4. Woman and practitioner build therapeutic relationship based on trust, woman feels empowered resulting in *motivation* to engage with service.	Milligan et al., (2017), Rayment-Jones et al., (2019) Interviews with stakeholders, interviews with service users.

Intervention	Context	Mechanism	Outcome	Evidence
		alleviated stress and anxiety and feels respected and considered.		
I4. Sharing of information between service and woman	C5 When a woman has a positive **trusting** therapeutic relationship with a practitioner who **trusts** their colleagues.	M5. **Resource:** Practitioners are open and honest with the woman. **Response**: woman feels respected, and more empowered with the knowledge and in control. Woman continues to trust the practitioner.	O5. Woman is more likely to engage with the other practitioners.	McGeer and Pettit (2016) Interview with service user
I5. Practitioners bring the attention on to the risks to the unborn baby in utero or after birth.	C6. Woman with support and encouragement from family, AND a	M6.**Resource**: The woman is also informed about risks.	O6. Woman is deterred from causing those harms and makes decision to	Interviews with service users. Roberts and Pies

Intervention	Context	Mechanism	Outcome	Evidence
	therapeutic relationship with practitioner, who has begun to engage with services.	**Response**: The woman feels guilt and blames herself for potential harm to baby.	engage in harm reduction measures.	(2011), Ehrmin (2001)
I5. Practitioners bring the attention on to the risks to the unborn baby in utero or after birth.	C7. Woman with poor support networks, who has yet to trust practitioners and low self-esteem	M6. **Resource:** The woman is informed about risks. **Response**: The woman feels guilt and blames herself for potential harm to baby.	O7. Woman is unable to cope with feelings of guilt and continues to use harmful substances, does not engage with service.	Interviews with service users. Roberts and Pies (2011), Ehrmin (2001) Rival Theory
I6. Peer support group which all women are encouraged to join and attend to gain support from each other and learn	C8. Peer group with mixed stages of recovery	M8. **Resource:** Women disrespect and ignore the zero tolerance policy. Women are exposed to	08. Women do not like the peer group because of these experiences and do	Interviews with service users, observations with practitioners,

Intervention	Context	Mechanism	Outcome	Evidence
new skills e.g. baby massage, caring for baby etc.		temptation as some women offer drugs or discuss drugs available. **Response:** this makes women in recovery feel uncomfortable "as if being dragged back"	not return. Women do not learn new skills, recovery support or build relationships.	stakeholder interviews.

Intervention	Context	Mechanism	Outcome	Evidence
I7. The service offer a flexible service of home visits, provide transport, use informal communication e.g. text, provide advice and practical support e.g. benefits, clothing.	C9. Woman with therapeutic relationship with practitioner, who has begun to engage with services. (Because women who are not engaging are not aware of the flexibility and support offered)	M9. **Resource:** The tailoring of the service, goal setting and choice offered. **Response**: makes the woman feel more involved in the control of the service received e.g. timing and location of appointments. This improves the woman's self-efficacy, improves empowerment.	09. The woman is more satisfied with the service and is more positive about her experiences with the service improving engagement.	Shahram et al., (2017), Milligan et al., (2017) Rayment-Jones et al., (2019) Interviews with service users, stakeholder interviews, observations with practitioners.

Narrowing the scope of theories

All nine of the above overall theories (in Table 17) could not be tested within the scope of the PhD, as explained in section Narrowing the scope. I therefore approached theory development in a problem-solution frame as expressed by Adams et al. (2015). This helped me create an Overarching Programme Theory Statement (as expressed in Figure 34) which addressed the problem the service was aiming to address and the theoretical solution. This programme theory was constructed of Intervention, Context, Mechanism and Outcome components which then supported the development of the three IPTs (Figure 35, Figure 36 and Figure 37) taken forward to Phase Two.

Figure 34. Overarching Programme Theory

The Service is an early childhood intervention offering an integrated, multidisciplinary team who work with pregnant women and new parents who have significant substance use. The team aims to reduce substance use and related harms to mother and child through health care, social care and support during pregnancy and up to 2 years post birth. The service holds the child at the centre of its focus with its primary aim to protect the safety and wellbeing of the child. This is evident in the team vision which encompasses four strategic aims of the Edinburgh Children's Partnership's vision and its alignment with the GIRFEC framework. The service also encompasses the guidance from NICE and Best Start maternity policies recommending non-judgemental, compassionate and empathetic care. This integrated team provide an adaptable intense service to engage women in harm reduction measures, commence recovery from substance use, assess and treat mental health issues, improve maternal health resulting in a healthy pregnancy and reduced neonatal harms from alcohol and drug exposure in utero. The service provides a programme to support positive parenting experiences and parenting capacity assessments to ensure safety of the child. The service is built on positive therapeutic relationships with families to encourage open and honest communication. The team members work from a co-located base allowing for formal and informal communication, information sharing and peer to peer support (colleagues). Overall the service aims to reduce health and social inequalities and alleviate the financial impact of transgenerational substance use.

Key: Yellow— Intervention, Red— Context, Green— Mechanism, Blue— Outcomes.

Table 18. ICMO from Overarching Programme Theory

Intervention	**Context**	**Mechanism**	**Outcome**
early childhood intervention integrated, multidisciplinary team health care, social care and support during pregnancy and up to 2 years post birth adaptable intense service programme to support positive parenting experiences parenting capacity assessments co-located base	Pregnant women and new parents who have significant substance use. holds the child at the centre of its focus Edinburgh Children's Partnership's vision GIRFEC framework NICE Best Start maternity policies Transgenerational substance use.	non-judgemental, compassionate and empathetic care. positive therapeutic relationships open and honest communication formal and informal communication, information sharing and peer to peer support	reduce substance use related harms to mother and child wellbeing of the child engage women in harm reduction measures commence recovery from substance use assess and treat mental health issues, improve maternal health healthy pregnancy and reduced neonatal harms safety of the child reduce health and social inequalities alleviate the financial impact

Figure 35. Initial Programme Theory 1

Initial Programme Theory 1

The service model for pregnant women with problem alcohol and drug use works because specialist practitioners work as a multidisciplinary team in a co-located service, and the range of specialist expertise in combination with daily staff interaction serves to strengthen coordination of care, problem solving and a shared understanding of roles.

Within a challenging and "gruelling" practice area (Context) the service (MDT, Co-located, specialist service) (Intervention) with mutual goals and team ethos (Context) introduces…

1. the opportunity for (formal and informal) communication (resource) which builds respectful, trusting inter-professional relationships (response) leading to improved communication about cases (outcome).
2. the opportunity for (formal and informal) communication (resource) improving practitioners understanding of responsibility and accountability (response) resulting in timely action (outcome).
3. skilled staff (resource) who bring an understanding of responsibility and accountability (response) and motivation and dedication (response) resulting in improved staff morale and retention, reduced burn out and timely action (outcome).
4. peer supervision (resource) which improves motivation and dedication (response) and an understanding of responsibility and accountability (response) resulting in improved staff morale and retention, reduced burn out, improved communication about cases and timely action (outcome).
5. a case co-ordinator (resource) which improves each practitioners understanding of responsibility and accountability (response) leading to improved communication about cases (outcome) and timely action (outcome).

Figure 36. Initial Programme Theory 2

Initial Programme Theory 2.

The service model for pregnant women with problem alcohol and drug use works as the practitioners use open, honest, non-judgemental approaches to encourage trust building with women who are often distrust and are fearful of services due to previous experiences. This approach helps to make women feel respected, considered and more trusting of the service.

If the service aims to build therapeutic relationships (intervention) with a woman who has previous experience of social work (who have fear and distrust of services) (context)

1. Then a non-judgemental approach and flexible service (resource) makes the woman feel respected and considered (response) and therefore more encouraged to engage (outcome).
2. The flexibility of the service (resource) offers practical alternatives (resource) alleviating stress and anxiety (response) (because of "hand holding", "takes pressure off") enabling women to engage (outcome).
3. Then offering open and honest communication (resource) the woman begins to trust the practitioner (response) leading to therapeutic relationships (outcome).
4. Then the practitioner sharing information (resource) with the woman will inform the woman and will lead to trust building (response) and strengthening the therapeutic relationship (outcome).

Figure 37. Initial Programme Theory 3

Initial Programme Theory 3.

The service model for pregnant women with problem alcohol and drug use works as it offers a flexible service (home visits, transport, informal communication, advice, practical support) (intervention) to a woman who has a therapeutic relationship with a practitioner and is engaging with the service (context)

1. then the tailoring of the service (resource) makes the woman feel more valued (response) as it meets her needs (outcome) leading to satisfaction and positive experiences with the service (outcome) and longer term engagement (outcome).
2. then the tailoring of the service (resource) offers choice (resource) strengthening woman's autonomy and improving her self-efficacy and empowerment (response) leading to satisfaction and positive experiences with the service (outcome) and longer term engagement (outcome).
3. then goal setting or laying out of expectations (resource) gives women a sense of hope (response) leading to motivation and positive behaviour change (outcome).

Chapter 6 Phase Two Findings

Phase Two, Testing programme theories

Objective – Test these theories through an iterative process of data collection and analysis.

During Phase Two of the study the three initial programme theories were tested through a series of interviews and case studies as described in Phase Two methods– Testing programme theories. The following section will describe the sample of service users and practitioners who participated in the study. Demographic data of service user participants are included in the form of tables and figures. I will then outline the IPTs as identified in Chapter 5 Phase One Findings. These are presented through original concept maps followed by evidence of the testing of each theory element. Theory components were either: refuted, meaning evidence suggested the initial theory was incorrect; refined, meaning evidence provided a clearer presentation of the initial theory; or deferred, meaning there was not sufficient evidence to meaningfully test the theory component. Emergent components as discussed in chapter four, will be presented throughout, illustrating new areas of each theory which presented during testing and refinement. Each IPT will be presented in turn, with evidence of analysis and refinement. Throughout this section I will bring examples from IPT development and present these as researcher hunches to link back to aspects of IPT which were tested through data collection and analysis. Concept maps and tables will be presented to illustrate the development of programme theories in C, M, O configurations. Finally at the end of each theory, a tested theory will be presented, colour coded to demonstrate aspects of the theory which changed during the testing phase. Blue highlighted text illustrates aspects of the theory, which were present in the IPTs, and green highlighted text illustrates aspects of the theory, which have changed. Table 24 provides an overview of each IPT component which was tested, data sources provided and outcome of the tested theory.

Sample

As described in Chapter 4, Realist evaluation methods section, both service users and practitioners were recruited to the study. The following section presents the sample characteristics however due to the small number of participants some demographic data has been withheld in order to avoid deductive disclosure (Kaiser, 2009).

Service users

Through the methods discussed in Chapter four, Phase Two, nine service users were recruited to participate in the study. Demographic data included in Figure 38, and Table 19 and Table 20, describes the sample including their parenting, substance use and health history. Whilst the sample of service users are small, the demographic data was utilised to better understand the contextual factors of individuals, which contributed to rival theorising, comparing and contrasting throughout data analysis and refinement. This approach, known as triangulation, is used to support the confirmation and refinement of study findings (Flick, 2018). Collating this data and comparing it with the routinely collected annual data from the service discussed in Chapter 1 Introduction, allowed the sample to be considered as a snapshot of the service.

Of the study sample, women were aged 25-39 with a median age of 35. Substance use in years ranged between five and 20 with a median of 10 years of substance use. These averages were calculated using median due to small sample size and outlying data. One participant was employed whilst the majority were receiving incapacity benefits. Four women were in couple relationships whilst five were not, however all women were in a relationship when they became pregnant. Most women were enrolled in the service with their second or third child and seven out of nine women had custody of their most recent child.

Figure 38. Key Demographics From n=9 Service Users

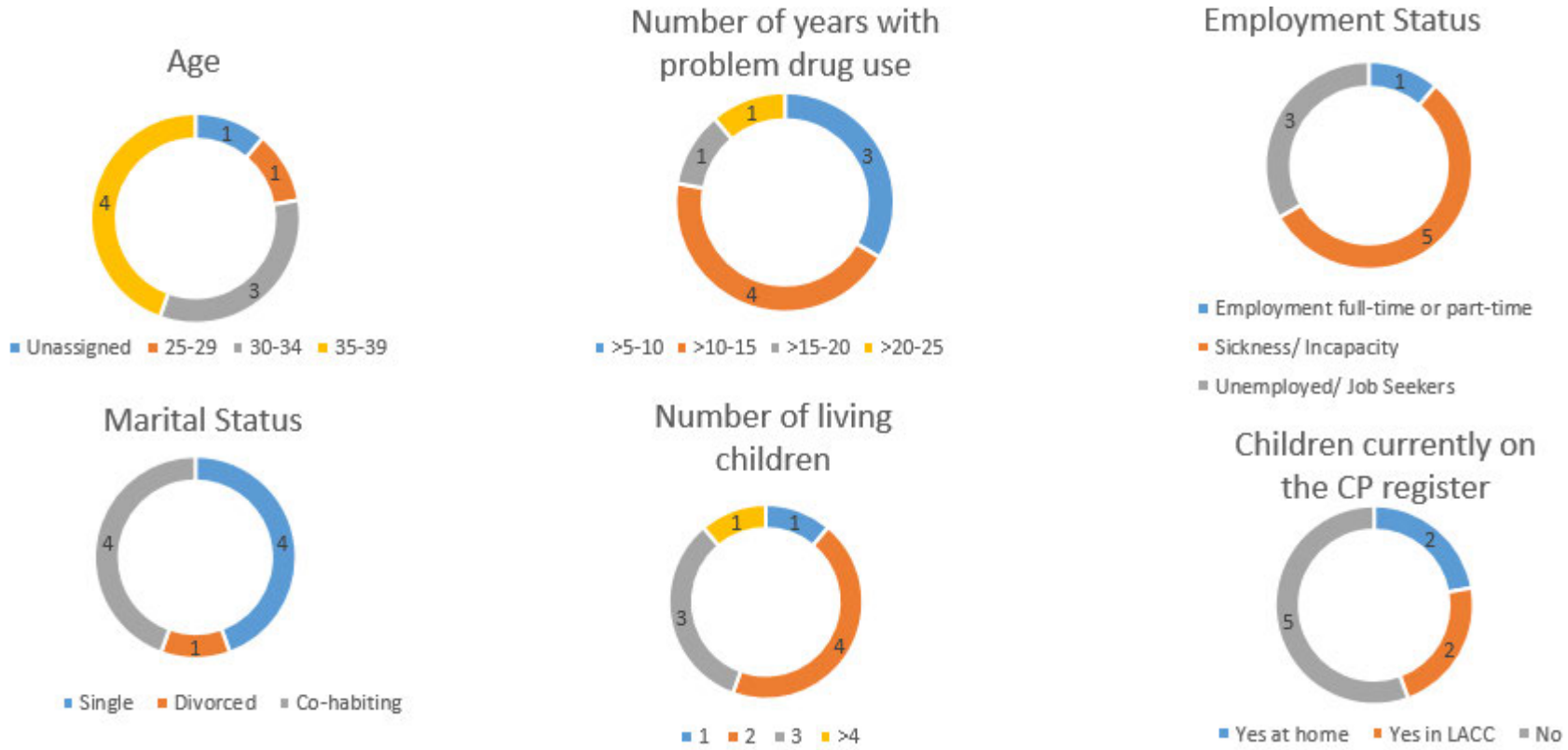


Table 19. Service User Participant Demographic Data

Participant	Accommodation Status	Age	Age Left School	Educational Status	Employment Status	Marital Status	Previous Involvement In The Service	Significant Mental Health Problems	Significant Physical Health Problems
1	Own tenancy	35-39	>15-17	High school qualifications	Employed full-time or part-time	Co-habiting	No	Yes	No
2	Own tenancy	35-39	>12-15	Informal classes	Sickness/ Incapacity	Single	No	Yes	Yes
3	Own tenancy	30-34	>15-17	Unassigned	Sickness/ Incapacity	Co-habiting	Yes	Yes	No
4	Own tenancy	30-34	>15-17	High school qualifications	Sickness/ Incapacity	Single	No	No	No
5	Own tenancy	25-29	Unassigned	Unassigned	Unemployed/ Job seekers allowance	Single	Yes	Yes	No
6	Own tenancy	35-39	>10-12	SVQ	Unemployed/ Job seekers allowance	Single	No	Yes	Yes
7	Officially homeless or living	35-39	>15-17	No Qualification	Sickness/ Incapacity	Co-habiting	No	No	No

Participant	Accommodation Status	Age	Age Left School	Educational Status	Employment Status	Marital Status	Previous Involvement In The Service	Significant Mental Health Problems	Significant Physical Health Problems
	in temp accommodation								
8	Own tenancy	30-34	>15-17	High school qualifications	Unemployed/ Job seekers allowance	Co-habiting	Yes	Yes	No
9	Own tenancy	Unassigned	>15-17	No Qualification	Sickness/ Incapacity	Single	Yes	No	Yes

Table 20. Service User Participant Parenting, Drug Use and Criminal History Data

Participant	Children Living At Home	Children Not Living At Home	Number Of Years Of Problem Drug Use	Drug Replacement Therapy	Historical Legal Issues	Drug Treatment Testing Order
1	Yes	Yes	>10-15	Methadone	Yes	No
2	Yes	Yes	>20-25	Subutex/Buprenorphine	No	Previous
3	Yes	Yes	>15-20	Methadone	Yes	Previous
4	No	Yes	>5-10	Subutex/Buprenorphine	No	No
5	Yes	No	>5-10	Methadone	No	Previous
6	Yes	Yes	>10-15	Methadone	No	No
7	Yes	Yes	>10-15	Methadone	Yes	No
8	Yes	Yes	>10-15	Methadone	No	No
9	No	Yes	>5-10	Methadone	No	Previous

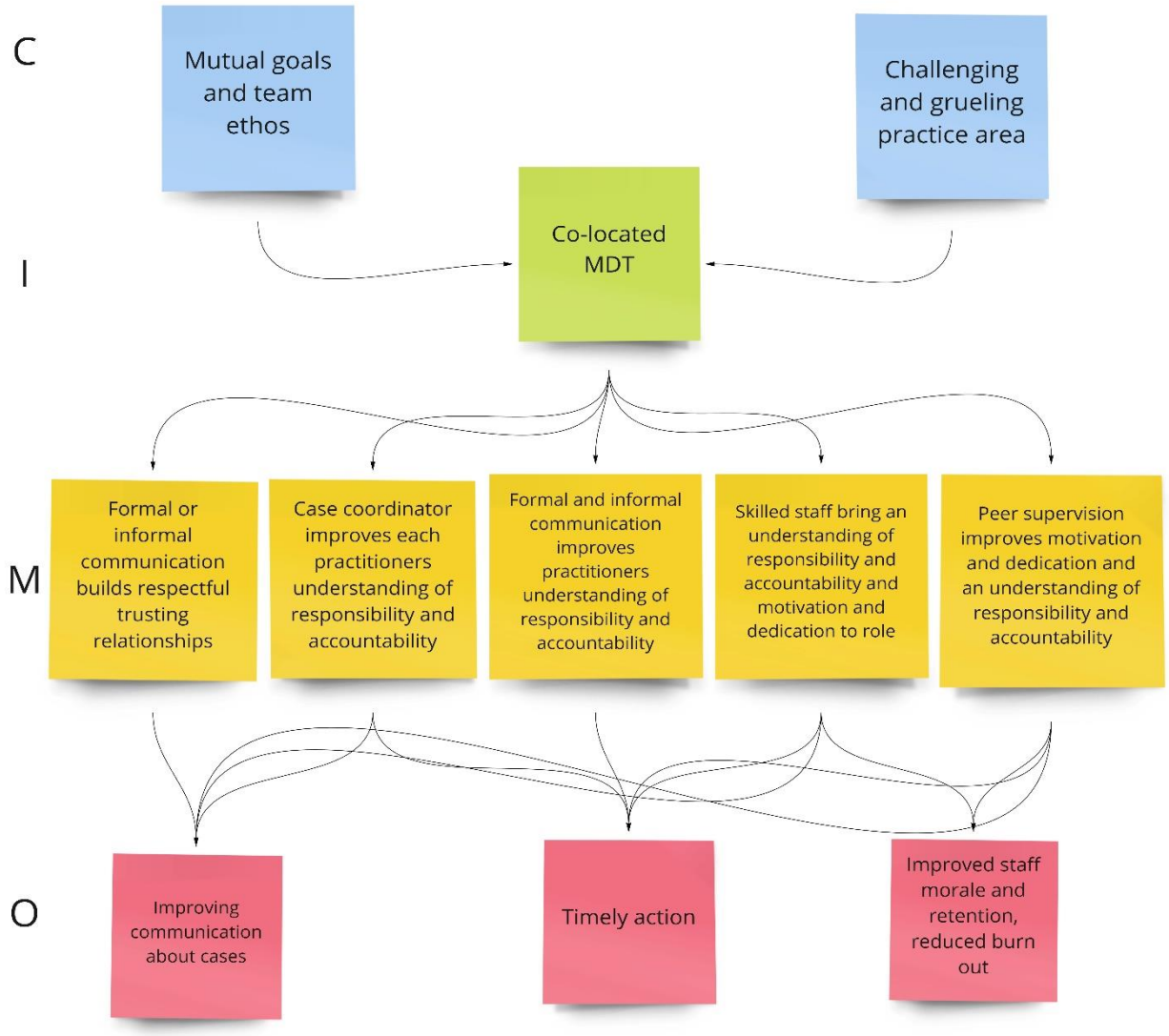
Practitioners

As described in Chapter 4, Realist evaluation methods, practitioners who worked within the service being evaluated were invited to participate in study interviews. Through the methods described in the previous chapter, 10 practitioners from a possible 11, participated. The aim was to ensure at least one practitioner from each disciplinary background from the multi-agency team participated which was achieved. Whilst demographic data including age, length of time in role and length of time in disciplinary background (e.g. nurse) was collected through self-completed questionnaires at time of interview, this data is not presented for risk of deductive disclosure (Kaiser, 2009).

Testing Initial Programme Theory 1

The following section will present IPT one as a concept map (Figure 39) which was developed during Phase One. The concept map presents the Context, Intervention, Mechanisms and Outcomes being tested in theory 1. IPT one focuses on the intervention element of the Co-located Multidisciplinary team (MDT) and how, through a series of mechanisms: communication and timely action, staff morale and retention can be improved. However, this is dependent on two influential contextual elements including mutual goals and team ethos of the MDT and the challenging and gruelling practice area. Figure 40, Figure 41, Figure 42, Figure 43, Figure 44, Figure 45, Figure 46, Figure 47, Figure 48, Figure 49, Figure 50, Figure 51, Figure 52 and Figure 53 outline the developments of the concept map throughout testing.

Figure 39. Concept Map IPT1 Prior to Testing



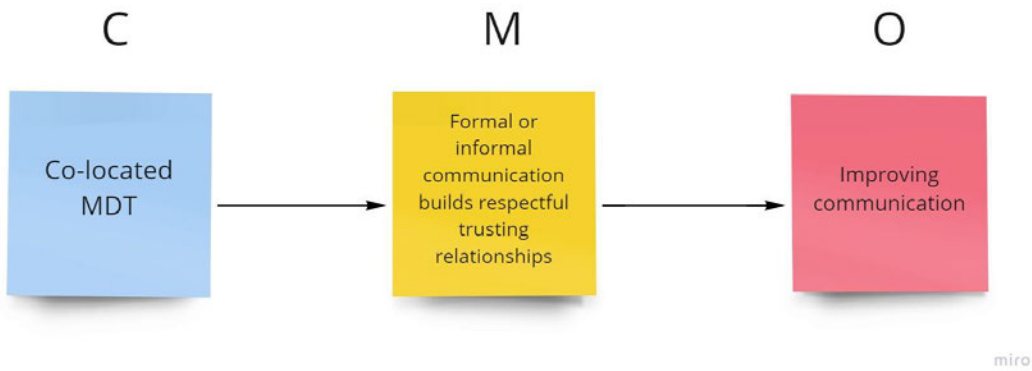
Improving communication (outcome 1)

A key intervention within this programme was the co-location of the MDT and its contribution to improving communication. As outlined in Phase One, it was thought co-location would allow for informal communication within the team as members of the team use the same office base. During theory development in Phase One, interviews with stakeholders highlighted the importance of both formal and informal communication enhancing information sharing and relationship building within the team. Evidence from Wener and Woodgate's (2016) grounded theory study of collaboration in co-location, highlighted the importance of face-to-face informal communication which led to timely service provision and strengthened inter-professional relationships.

Therefore, the following "if…then…because…" statement was constructed in Phase One and tested in Phase Two through interviews with staff and observations of practice.

"If this service is co-located then, communication will improve between practitioners as opportunities for formal and informal communication will arise and practitioners will be visible and known to each other."

Figure 40. PT1. CMO 1



Whilst this was true to some extent in the form of informal discussion and formal team meetings, many underlying factors contributed to communication success and failure as presented below.

Informal communication

Co-location of the team allowed for sharing of information in the moment, picking up from other practitioners in the passing or overhearing discussions between other practitioners leading to important information sharing. As the complexities of each case changed regularly and were unpredictable, keeping up to date with developments was essential and informal discussions aided the exchange of timely information in the moment.

> *Having that [co-located] base is, I think, really key because you'll always speak to somebody that knows something about something, because we're all listening all the time to what's, kind of, going on. I think the location is key.*
>
> (Practitioner Interview 7.)

Formal communication

Formal communication was enabled by a mandatory weekly meeting which was considered "protected time". This managerial expectation led to compliance by practitioners as ground rules are clear that attendance at the team meeting was essential.

> *The only time [the manager] will say you have to be at the team is at team meetings, you're not allowed to bow out of that and that is really crucial.*
>
> (Practitioner Interview 4.)

Managerial leadership and modelling of the team meeting also enabled information sharing within the team. The manager took steps towards improving communication about cases by setting an agenda and prioritising cases that needed more support e.g. cases needing reports, cases at crises. However, despite having all practitioners in the room at once, the team meeting brings its own barriers to communication within the team. Practitioners highlighted the service was "stretched" meaning there was little time for the work they require to do. Practitioners' diaries were full, they often did not have time for lunch breaks and were juggling the demands of their client interactions and their administrative work.

> *And a team meeting can be really good for that [sharing information], but also the team meeting can be whipping through all the patients and it's really the time constraints and we've got lots to do in this.*
>
> (Practitioner Interview 7.)

This constraint on time leads to frustrations regarding the weekly team meeting which can take a lot of time and are not relevant to all team members.

> *Some people will talk about things that I would feel you could do in supervision or you could do maybe with just the professionals you are working in, […] when you have to wait your turn it can be quite frustrating when people keep going over the entire journey every week, and you are looking at your clock and thinking I need to write this, I need to be here, just say what you need to say quickly and kind of move on.*
>
> (Practitioner Interview 6.)

Informal emotional support

Co-location supported the development of working relationships and gave practitioners the opportunities needed to support each other in difficult or challenging times. In these instances, the co-located office space was the environment for face to face informal communication and reflection. A practitioner from the first stakeholder interviews described the practice area as "*challenging and gruelling" (Stakeholder Interview)*, outlining the complex contextual backdrop of the service.

> *Coming back here I thought, got to have my lunch and I was just sat having it and I spoke to (practitioner) about how horrendous [the case conference had been] and I spoke about it and (sigh)… I used to go home at nights and think about it…now I have taught myself better that no…I can't have my work coming home because that's my work.*
>
> (Practitioner Interview 2.)

Due to this challenging and gruelling context, practitioners relied on the co-located office space to provide informal emotional support. All practitioners acknowledged it was essential to seek support to managed their own stress and wellbeing.

> *I think actually coming in somewhere and having that face to face discussion is so important. I think it's important to feel part of the team, to come in and see your colleagues and I think if you have had a challenging meeting or you have had a really difficult visit with a client or I know quite a few of our discharge planning meetings at the hospital when baby goes into care, you are trying so hard to support the parent but actually it's a lot for you to deal with cause emotionally its really difficult. So I think coming into an office and having that base that you can come in and you can offload to your colleagues I think that is really important for our own wellbeing and our own mental health to actually have that base and there is most likely going to be someone to speak to or to offload on.*
>
> (Practitioner Interview 3.)

Some practitioners highlighted the importance of self-reflection, acknowledging when they had not been in the office recently and when it was necessary they touch base with their colleagues as co-location alone did not provide support, they were required to seek opportunities within the setting. In this quote, "It" refers to co-location providing informal emotional support.

> *[It] does work but folk have to make that work, it's not a circumstance thing, it doesn't work just because somebody happens to be in the office, you've got to seek that out sometimes. You've also got to be able to judge whether you've been out of the office too much and whether you need to be in the office more. You've also got to analyse why have I not been in the office that much and what's that about?*
>
> (Practitioner Interview 10.)

This demonstrates that utilising the co-located office base had to be prioritised by practitioners' in order to receive the outcomes it could offer e.g. improved communication about cases, reflective practice and peer support.

Formal emotional support

Formal communicative arrangements in the form of peer supervision were encouraged by management, however prioritising these sessions was often difficult due to the demands of work load.

> *I think I only went to one [peer supervision] because during meetings and crisis we just had to keep postponing it, so I think there needs to be more of a, you know if you have got workers going off sick because they can't really piece all this together and let it out to get that support, I think there needs to be more of a focus on that [support].*
>
> (Practitioner Interview 6.)

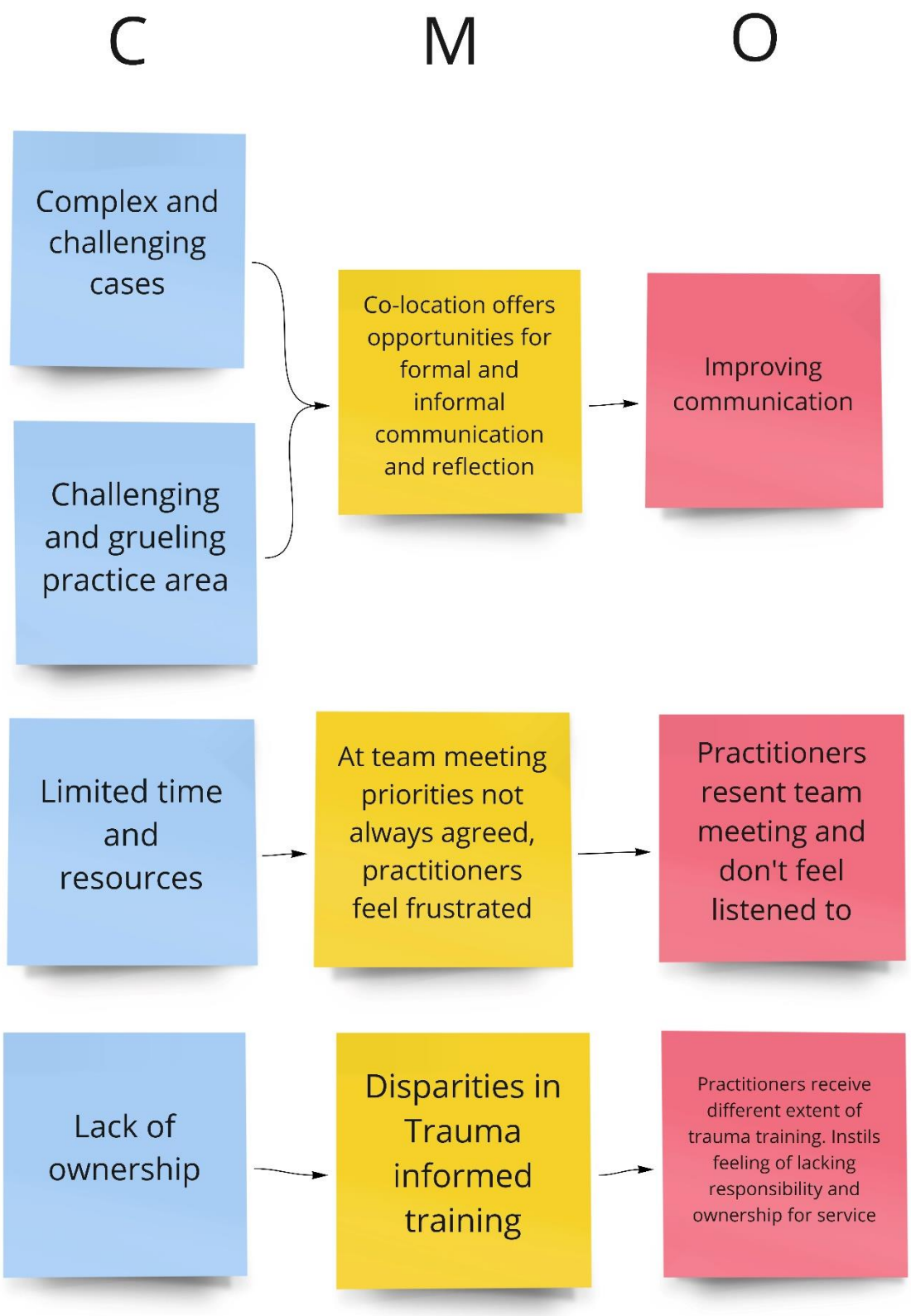
Whilst all practitioners highlighted the importance of managing their own wellbeing; opinion differed as to whose responsibility it was to ensure a supportive climate within the team prioritising and focusing the importance of staff wellbeing. Some practitioners reflected on discussions within the team which had raised concerns regarding the lack of support however in their opinion this was not taken further and actioned.

> *I think an external source [for providing staff support] would be good, we kind of spoke about it but nothing was ever kind of ever done or followed up.*
>
> (Practitioner Interview 6.)

However, management raised the importance of practitioners taking ownership and responsibility for their own needs and felt a *compassionate approach* within the team was essential. Multiple resources were highlighted by management which contributed to the development of a compassionate model of care — for example, *self-care assessment tools* were available for practitioners to reflect on and plan their own self-care and stress management. This was assumed to develop collective awareness and mutual support within the team. *Trauma- informed training* was also available for practitioners to attend however there were inequities in access to training due to individual professional job sectors. Disparities in the extent of responsibility and ownership of practitioners' wellbeing across commissioner level, management, team and individual resulted in uncertainty and a sense of frustration from practitioners.

These examples demonstrate a lack of ownership for the service which practitioners were aware of, outlining this as a contextual factor impacting the team dynamics.

Figure 41. PT1. CMO 2.



Flexible working (Intervention) as a barrier to co-location (Emergent component)

There were several pros and cons identified for flexible working versus co-location which produced different outcomes. A barrier to co-located based work was the limited availability of computers and desk space which often meant practitioners wouldn't risk going to the office if they could use their emails on their phone or use their laptop at home.

> *[Co-located base] has its benefits that everybody is just in that same one place, but unfortunately the difficulty is that we don't have like a one desk space because we hot desk so that you know like on a Thursday everybody is in and there's not enough seats for everybody.*
>
> (Practitioner Interview 1.)

Management to allow home working and working in other clinical or administrative bases across the city supported a flexible working enabling practitioners to work more efficiently across the city, checking emails on the go and communicating in the moment with each other.

> *An iPhone gives you access to emails, it gives you the ability to be on the go doing your outreach work whilst keeping that level of communication going. You know if someone sent me an email and there were concerns I could look at that before going in [to the home visit…] I could think ok I am going into that visit now I will raise that issue when I go in […] that's your tool when you are out and about.*
>
> (Practitioner Interview 4.)

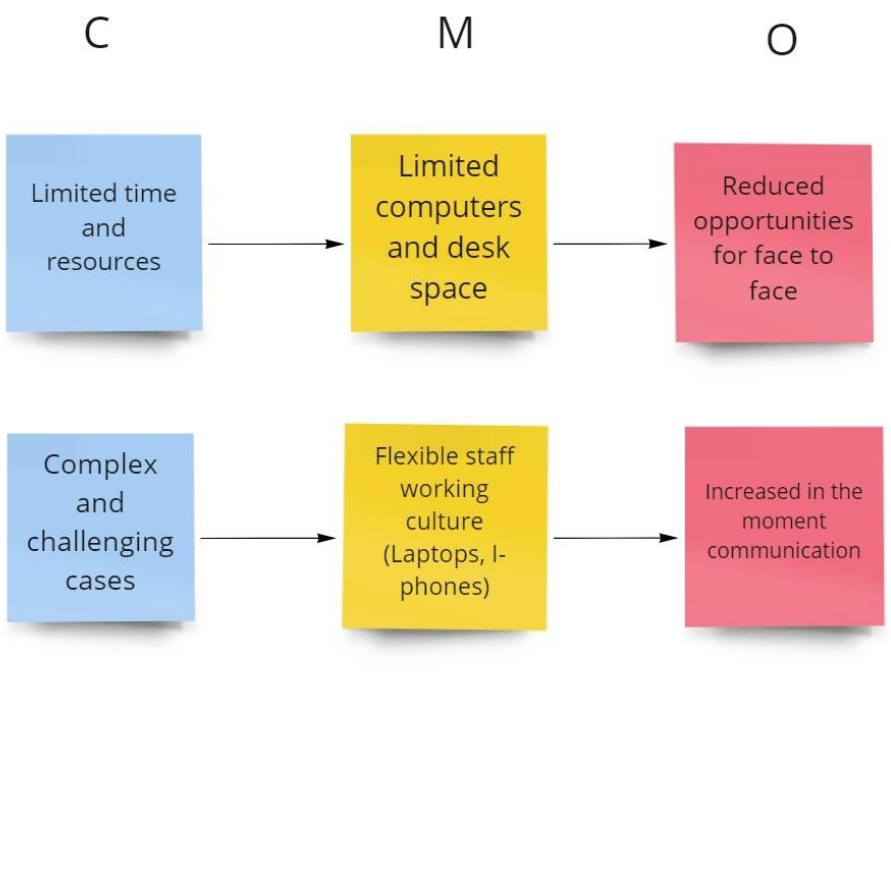
However the flexible model reduced opportunities for informal communication in the co-located base which was considered essential to some practitioners who reflected that face to face communication was more valuable depending on the situation. Written communication in the form of emails could be direct and not reflect the tone of the message risking the content being interpreted incorrectly by other practitioners.

> *Sometimes you can send an email and you don't know how the other person is going to perceive it […] So sometimes especially see if you're out and about and you quickly send an email, it's something just passing on information but you*

don't know how that person is going to receive that, so when it's face to face it removes that so definitely the face to face thing is beneficial from that.

(Practitioner Interview 1.)

Figure 42. PT1. CMO 3.

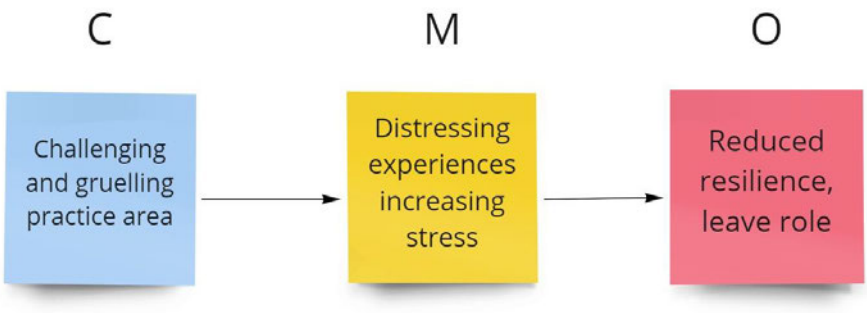


Challenging and gruelling practice area (Context)

A main contextual background raised in the initial stakeholder interviews was the challenging and often gruelling practice environment. This early theory development in phase one informed a hunch expressed below as an "if…then…" statement:

If staff are not well supported in the difficult working environment then they will become more stressed and affected by the experiences and will not be resilient to continue in the role long term.

Figure 43. PT1. CMO 4.



This "if…then…" statement was further explored in interviews with practitioners who resonated the challenges that working in this practice area presented.

> *When I'm hearing her (service user), (sigh) it's so hard sometimes, you know I could feel my eyes, cause [the mother is] crying, breaking her heart and…you're not, you know you're not human if you're not going to feel that and she's just crying. We let her speak and we are trying to keep it you know [together].*
>
> (Practitioner Interview 2)

The emotional burden practitioners faced on a daily basis required them to control their own emotions and maintain a professional appearance in order to support the client in troubling times. Reflecting on these times made the practitioners feel emotional about the experience and expressed empathy for their clients.

> *You know you can't not feel for these women, you can't, and (pause) a part of me I don't want to not, because I think if I got to that stage then I wouldn't do this job because I want to be able to [feel], I want to do what's best for these babies, and children of course but I want to help these mums be able to do it, that's my main passion, if I didn't have that then I couldn't do this job so, I don't want to lose that. I suppose it's empathy, you know that understanding what they are going through and why they are the way they are, but what we can do to help you know and I think if I didn't have, feel that, I wouldn't do this, I'd leave, because you know, I don't want to be affected but I want to feel that kind of way [empathetic], I think it's important.*

(Practitioner Interview 2.)

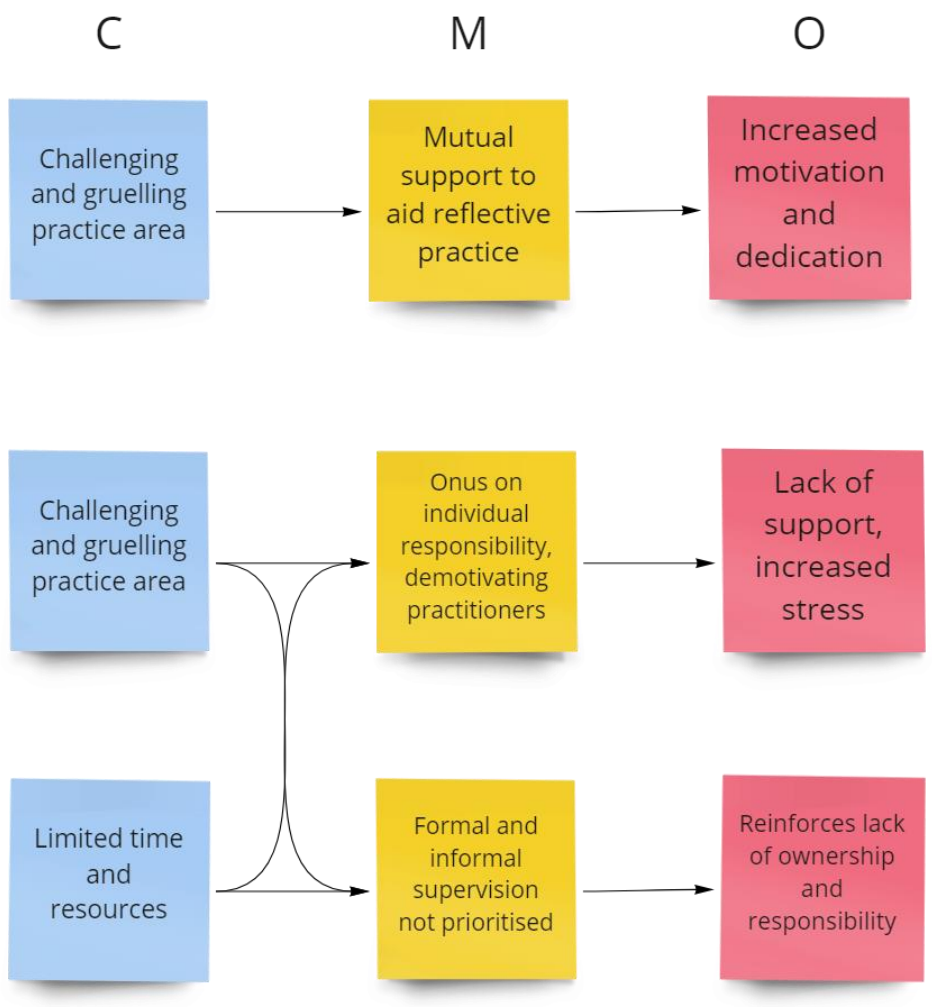
Practitioners highlighted the importance of reflecting and acknowledging this deep empathetic awareness which helped to continue both motivation and dedication to their vocational work. Practitioners also expressed how vital, mutual support from colleagues was, in ensuring this reflective practice could take place when required. However, many practitioners raised concerns that they did not feel they had enough specialist support to deal with the traumatic issues they faced in their day-to-day work.

> *I think we have all spoken about it is a difficult job, it is really traumatic, when people are you know pouring their heart out to you or kids are particularly taken into care straight from hospital, two days after they have been born, for me there could be a bit more trauma informed sort of counselling around that, just check ins as well, especially if it is the end of the day, we try to [work] eight till four so everybody is kind of safe at the end of the day, if you are having a particularly tough or long day and you have to wait till supervision to do that. And you do bounce off your colleagues and you do have peer support and peer supervisions, but again I think I only went to one because during meetings and crisis we just had to keep postponing it.*

(Practitioner Interview 6.)

This practitioner explained that the challenging and gruelling practice area meant practitioners needed substantial support. Despite being offered peer or management supervision, due to limited time and resources and overstretched practitioners formal and informal supervision was not always prioritised. In addition, the onus on individual responsibility for utilising support systems and enacting self-care strategies demotivates practitioners. Therefore, practitioners didn't receive adequate support to deal with the personal effect working in this environment could have on the practitioner which resulted in increased staff stress and potential sickness. Again, this reinforces a lack of ownership and responsibility from organisational buy-in for the service and the practitioners.

Figure 44. PT1. CMO 5.

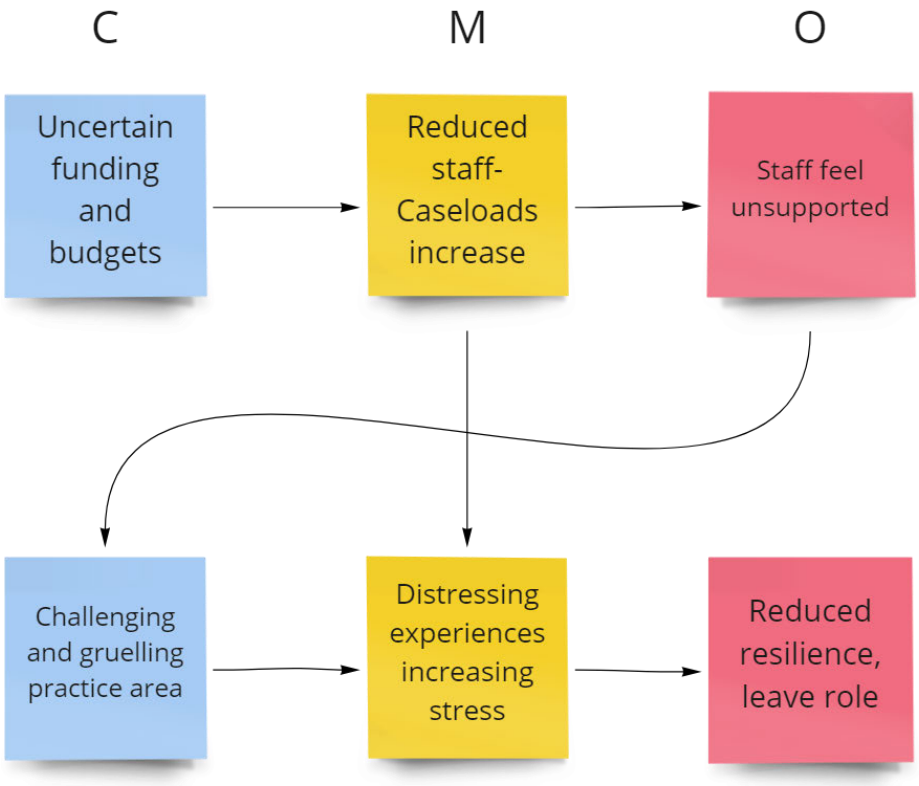


Ownership and responsibility (Context) affecting funding and resources (Emergent component)

When carrying out scoping interviews with stakeholders within the service, instability of service provision was an evident concern of management. The service had been commissioned by multiple funding sources at the point of initial development including NHS, local authority and alcohol and drug partnership. Over time the commitment to funding from each agency had fluctuated and the hierarchical management structure had changed leaving the service to be managed by children's disability sector, which did not feel to the practitioners and managers as an appropriate aligned division. However, the extent to which it was affecting the workings of the team and the wider contextual influences were unknown. IPT development suggested:

"If funding is uncertain and budgets are cut then the service will not be sustainable and uncertainty, reduced team members may lead to practitioners stress/case load increasing, if staff do not feel well supported in the difficult working environment then this stress and pressure may lead to reduction in individual resilience and they may choose to leave their current role".

Figure 45. PT1. CMO 6.



During IPT development and narrowing of the scope of the study the context of ownership and responsibility of the service was not explicitly included. However, during testing other aspects of the theory, it became evident this service level context was impacting other aspects of the theory. Through realist interviewing it became clear that a key factor influencing the smooth workings of this MDT is the lack of ownership for the service which contributes to instability in funding, affecting many aspects of the team.

Interagency ownership and vision

On one level bringing multiple agencies together allows for the right combination of disciplines to address the complexities of each case. However, as a team there appears to be a lack of interagency ownership and vision for the service.

> *What doesn't work so well in terms of a management position is that we don't have a strategic vision within the partnership, so that's health and social care and children and families and NHS, we don't have a strategic vision about why we actually have [the service] and who's prepared to do that?... So, it's almost been taken for granted that we exist and this is what we do and everybody's happy with it, whereas the partnership really needs to take ownership of it*.
>
> (Practitioner Interview 10.)

Funding instability

This uncertainty brings concern to the practitioners but also hinders the progression of the service. Developing and improving the service is challenging when there is minimal strategic support which brings uncertainties of future funding. Without vision and direction at a strategic level, priorities and targets cannot be outlined and progress made. Restrictions in funding therefore means restrictions in training and support for practitioners, lack of resources and limited funds to overcome challenges with service provision. Some practitioners highlighted the impact funding had on providing accessible outreach groups in the form of peer support for parents.

> *One of the biggest issues for me is we can't get a venue that's free in the city centre...Having a resource that we can have something once a week for a couple of hours, because we've not got any money. We've not got any, kind of, resources to pay for anything where people can come in.*
>
> (Practitioner Interview *7.*)

Practitioners were aware there were limited resources to support changes and developments in the service and therefore this impacted on future planning of the service including models of discharge to improve the transition from intensive support to mainstream services.

> *I wonder if we can do a model, if we were transitioning to a new CPN or new worker not just abruptly saying well that therapeutic relationship ended now you will have a new one, we need to sort of have that melting into the next one. How we do that? I don't know, it comes down to resources.*
>
> (Practitioner Interview 5.)

For many practitioners the funding uncertainties were clear day to day and impacted on effective teamwork. Some practitioners were on part time contracts which meant the essential process of communicating effectively across the team was made that little bit harder. Ensuring the right practitioners were attending important case meetings was even more challenging by the juggling of part time staff.

> *We're a small team with cuts in funding which doesn't always help, you know, because some of the (practitioners) are part time so that,[…] that can hinder it because we don't have as many staff as we could have […]there are core groups and case conferences and we've got to split ourselves between and its maybe been really important that you go to that meeting but its maybe really important that I go to that meeting so, sometimes that can be difficult.*
>
> (Practitioner Interview 2.)

Time and resources

Time and resources were limited for the team despite being a specialist service. Practitioners reported client's needs demanded a lot of their time due to the intensive outreach model. At the start of a client's journey the practitioners were often focusing on trying to locate the clients, establish relationships with them and assess their needs which could take up a considerable amount of time given the complexities of each client. Many women were not referred to the service until their second trimester and because of the child protection agenda and women's previous experience with social work services, many women did not actively engage with the service at point of referral.

> *Certainly, when they are pregnant, we are really just running about after them.*
>
> (Practitioner Interview 1.)

> *I can't pinpoint exactly what one thing that I do, its housing, financial, budgeting, helping them get to appointments, to benefit agency appointments, emm filling in forms, getting them to their scan appointments, attending them to any meetings they've got. Advocating on their behalf and talking through people and that is all, we try and do all that before baby is born, to get preparation for baby, help them get the equipment that they need, things like that, so that's all building up a relationship, so that all that, I do during pregnancy.*
>
> (Practitioner Interview 2.)

Practitioners would often discuss how busy their diaries were and how this impacted on other aspects of their team working and their clients' needs. Trying to arrange times for joint visits could be challenging when practitioners had competing demands for their time. Constraint on time as identified here also affected their opportunities for reflection.

> *Occasionally, things get missed but that's only because we're stressed and we're busy...I think it's hard because our diaries are all full and we're all really busy and it's really time constraint and it's really challenging to step back and think how are we managing this? As individuals, as professionals, as a team.*
>
> (Practitioner Interview 7.)

Lack of time for self-care and reflection

The demands of the service on each practitioner often meant that there was not enough time to allow for reflective practice and opportunities to confide in their colleagues and support this essential self-care process. Due to the awareness of each other's heavy workload, picking up the phone to speak to someone about a difficult day may be avoided for fear of adding to someone else's busy case load**.**

> *I don't think I actually think, I don't want to bother people. I don't think that...but that might be something that's in my subconscious, that in a way, because we're all having difficulties.*
>
> (Practitioner Interview 7.)

Lack of time or the extent the service demanded on the practitioners' time meant that prioritising or setting aside time for self-reflection or sharing experiences with

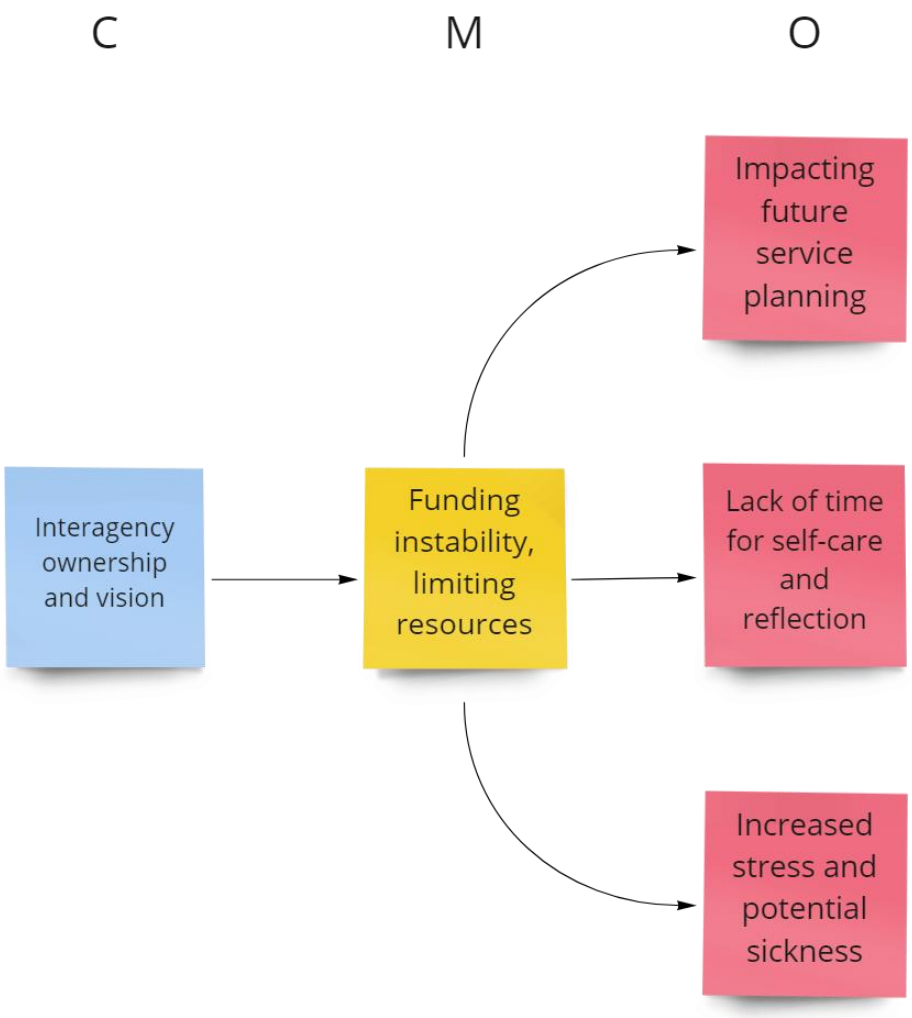
colleagues was difficult. This then had a ripple effect on the team as practitioners were aware those who had become over stressed and required time off then further increased the demands on the team.

> *Yeh and then a staff member goes off sick and then that's just makes everyone else's job even more difficult and there is a pressure there because you don't want to let your colleagues down, but I think it would be clear if the manager was more like you are having your lunch today, you are sitting down we are doing this.*
>
> (Practitioner Interview 6.)

It was clear from all practitioners that the service was fast paced, and practitioners were fearlessly committed to meeting the demands of their clients. However, this was impacting on the wellbeing of the team itself as clients were prioritised at the detriment of individual practitioners.

> *We've got an hour and a half for our Christmas lunch on Thursday…And three members of staff have said I don't have time for that…And, I think, actually, we need to stop… the thing is we really care about our clients and we want them to...you know, we want to give them the service that they deserve, [...] but we're not good at, I think, at taking time out.*
>
> (Practitioner Interview 7.)

Figure 46. PT1. CMO 7.



Mutual goals and team ethos (Context)

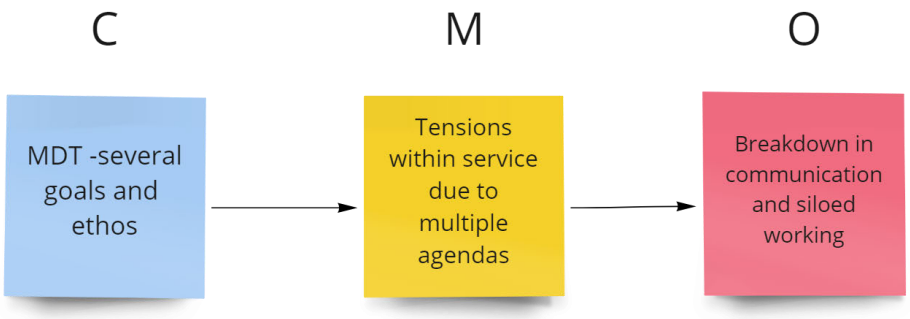
During Phase One stakeholders explicitly discussed the role of the team ethos, describing the importance of *"singing from the same hymn sheet"* (Stakeholder interviews) and having a shared philosophy. A closer examination of wider literature regarding teamwork highlighted the value and purpose a shared ethos has in directing the team to achieve mutual aims (San Martin-Rodriguez, 2005). However, when exploring some of the background policies I sensed different visions or ethos may be included in the service. Whether or not this was creating tensions or was complementing a blended approach to the service became an interesting and vital element to test and as part of this testing I developed rival theoretical hunches:

"If an MDT approach is applied to this service then service focus and ethos will cover many aspects of the service users' needs e.g. maternity, addiction, mental health and

child health. This can ensure all aspects are managed however this might cause tension within the service as multiple agendas are addressed."

"If an MDT does not have a mutual goal or focus then the practitioners might focus on their own areas of discipline leading to breakdown in communication and siloed working."

Figure 47. PT1. CMO 8.



Vision at a strategic level was lacking as previously mentioned in the lack of ownership for the service.

> *So that's one of the challenges about being a multiagency team is who's taking responsibility for this, is it the NHS now or is it a council thing, actually can the partnership just get together and decide that they both do it [take responsibility]? That's one of the challenges in it.*
>
> (Practitioner Interview 10.)

This risked the lack of a "strategic vision" (Practitioner Interview 10), to allow the child protection agenda to dominate the service. However, the service manager attempted to mitigate one dominant approach by taking responsibility for directing the service vision and ethos (as further outlined in the role of Positive supportive management (Emergent component), by fostering a culture of compassionate teamwork and aiding communication.

> *So it is an absolute sum of its parts and the team leader has to be the one that is driving that forward with a clear vision, a clear ethos, and a positive culture of value within that.*
>
> (Practitioner Interview 10.)

The annual reports published by the service outlined their strategy and vision, aligned with the local Children's Partnership Vision (Anon, 2021), The Best Start (Scottish Government, 2017a) maternity guideline as well as the House of Commons, First 1000 Days of Life frame work (2017). Over the course of the study, the annual reports included more aspects to their vision, latterly including "The Promise" (Scottish Government 2020) and its principle of "whole family support" (Scottish Government 2020, p. 57-58).

"[The service] provides intensive family support in line with the 10 principles as outlined with The Promise"

(Anon, 2021)

Despite these policies being outlined in the annual reports, there was some dubiety about the teams' ethos. Each practitioner had their own way of framing the service vision or team ethos, which varied depending on their disciplinary background. Generally speaking, those closely aligned to child health and welfare services viewed the service as having a clear child-centred approach which required the child protection agenda to be at the forefront of every aspect of the service. Whilst those aligned with adult services viewed the service as more centred around the woman's needs. However, this divide was something of great complexity as the needs and priorities of woman and child were so intertwined. When breaking it down, it was clear child protection was at the core of every aspect of the service and any element of the service which appeared to focus on the woman was in turn protecting the unborn or young child. Child protection was given greater priority and if the needs and goals were incompatible or in conflict, child protection eclipsed women's health and wellbeing.

Blending of disciplines

This practitioner reframes these potential tensions by highlighting the positive aspects of embedding adult and child services to improve the narrative on wider health and social issues and engage parents.

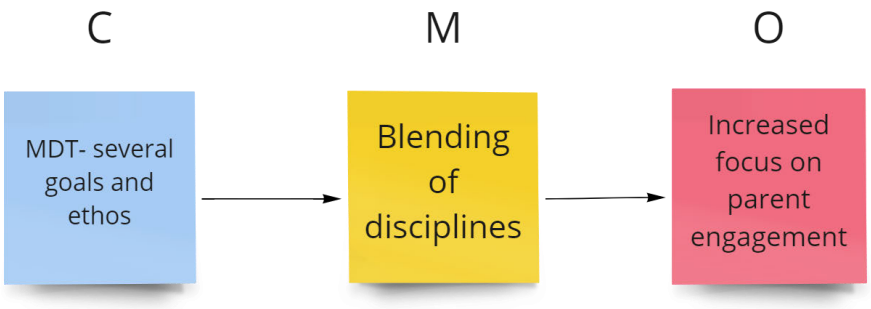
> *I think you need […] to have one person that does that, that pulls it altogether because the aim becomes the same, the ethos of the team becomes one, so you're not factioned off. And there's always going to be conflict because there is always going to be conflict about this mum needs more time, this is her trajectory, these are her needs, and a baby within that is going to sometimes be a conflict of this, no, the baby needs a primary carer who can keep them safe now, not in two years' time, not in a year's time…So the field of addictions with looking at the needs of a child there's always going to be conflict and tension within that and it's to try and ensure that you have a model of practice that has a child's plan, that is allowed to address some of the wider issues, some of the more complex issues but to do, do it in a planned way and a meaningful way and a way which engages parents to get on board with that as well.*
>
> (Practitioner Interview 10.)

When I attended team meetings and raised the question of team ethos it was clear there were differences in opinion about what ethos the team had and what role it played. When asking the practitioners to outline their own roles within the team and what they did for clients, discussions started to emerge about who the "client" was for that practitioner and what "focus" practitioners had.

> *The Early Years Officers believe the focus of service and client is the baby however the CPN… said their client was the adult- the woman. There was a brief discussion about which took precedence and everyone agreed this was something interesting that they were coming from different points of view. This is exactly what I have been aware of in my theorising and how this impacts the service is so interesting. The group implied this could be positive as they see different perspectives but can cause issues in priorities.*
>
> (Reflection from team meeting 10.10.19)

Practitioners involved in drug use and mental health were clear they worked within adult services and were supporting the health and wellbeing of the woman. However, practitioners who worked in child services believed every member of the team regardless of original discipline, worked for the health and safety of the child. It felt tense at times as practitioners tried to defend their views highlighting regardless of their intent, by supporting the health and wellbeing of the woman they were in turn supporting the health and wellbeing of the child. This context is further discussed in IPT2 and IPT3 as it impacts on the services received by clients.

Figure 48. PT1. CMO 9.

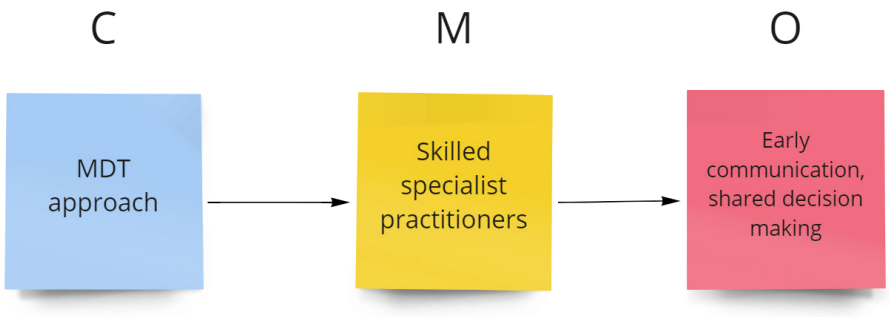


Confidence and transparency (Mechanism) (Emergent component)

Practitioners highlight the importance of being skilled and experienced within the specialist area to meet the needs of the clients in a highly complex setting but also aid team working to benefit the clients. During initial programme theory development, it was thought skilled staff were a key resource to ensure quick referral, assessment and action for clients. This informed a hunch:

"If an MDT approach is applied to this service then service users will receive input from skilled specialist practitioners who can manage cases in a timely manner, sharing decision making, anticipate issues and prevent problems by communicating concerns early."

Figure 49. PT1. CMO 10.



However, during theory testing it became clear there are many elements that skilled experienced practitioners require in order to work collaboratively as a team to ensure the team is greater than the sum of its parts.

Confidence

Practitioners highlight the importance of confidence in themselves and each other. Practitioners have confidence in their colleagues' abilities and use these resources to support their own practice and the needs of the client.

> *I think we are really good at knowing each other's skills and knowing who to go to for certain things […] and I think the team make you feel really valued, like I think when you come up to a team like this and everybody has their own skills and knowledge, I think everybody is good at making you feel that you know something specific in that area. And I think when they come to you asking your advice it makes you feel good, like oh I am glad I was able to help my colleague regarding a certain question or situation or something like that.*
>
> (Practitioner Interview 3.)

Practitioners also need to be confident in their own practice in order to manage scrutiny from their colleagues. This confidence requires critical self-reflection when assessing their own practice within the team.

> *You've got to have confidence in yourself, you've got to have sensitivity amongst your team so that if you have concerns you can share them without people getting defensive.*

(Practitioner Interview 10.)

Being in a multidisciplinary team naturally brings different opinions to the table and resulted in colleagues challenging each other's practice and approaches. This was considered by practitioners as an opportunity for reflective practice, to ensure clients received adequate and appropriate care.

> *It's good that there is different disciplines really emm so it's really is looking at hopefully looking at every aspect as a team and then as a team be able to go out to that mum or that family and offer whatever resources that we have, emm me as a practitioner I suppose it's just good experience to work with because we don't all see eye to eye, so it's quite good to sort of have the differences of opinion and to kind of look at like why I am I doing that and yeh I do agree why I am doing that actually so it just sort of can help you to really challenge yourself and make sure you're doing what you're doing and why you're doing it really.*

(Practitioner Interview 1.)

Transparent communication

This level of transparency within the team also allowed for a deeper integration of the team. Through transparent communication practitioners can focus on the needs of the client through sharing information and working together to problem solve issues. This was especially true when service users were believed to be separating practitioners and manipulating relationships to meet their needs.

> *Our service users will also try and split you, they'll try and divide and conquer, if I get this person on my side I might win this battle. Because that's the strategy that folk use to get where they want to get to if they've got a need and you can kind of get that…but that's the strength of a team is when folk that are working with us know that we all chat and we all know and we all share and it's off the same page, so they might try that but they don't get very far.*

(Practitioner Interview 10.)

On the flip side some practitioners explained how their work with clients was affected if they were not fully informed by other practitioners on their progress.

> *A client will sit and tell you "I am stable, I've no used in the last six weeks, I am doing really well". Now I take them for what they say, but if the addiction worker doesn't share with me that every toxicology has been coming back positive, I can't challenge the client on that and link it to her parenting. So I am making an assessment that is not accurate. So that communication. A client will tell you they are stable, even though they are not. So that communication is crucial.*
>
> (Practitioner Interview 4.)

Building confidence and transparency over time

This level of confidence and transparency was considered to build up over time in the team meaning new staff members did not have this confidence and transparency when starting with the team. All practitioners discussed the challenges new staff met when starting in the team, especially understanding the level of integration the team worked at. Expectations of shared information and shared responsibility was different to specialists working out with a multi-agency team and it was thought it took around 12 months for new staff to start working in the same transparent way as their colleagues.

> *It takes staff a long time, I would say for every new staff member it probably takes them a good year before they can sit around that table and do it confidently. And you just have to be sensitive to that, I suppose.*
>
> (Practitioner Interview 10.)

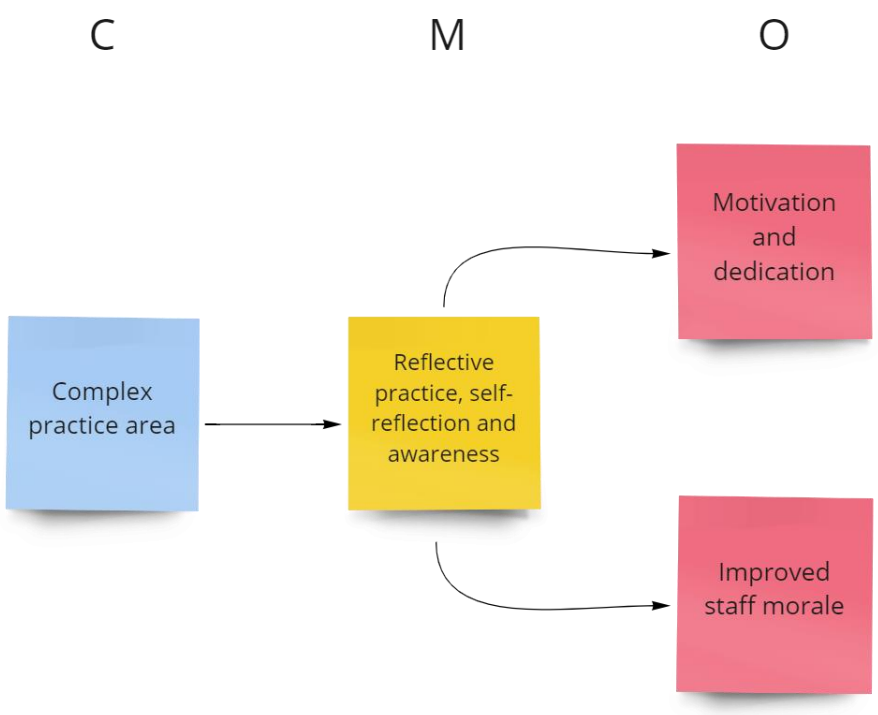
New staff brought positives and negatives to the MDT for different reasons. Some practitioners felt it was very healthy for the team to have staff turnover as it brought an opportunity to evolve the team and the service itself. Whilst other practitioners highlighted the barriers to effective communication new team members brought as they did not appreciate the expectations of shared information. Although new staff were required to be experienced in their specialism and have a desire and interest to

work in the complex area, it took time for some staff to reach the same level of experience and understanding of child protection.

It was clear in this highly complex practice area, competent practitioners were required as they brought skills in reflective practice which allowed for self-reflection and awareness. These skills, in conjunction with informal and formal supervision supported motivation and dedication and improved staff morale.

> *I think it would be really difficult to stay motivated, but it is just having confidence in your practice and, and seeing the little changes, and not expecting people to cartwheel down the street and actually if they have gone to using £100 a day crack to using every other day, for me, that keeps me motivated because I have helped with that change.*
>
> (Practitioner Interview 1.)

Figure 50. PT1. CMO 11.



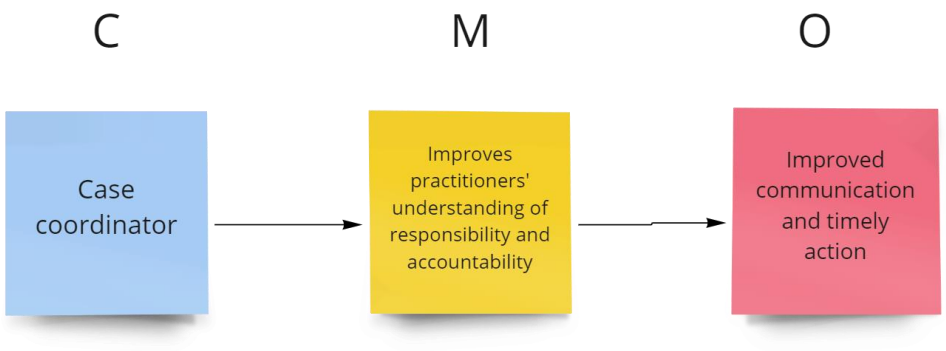
Role identity to support integration (Outcome) (Emergent component)

Initially when developing the programme theories in Phase One I had been led to believe the role of case co-ordinator helped to identify the roles and responsibilities of

each practitioner working on each case and in turn increased practitioners' accountability. A case co-ordinator was identified when a new service user was referred into the service and their role was to lead the case and co-ordinate all information for sharing with appropriate services in line with child protection practices, (e.g. case conferences, pre-birth planning meeting). With this role in mind, a hunch developed that:

"A case co-ordinator improves each practitioners' understanding of responsibility and accountability leading to improved communication about cases and timely action."

Figure 51. PT1. CMO 12.



Processes to identify roles

However, during testing it became clearer that the case coordinator role was a more practical role to ensure the collation of adequate information for each case report. Practitioners' role identity, responsibility and accountability were understood because **of multiple team processes**. Most importantly being aware of other practitioners' roles was an essential element to successful integrated teamwork.

> *That's the whole purpose of the team you know, we have set roles and we will focus on our jobs but if we have to jump over... And I think what's helped over the years is doing joint visits with people in the team and you start to learn like I hear what (practitioner) says about things or, emm I think right ok what she said …you pick up things. So it's important I think that we are all up to date on each other's jobs as well.*

(Practitioner Interview 2.)

Shadowing

When new staff members joined the team, they would start by shadowing each team member to gain an understanding of each practitioners' role and their interaction within the team. Additionally, a specific "away day" had taken place to reorient the team and gain insight into each other's roles and responsibilities. These practical resources were regarded as essential by all practitioners to understand how the team worked as a whole to meet the needs of the clients.

> *When you first start you don't have a caseload so you go out with all the different disciplines and it gives you an idea of what it is that they do and then during the meetings on a Thursday we should really be discussing this is the plan, who's doing what, emm there doesn't tend to be, because the substances is left to CPN, parenting, and you know it is divvied out and there is overlap but there doesn't, there has never been a time where it's like oh that was my job and you've done that.*

(Practitioner Interview 1.)

Co-location

Building on these practical resources, practitioners also mentioned more subtle processes which support role identification, responsibility and accountability and how this aided integration to meet the clients' needs**.** Co-location itself was identified as a resource which allows practitioners to gain further insight into the working roles of each practitioner. One practitioner highlighted how her understanding of parent-child contact visits had increased through co-located working, giving her more confidence to discuss the process with clients and signpost them to people for further information.

> *You get a better understanding of what other people are doing…I never really really knew about...oh, they're having a contact, right, but I understand now all what's involved in that, and what people are [doing]... so that is good for me, but then in turn I feel like I can have those discussions with clients now and if they ask me a question I can say, well, this is my understanding of it, but, you*

> *know, just check it out with (practitioner). I know that what I'm telling them… I'm confident in what I'm telling them.*
>
> (Practitioner Interview 8.)

Although on the surface this might seem a simple practical addition to team working, by increasing practitioner's confidence and understanding in all areas of the client's needs increases the integration of the team. By the practitioner gaining knowledge and understanding of one area of the service this in turn gives the practitioner a deeper understand of the clients experiences and potential challenges they may be facing. The practitioner can then use this information to better support the client and meet their needs.

Another practitioner highlighted the importance of open communication with other practitioners within the team to discuss the role of each practitioner and explicitly how each role was going to work to reach a common goal. Again co-location aided the communication as these conversations could take place in an informal manner.

> *I think coming into the office and having that communication and saying right what work are you doing? This is what I am doing with this family, what can we do to make sure we get this same outcome which is you know the child having you know safe parents to live with and mum and dad to be in a good place. And I think its communication that is key and I think sitting down and chatting to your colleagues who are working on the same case, I think that's vital.*
>
> (Practitioner Interview 3.)

Overlapping of roles

Other practitioners highlighted the difficulties in deciphering roles and responsibilities and the cross over which is embedded in an integrated team. The complexities of the client's needs and the service input overlap in many different ways. One practitioner described it as "a big ball of wool" (Practitioner Interview 8.) explaining how the health and social needs were interlinked and therefore so was the integration of the service. As practitioners work together in their roles they also support the roles each other bring to the service.

> *I suppose at core group meetings if the child's plan is in place and there is allocated, its included in the child's plan what your role is, it's doesn't mean it can't be duplicated […] so it all connects together, you know we all have separate roles but sometimes to link together you can't not and we do joint visits …we are all working and doing our different bits but it is for the same outcome.*
>
> (Practitioner Interview 2.)

Working together to achieve outcomes

The key element to the above quote acknowledges that the practitioners are all working together to achieve the same outcome. In many aspects of the service, it was evident practitioners worked together to reach a mutual goal and this was noted during an observation of practice.

> *I attended a home visit with a practitioner to see a pregnant client. When arriving at the visit it was clear the client was experiencing withdrawal symptoms as she had not been to collect her daily prescribed methadone. When discussing this with the client it transpired that she was waiting for another practitioner who was due to visit that day too. The client did not have enough time between the two home visits to attend the pharmacy to receive her medication. She also did not have any credit in her phone to contact either practitioner to rearrange the visits. With permission from the client, the practitioner in attendance phoned the other practitioner and explained the situation. Because of the practitioners skills she was able to assess the urgency of the client's symptoms. The practitioner also knew who to contact and was confident to communicate the client's needs effectively. The practitioner in attendance confirmed the appointment was rearranged to suit the client's needs and the home visit was cut short to ensure the client could attend the pharmacy immediately. Because both practitioners knew each other and had trust in each other's abilities the client's needs could be met in a timely manner.*
>
> (Field note reflection 31.07.2019*).*

> *I would hope, and I believe that everybody has the same approach to their work, that we all respect the clients and we all want the best outcomes for baby and the client.*
>
> (Practitioner Interview 4.)

Although the practitioners could agree on the outcomes they were aiming for, the focus or approach was not always clearly aligned. This overlapping of roles can bring tensions within a service that combines health and social care practitioners. Each role brings an agenda to the service and a style of practice as previously outlined in the complexities of mutual goals and team ethos within an integrated team of both adult and child services. Whilst role identification would presumably outline the responsibilities of each practitioner clearly, some practitioners felt the responsibilities of different parts of the client's needs, more than others did. For practitioners closely aligned with social work services the responsibility of co-ordinating and communicating with social work seemed to weigh heavier on their workload.

> *Although the social worker knows that there is a CPN, or a health visitor, they always seem to come to the early year's officers first. I think its cause we cover so much with the client. You know the CPNs are really for addictions and relapse prevention work and mental health, and that's what they cover but we kind of cover all bits of that.*
>
> (Practitioner Interview 2.)

Practitioners reflected this may have been because social workers had closer working relationships with Early Years Officers than adult services. Whilst other practitioners acknowledged that Early Years Officers who were employed through the local authority had access to IT systems and documentation that health care staff did not. This was a barrier to integrated team working as not all practitioners could access the clients' entire record.

> *I think sometimes some people do feel that they're doing maybe a little bit more with regards to, like, the computer software and all those things that maybe other people can't always access and they're maybe feeling that they're a bit*

> *lumbered with having to put all these things on, which can feel quite stressful.*
>
> (Practitioner Interview 9.)

"Role-ing" in collaborative teamwork

Although integrated team working meant sharing information and communicating across the team, there was an underlying assumed responsibility that each discipline continued to hold ownership for their part of the puzzle. Practitioners explained examples of how the roles within the team worked on many different levels and from different perspectives to support clients to reduce their drug use, improve their parenting capacity and have successful health and wellbeing outcomes for both themselves and their baby.

> *If the main issue for somebody is substance use and I am working with that person, of course I am going to mention it, to say how have you managed? [Cannabis use] is one of the issues that we were saying about baby coming home so I am not going to not talk about that because that, I am not going to go into as much detail about recovery but I will talk about the impact it has, you know how it is caring for a baby and responses to them when using cannabis, so it's not that I won't discuss that however I won't go into as much depth as what the addiction nurse will do.*
>
> (Practitioner Interview 2.)

Although the practitioners are aware of their own role within the service, the complexities of mental health, drug use and child protection are so deeply connected that elements of each role overlaps at times. This layering of responsibility within integrated services blurs the lines of responsibility within the roles and may lead to tensions. Both practitioners and clients reflected on potential tensions which occurred when sharing information with clients. Practitioners didn't want to "step on toes" (Practitioner Interview 2.) of other practitioners and disclose information, e.g. toxicology results. Whilst practitioners appreciated this may impact on the therapeutic relationship the client and practitioner had developed, by not sharing information, this also risked the trusting relationship the practitioner had built with the client.

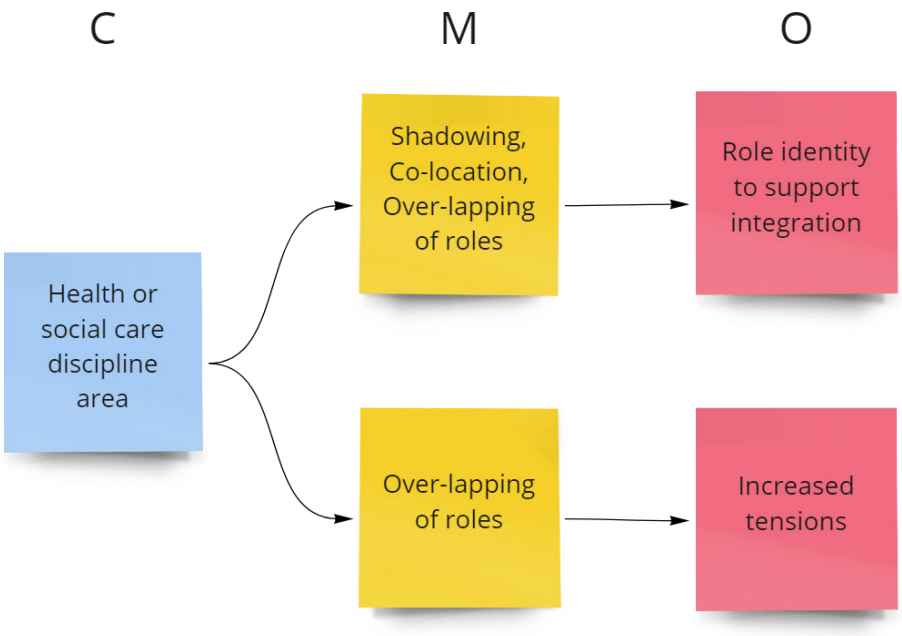
> *I know the toxicology has come back positive…and the addictions nurse is not due to see them for another two weeks and they say "I want the toxicology, it must be back", "well you need to speak to the addiction nurse", you know it's a hard thing cause you can end up saying well your toxicology's come back and sometimes in the context I need to say that.*
>
> (Practitioner Interview 2.)

This practitioner highlighted that in this scenario because the toxicology result would impact on child protection decisions, the practitioner felt this took precedence and would ultimately override other practitioners' agendas. For clients who acknowledged the service was a team of practitioners working together, it was most important to them they received the information as soon as possible regardless of who was sharing the information.

> *As far as I'm aware, I would probably have to find out from the drug worker…I would just rather anybody told me, especially if there was a reason, that I'm wanting it or needing it or whatever, then aye, certainly. That's something you can get really anxious over…So aye…because everybody's going to find out anyway, so it doesn't make a difference, so I wouldn't care if like the parenting officer told me or whatever, as long as I got to find out, I wouldn't really care who told me.*
>
> (Katie.)

This is highly relevant as therapeutic relationships had such value in encouraging engagement and improving outcomes as explored further in testing IPT 2. These opportunities to communicate with women give practitioners openings to show respect, honesty and build trusting relationships.

Figure 52. PT1. CMO 13.



Positive supportive management (Emergent component)

The role of supportive management was not initially present in the programme theory development stage as teamwork was viewed as driven by mutual goals and team ethos. However, when interviewing practitioners from the service about their experiences of teamwork the management role was clearly influential.

In light of uncertain and insecure funding and ownership of the service a positive supportive management embraces a strong leadership for the team. Directing vision and supporting individual practitioners the team leaders' role was acknowledged by most as essential to the team.

> *[The team manager] knows exactly what's happening. She's in…you know, she's in control. She's very supportive. And like I say, just even taking interest of…really wanting to learn about each role I think is massive. And I think it's what makes a difference. And I think she has encouraged us over the years to really be aware of what each other's role is.*
>
> (Practitioner Interview 9.)

Fostering a culture of compassionate teamwork

The team leader role also had an objective view, which could be utilised to support practitioners in their individual work but also manage the team working together.

> *There are times when folk might disagree (with each other), but (the team leader) might need to make a decision and (the team leader) will have really clear reasons for that and (the team leader) will communicate that, so communication would be key within that.*
>
> (Practitioner Interview 10.)

Specific resources were in place to foster a culture of compassionate teamwork including lone worker policies, management and peer supervision and plans for self-care assessments.

> *Supervision regularly for everybody on a frequent basis… self-care assessments at the moment as well for staff to look at their model of self-care within the workplace. Identifying and realising when people are stressed and what that looks like for them.*
>
> (Practitioner Interview 10.)

Most practitioners felt encouraged and motivated by the team leader's actions, be that setting aside time to supervise individuals or investing in individual development. By being given praise and recognition, practitioners felt respected in their role by the team leader but also worthy of a place in the team.

> *She also takes that step back and lets you as a worker take on your role and she never makes you feel that you don't know what you are doing. She maybe just sees it from a different angle...you know she's so positive and she's great at giving praise and she always recognises the work you are doing for the clients, but she is just so good to have there you know to give you a different view on something.*
>
> (Practitioner Interview 3.)

Aiding communication

The team leader's role was important for assisting with communication between practitioners when other resources had failed. This was especially important when new staff joined the team or meetings had been missed.

> *Sometimes the whole team can't meet and actually when you miss the team meeting that's...you are out the loop a wee bit and you're needing to catch up, but you just...our team leader is always where I would go if I wasn't...if I didn't know what I was doing I would go to (team leader) and say, right, I'm going out, I don't know what the situation [is] and she would update me of anything that I hadn't been informed of because people do go from visits to case conferences and we've got commitments to sit in meetings where we can't answer phones and things so having (team leader), kind of, really here and at the helm really is key as well to getting the right information.*
>
> (Practitioner Interview 7.)

These influencing mechanisms lead to improved communication within the team and improved staff morale and retention within this complex and challenging practice area. This compassionate model of team work was highlighted by many practitioners who reflected on mutual support they had or could receive from their colleagues.

> *But I think the team is so supportive of each other. I know I could pick up the phone to any one of my colleagues and be able to offload and I hope that they would feel the same about me, cause' I think we are always good at saying do you know we are here, you need to speak to us, you need to offload cause it's hard going.*
>
> (Practitioner Interview 3.)

The role of confidence and transparency in team members

However practitioners also acknowledged that although mutual support was there, it didn't mean it would be utilised. Although the team leader encourages a compassionate team model which aids communication, reflection and supports self-care, practitioners

must also be accountable and take responsibility for their own reflection. This transparency is key to allowing all the other elements to actually "work" successfully.

> *You have to take responsibility for debriefing, you have to. So there's a lot of ownership and responsibility taking as well …But we've got a competent workforce and they're really good at that and they're really good at picking up when they see their colleagues as well need that extra support, so there's a lot of mutual support as well.*
>
> (Practitioner Interview 10.)

On reflection this awareness was more likely to be present in skilled, competent practitioners who were confident in their practice and their abilities but who were willing to show vulnerabilities.

> *But in order for the mutual support to work you've got to have folk that aren't guarded and feeling confident in their role and able to put their hand up and say, I struggled with that meeting, that was really distressing actually.*
>
> (Practitioner Interview 10.)

Practitioners reflected on the importance of self-reflection but acknowledged there were challenges that at times outweighed the supportive mechanisms of co-location, peer support and transparency, as time constraints impacted on practitioners' abilities to prioritise their own needs.

> *And that's the real challenge. That is. That is something that we're all aware is not working, actually...that well, I don't think. It does, it does at times, you know, and people will phone and if you're...that's the important thing of coming into the office, because there's usually somebody to talk to. Because you can hold onto it. You can hold onto things and we always encourage folk, if you've had a really difficult day and you've been out all day, kind of, on your own, doing visits and you're going home, to pick up the phone and talk to somebody. I don't do that, and I know I don't do that, but I should. There's lots of times I should, and I manage my own, kind of, mental health and how I manage my work myself, actually. I bring it into the...if I'm in the office and somebody's*

> *here, I'll chat, or if somebody calls me, or I do call for something, I won't say, "oh, that was a really difficult visit and things". I have done it a few times, but not that often, and I suspect we're all quite the same, and we all do that.*
>
> (Practitioner Interview 7.)

Although it was clear skilled practitioners held the ability for self-reflection, new staff had more opportunities to engage in reflective practice with their peers. This was evident as some longer-term staff highlighted, they used to call their colleagues when they first started working in the team to ask questions. Whilst more recently new staff were very engaged in self-reflection and advocating this as a way of managing stress. When practitioners were discussing reasons, they did not seek opportunities for mutual support, it became clear staff were more confident in their practice area and used other strategies to manage stress e.g., exercise. However, opportunities for reflection were presented for new staff who sought reassurance and learning needs from their peers.

Some practitioners who were the only discipline in the service reflected it was more challenging to seek the support required and they felt more isolated in their role than their colleagues who were working alongside other practitioners in their discipline. In these cases, the role of peer support was considered a very valuable opportunity for supporting reflective practice however as previously outlined, this was not always prioritised as required.

Figure 53. PT1. CMO 14

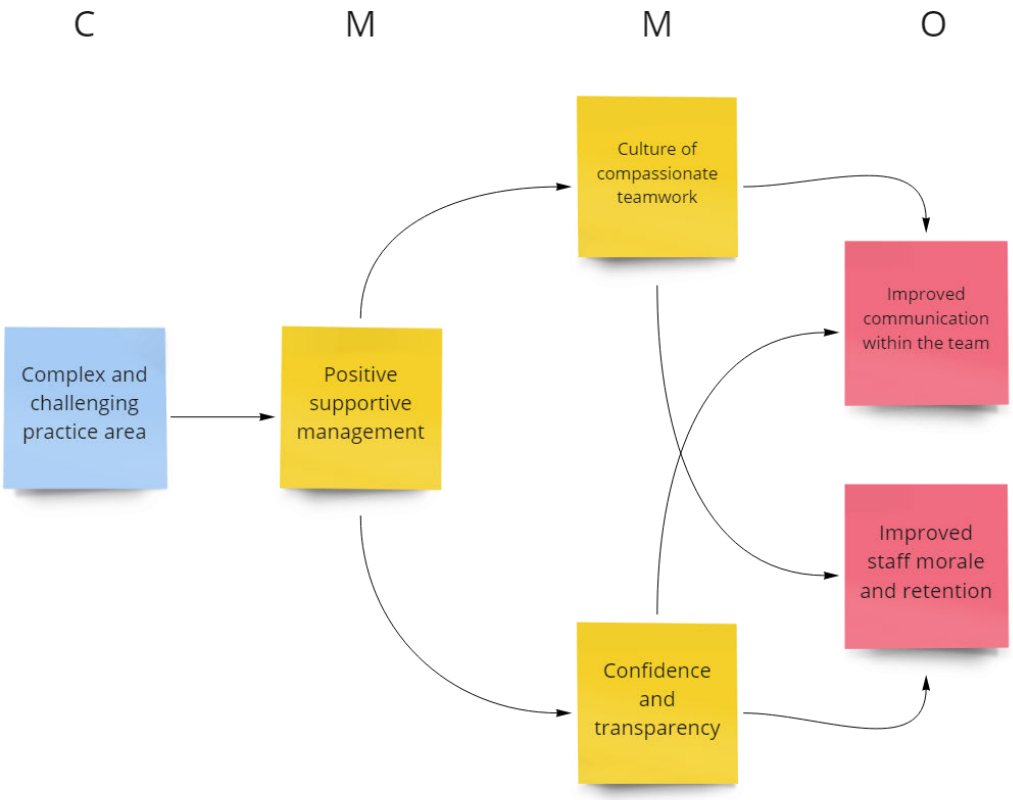


Table 21 summarises the context, mechanism and outcome elements which were tested and refined during phase two. At this stage connections were becoming clear as to the causal interactions between specific context, mechanisms and outcomes.

Table 21. Tested PT1 Context, Mechanism, Outcome Developments During Testing (Phase Two)

Context	**Mechanism**	**Outcome**
Child Protection Agenda	Flexible service offers practical alternatives (resource) Alleviates stress and anxiety for women (response) Practitioner sharing information with the woman (resource) Informs the woman leading to evidence of trustworthiness and trust building (response) Continuity of practitioners overtime (resource) Provides opportunity to get to know woman (response) Evidence from practitioners of trustworthiness (resource) Increases women's trust in practitioner and service (response)	Enables woman to engage Practitioners knows the woman Flexible and individualised interventions Woman feels known Increased trust and decreased fear Encouraged to engage Strengthening the therapeutic relationship
Fear and Distrust, Stigma and Discrimination Child protection agenda	Persistent and assertive measures/interactions over time (resource) Offering open and honest communication (resource) Woman begins to respond honestly and trust practitioner (response) Non-discriminatory approaches and flexible service (resource) Makes woman feel respected and considered (response)	Increased trust and decreased fear

Context	**Mechanism**	**Outcome**
Health and social care discipline area (Child protection agenda) (Fear and distrust, stigma and discrimination)	Flexible service offers practical alternatives (resource) Practitioners opinions differ about who the "client" is, the main aims of their role and the approach depending on their discipline (resource) Practitioners bring different approaches to the service and different agendas (resource)	Affects length of time to build Therapeutic Relationship and ease of building trusting Therapeutic Relationship Affects women's motivation
Women returning to the service	Having previously built Therapeutic Relationships and knowing practitioners and the service (resource) Women are more trusting of individual practitioners, feel more at ease and less apprehensive (response)	Build Therapeutic relationships quicker

Tested Programme Theory 1.

The service delivery model for pregnant women with problem alcohol and drug use works because specialist practitioners work as a multidisciplinary team in a co-located service, and the range of specialist expertise in combination with daily staff interaction serves to strengthen integration, aid peer support and meet the clients' needs.

Co-location (Intervention)

Co-location offers opportunities for informal and formal communication required for complex and challenging cases and face to face communication and reflection improves communication about cases. **This improves integration of team working and meets the clients' needs by**:

1. Providing opportunities to improve understanding of practitioners' roles and increases confidence in own practice.
2. Increasing practitioners' understanding of their own responsibility and role within the team.
3. Giving practitioners a deeper understanding of their clients' experiences and needs.

However, limited computers and desk space means practitioners are encouraged to work in a flexible approach using laptops and smartphones, which reduces opportunities for face-to-face communication whilst increasing opportunities for in the moment communication on the go.

Weekly team meetings are held in the co-located office to support communication and information sharing of complex and challenging cases, however practitioners' priorities are not always agreed. When there is limited time and resources and practitioners feel stretched, waiting to share information leads to feelings of frustration. Despite raising issues regarding the functioning of the team meeting, practitioners begin to resent the formal meeting process, as their concerns are not acted upon.

Leadership and culture of compassionate teamwork (Intervention)

Within the MDT, practitioners are experienced, confident and transparent bringing self-reflection and self-awareness. Despite a lack of ownership and responsibility for the service, a strong leadership model employed by the service manager in conjunction with the dedicated reflective practitioners, **fosters a culture of compassionate teamwork improving staff morale and retention through:**

1. Manager being present, visible and available in co-located base and offering time to practitioners through supervision and ad-hock interactions, which allows practitioners to feel encouraged and motivated.
2. Manager offers praise and recognition, which improves practitioners' feelings of respect and worth within the team.
3. Offering open communication and being transparent, practitioners trust the team leader and feel able and confident to speak to the team leader about specific case information.
4. Improving communication within the team and improving timely action.

Practitioners experience increased motivation and dedication to vocational work when they are provided time protected peer supervision despite limited time and resources in the service. Mutual support from peers allows for self-reflection and is essential within the challenging and gruelling practice area.

However, due to limited time and resources practitioners fear adding to their colleagues work load and practitioners will not "offload" to colleagues which increases their own stress. When practitioners do not receive adequate support, they "burn out" resulting in possible staff sickness and further pressure on the team.

Integration (Intervention)

The service delivery model for pregnant women with problem alcohol and drug use faces barriers to integration because specialist practitioners work according to their discipline background and underpinning guidelines, **which bring different aims, goals, and ethos of practice.**

However, the practitioners must work within a challenging and gruelling practice area with complex and challenging cases. The team faces a lack of ownership, limited time and resources and covers different health and social care discipline areas (Context).

Therefore the service (Co-located, Integrated MDT, with a Culture of Compassionate Teamwork) (Intervention) introduces…

Due to differences in health and social care discipline area, practitioners' opinions differ about who the "client" is, the main aims of their role and their practice approach. Practitioners' roles and responsibilities overlap and practitioners bring different approaches to the team. This produces complexities of the service goals and ethos and can raise tensions within the team.

However strong leadership from the service manager and transparent communication supports a layering and blended approach to help the team work together to achieve outcomes in an integrated way.

Differences in health and social care discipline area produce barriers to integrated team working because:

1. Practitioners face disparities in access to IT systems and case files,
2. Disparities in demands on communication and co-ordination with external services.
3. Resulting in certain disciplines feeling an increase of responsibility to access case files, and reliance from external services e.g. social work.
4. Disparities in training and support due to differences in health and social care discipline areas e.g. trauma informed training.
5. This fosters a sense of a lack of ownership and responsibility for the service.

Because practitioners feel there is a lack of ownership and responsibility for the service, practitioners concerns are not actioned and they feel there is a lack of priority

for their wellbeing, demotivating them. Therefore, practitioners do not prioritise their own wellbeing and do not receive adequate support resulting in “burn out” and possible staff sickness.

Figure 54. Tested Programme Theory 1 Concept Map

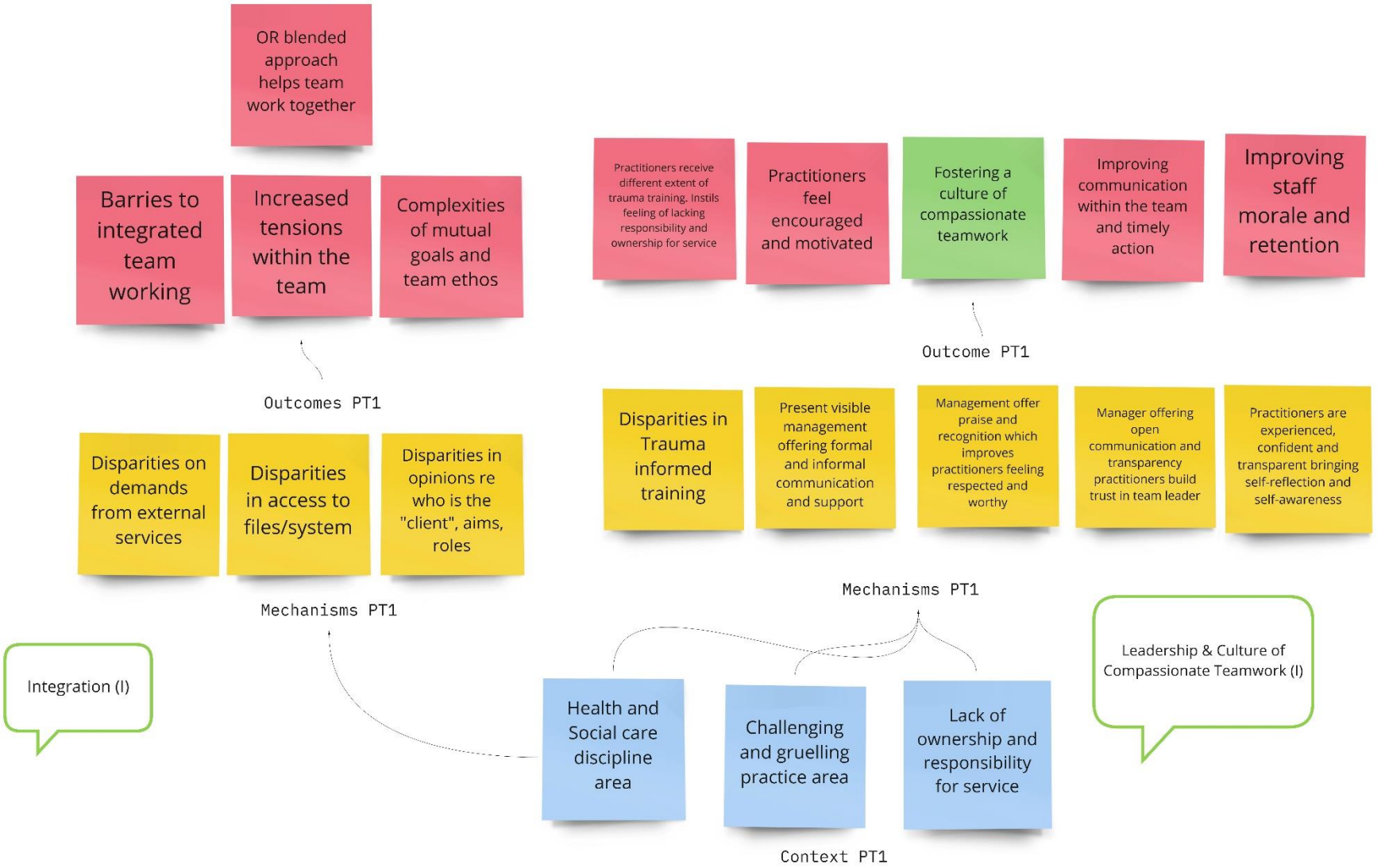
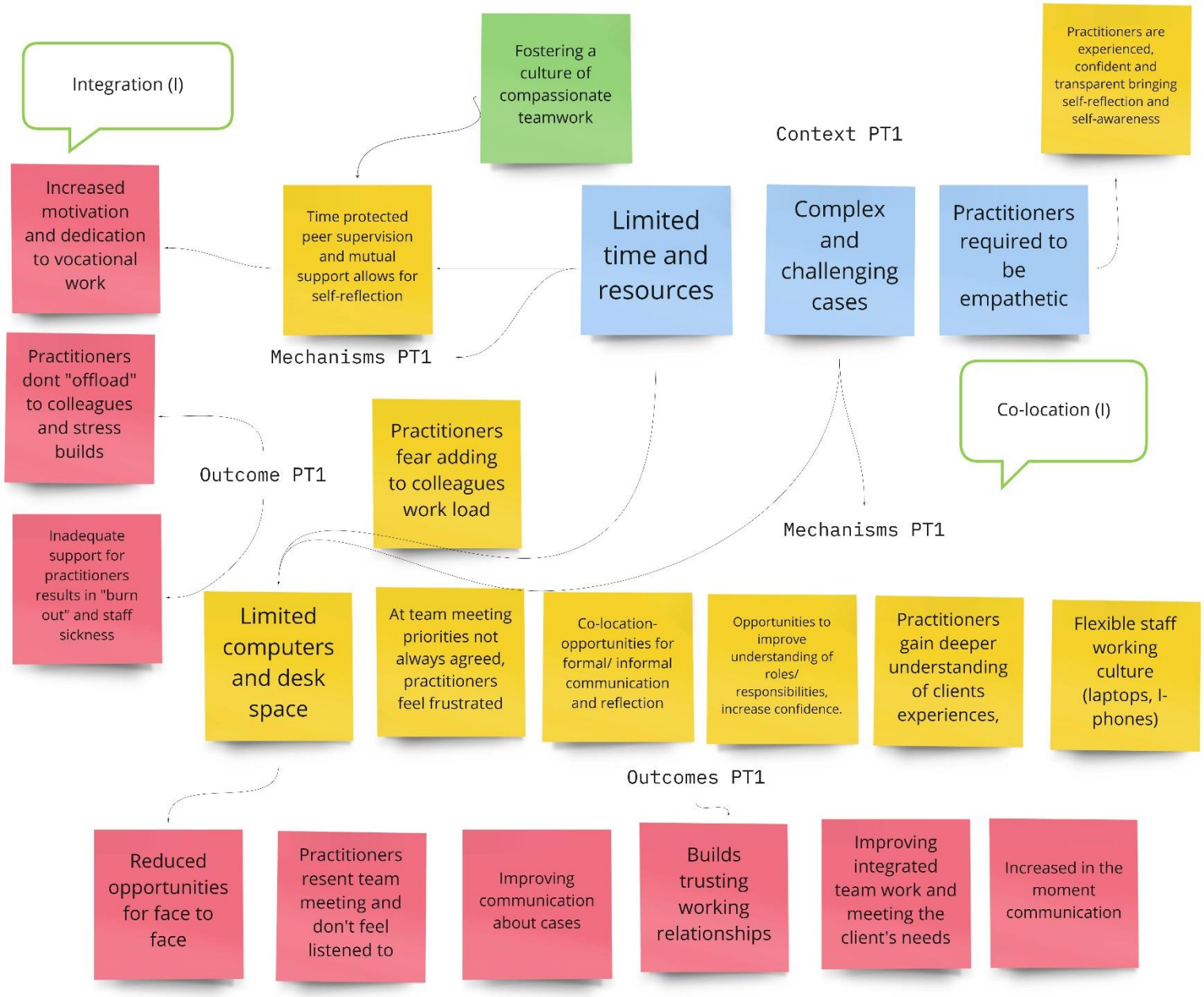


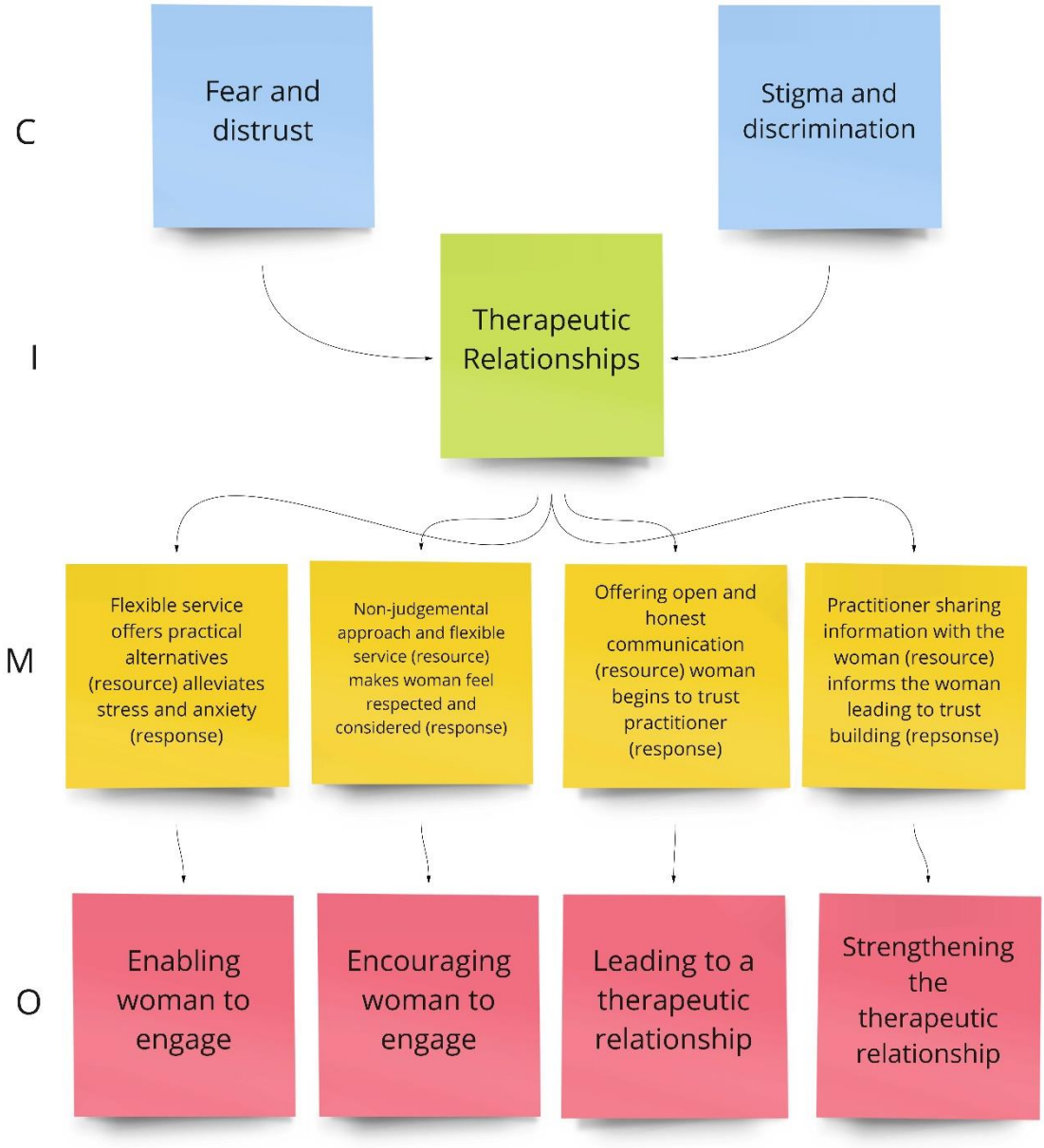
Figure 54 continued.



Testing Initial Programme Theory 2

The following section will present IPT two as a concept map (Figure 55) which was developed during Phase One. The concept map presents the Context, Intervention, Mechanisms and Outcomes being tested in theory 2. IPT two focuses on the intervention element of therapeutic relationships. Through a series of mechanisms: flexible service, non-judgemental approaches, open and honest communication and trust building which leads to engagement and strengthening therapeutic relationships. However, this is dependent on two influential contextual elements including fear and distrust and stigma and discrimination. Figure 56, Figure 57, Figure 58, Figure 59, Figure 60, and Figure 61 outline the developments of the concept map throughout testing, whilst Table 22 outlines the final tested CMOs and Figure 62 displays this as a final concept map.

Figure 55. Concept Map IPT2 Prior to Testing



Therapeutic relationship (TR) building (Intervention)

Throughout the testing of this theory the term "therapeutic relationship" was used interchangeably with trust building, communication and relationships. The term held different meanings for practitioners and women although their meaning could be interpreted to function in the same way. Towards the end of testing this component the term "relational based practices" was adopted as this term more appropriately described the efforts made by practitioners and the subsequent experiences described by service users. Going forward "relational based practices" will be used in Phase three instead of "Therapeutic Relationships" and is outlined in the tested theory below.

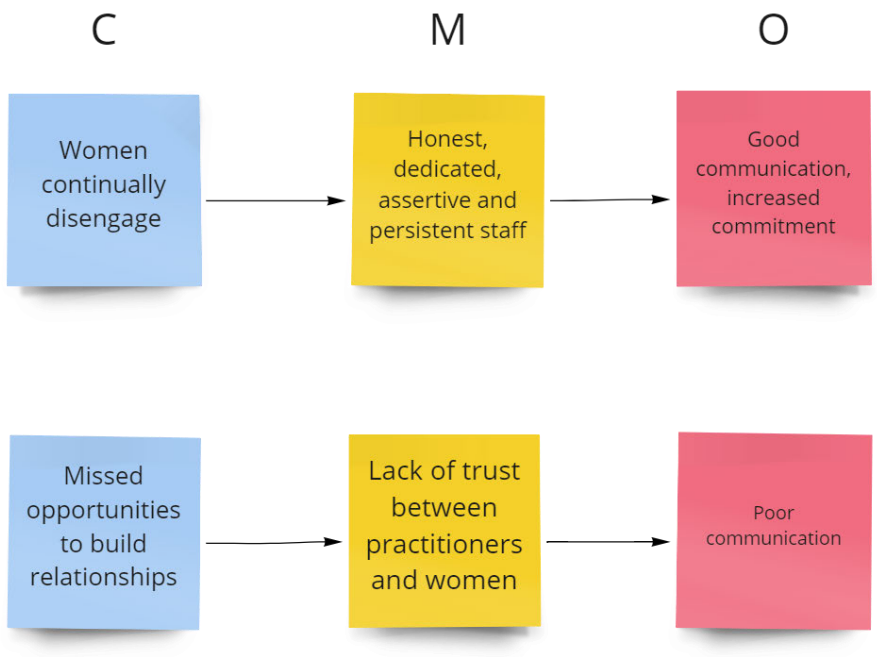
However, the term "Therapeutic Relationships" will still be included in IPT 3 testing because it was the term used during this phase.

The building of therapeutic relationships (TR) was highlighted in the initial stakeholder interviews, which emphasised the importance of open and honest communication with clients and sharing information e.g., progress, child protection concerns etc. This was further described in the team meeting when practitioners outlined their roles within the team and their main aims creating researcher hunches such as:

"If staff are honest, dedicated, assertive and persistent then this will build more trusting relationships with women encouraging good communication, increase commitment to work with women to reach the best outcome for them even when women continue to disengage."

"If there is no opportunity for staff to build relationships with clients then communication will be lacking and trust will not be built."

Figure 56. PT2. CMO 1.



All practitioners identified that therapeutic relationships were key to engaging women in the service. Engaging women was one of the main first outcomes prioritised by the practitioners especially in relation to providing a prescription e.g. methadone to initiate harm reduction measures and attempt to stabilise the woman's drug use to reduce risk to the fetus in pregnancy.

> *If we can get that [substance use] really stable during pregnancy we know that is great for mum and for unborn baby…so that is definitely our focus.*
>
> (Practitioner Interview 5.)

> *I think once they are engaged the outcomes can improve.*
>
> (Practitioner Interview 1.)

During the testing of this theory component, it became clear there was more to building a TR than non-judgemental approaches, open, honest communication and a sharing of information. These mechanism resources were thought to trigger trust between the woman and the practitioner resulting in strengthening the TR. Both women and practitioners were clear that honest and open communication between each other, built trust within the TR however several additional elements also influenced trusting TR, e.g., non-discriminatory approaches, trust building over time and evidence of trustworthiness.

Non-discriminatory approaches

It is important to note that the term "non-judgemental" was considered to be the appropriate term to describe practitioners approaches in the early theory development phases. However, through theory testing, the term was changed to "non-discriminatory" as it was clear judgements were made by practitioners in terms of parental capacity. As this was a core aspect of the service, I considered it more appropriate to use the term "non-discriminatory" however in further quotes both terms may be used interchangeably by participants, demonstrating their own interpretations.

Practitioners and women both reflected on the importance of non-discriminatory approaches which helped build TR. These approaches made women feel respected and considered, allowing them to be more open and honest and have their own views and

opinions considered. Two practitioners discussed examples of this in their work with families. During a challenging time for one couple who were having to say goodbye to their new born baby, the practitioner asked the parents how they wanted to manage leaving the hospital. Recognising this as a very upsetting event in the parents' life the practitioner helped the parents take ownership over the situation and do what they felt was right for them.

> *The last discharge meeting I was at I went into the cubical where mum and dad was with the baby and social worker who is amazing and has lots of empathy for clients as well, her and I are on the same page which makes a big difference. She said "how do we want to do this?" and I said "why don't we ask them? Why don't we ask mum and dad how they want to do this?" so they said "can we leave first? Can we give the wee one a kiss and not watch the foster carer walk out?" I am going to get myself upset.*
>
> (Practitioner Interview 4.)

Here the practitioner highlights empathy towards the family which allowed the practitioner to communicate openly with the parents, including them in the decision-making process and encouraging them to be assertive.

Another practitioner highlighted the importance of listening to women and being available to them. Being friendly and compassionate helps to encourage open and honest communication and by listening and offering support and advice, the woman is seeing the communication is working both ways. The practitioner highlights the negative outcomes associated with not listening to women and not allowing them to "have a voice" (Practitioner Interview 7) which would prevent them from engaging with practitioners and potentially increase risks to the child as professionals would not be as involved.

> *Ultimately, they'll do what they do when I leave. My...I think that the most important part for me is to build up a trusting relationship and if a mum picks up the phone to me regularly that's key because I, kind of...they're asking me things. They're saying what do you think I should do? This has happened, is that*

> *okay? That's what I want. I want them to come to me...I need to be friendly and compassionate and listen to them and give them a voice. I think that's really key, because if they don't think they have a voice and they don't think that I will listen to what they say they're not going to come to me and that increases the risk for these really, really vulnerable children, so the relationship is key.*
>
> (Practitioner Interview 7.)

Open and honest communication

Open and honest communication from practitioners was welcomed by women and was highlighted as a different experience with the service compared with previous experiences. Women valued being kept informed and this meant they were more prepared when it came to case conferences or child planning meetings. By sharing information with the women, women felt respected and included in the process.

> *At least they like told you, like straight up what was going on and explained everything, like before I didn't have that.*
>
> (Louise.)

Although this helped build trust within the therapeutic relationship, this trust did not always extend to the wider service or social work. For women with fear and distrust of services, building trust and respect was an essential part of the therapeutic relationship but because of this context, could be very challenging. The child protection agenda also inhibited a mutual trusting and respectful relationship due to power imbalances between service user and practitioner. Whilst practitioners were being open and honest about the assessments and reports being written, women remained feeling out of control due to the child protection agenda and an underlying system level stigma.

> *'Cause I wasnae bothered when they told me [about child protection register] but when the letter came with the wordin' that's when it annoyed me… just the words, they words annoy me: abuse or neglect, it's like he's no here and like I am no neglecting him now like ken and I'm no gonnae when he comes so, it just honestly if they worded it differently, I wouldnae even have been that bothered about it.*

(Rachel.)

Whilst most women found the practitioners to be friendly and non-discriminatory, some described a wider sense of stigma experienced throughout the process. Understanding or making sense of why they had been referred to the service raised questions about how they were perceived by themselves and others.

> ***I know you said you sometimes felt judged.***
>
> *I never felt judged by the people…I just felt like I didnae have an option, I told them I was in a stable environment, they had been out to my house, they had been out to their dads house…I didn't feel judged by the people from [the service], but when you read back at the reports and stuff it's like that doesnae [add up], not that there was ever a bad report, you can have a look at the reports, it was just like, if I had a say in the first place you [the service] would never had been involved. It's like whatever is going on behind the scene. Behind the scenes. Like none of them made me feel uneasy or judged…I mean like the bigger picture if you like.*

(Jess.)

Trust-building over time in the context of fear and distrust

Trust built up over time, often taking many interactions with staff before women started to be honest with them. The need for multiple interactions was identified due to the previous experiences affecting women's abilities to build relationships and trust practitioners. Women's previous experiences with social work and other services meant women were inherently fearful and distrusting of the service. Women were fearful that their child would be removed from their care as they perceived the service to be influenced by social work practices and wider child protection agenda. These fears prevented women being honest with practitioners about their drug use and prevented them from disclosing their past.

> *I thought they were judging me and all that because of my past, and so like I wouldnae like I didnae warm up to them for a couple of, I would say the fifth, six time meeting them actually and it was when [practitioner] was like, "I lay all my cards on the table, I will no lie to you" ken, I thought well she's being honest*

> *and upfront with me so, and like they had started to help me with stuff and I thought maybe they aonae, and they are actually good and their no judging me, so I warmed to them after five, six times of meeting them individually.*
>
> (Rachel.)

Women's fears of child removal confirmed a justified reality when the service's annual reporting data was reviewed. Annual data from the service report 60% of babies were either cared for in kinship placements (13%) or Looked After Accommodated Care (LAAC) (47%) after birth which reduced to 40% (13% kinship, 27% LAAC) at point of discharge from the service between 2018-2019 (Service Annual Report 2019). The current policy context of risk aversion instils fear in families, of child protection in Scotland, as the guidelines for risk assessments throughout pregnancy and after the baby is born to plan the safest environment for the baby which include being looked after and accommodated in foster care (LAAC).

One service user disclosed she had been scared of engaging with the service when she was referred and didn't want to meet with practitioners because of a previous experience of social work with her first child.

> *When I was down south I got myself into a bit of a bad situation when my son was 12 and I didn't even get to say goodbye, they [social work] just come and took him and took him to his Nanas, I think that is what, it [fear] started from there, and they [social work] weren't very nice, I was down south all on my own, all my family were up here, I think that is where it stemmed from, I just felt all alone, I was petrified and I did whatever they said and like, it did work out in the end but it was still daunting, scary, I think that's where the fear come from.*
>
> (Louise.)

Another woman described being in foster care herself as well as having her previous children removed.

> *I got a new social worker and her attitude stunk she was completely different ken what I mean, and I felt like that affected me so, cause I felt like I wasnae winning, cause they kept on saying "you're getting [child] back in the March", March came away, and "you need a carpet for the hoose to get him hame" and*

> *at the time I didn't have any bloody money so I went to [name] who sold drugs I thought he would help me get the carpet but I ended up taking Heroin.*
>
> (Emma.)

Most women had negative perceptions of the service initially because of these experiences and were reluctant to engage for the fear their child would be removed from their custody. However over time women began to engage more with practitioners as their trust built within the TR. This was shown in my conversation with Emma.

> ***How long did that take to sort of build up?*** *It took a long time but that's just the way I am, trusts held.*
>
> (Emma.)

Practitioners also agreed that TR took time to build up and could often take months and multiple interactions with women to reach a point of basic reciprocal communication. One practitioner reflected on a challenging case which resulted in many failed appointments and multiple attempts at communicating with the woman before she began responding to text messages and attending appointments. The practitioner highlighted the persistent but friendly approach she took to encourage the woman to engage.

> *I think it's just giving them the time...But I think she knew she could come up here [to the service] and if I was in, I would drop what I was doing and I would sit and see her, and I think she knew she had someone she could do that to…She didn't really engage, [with other services] but I think the thing with us […] is sometimes we just we keep trying and we keep giving them appointments and saying "I will be here at this time" and if they don't turn up I will send them another letter, whereas I think a lot of services, you miss three appointments your off the list and you need to get re referred, whereas I think everybody in the team is so good at trying to do their best to get this client to engage that we will do anything. There was times when she wouldn't turn up for appointments so I would be round knocking on her door and you knew she would answer like "Oh" and I would be like "Oh you never turned up for your appointment is*

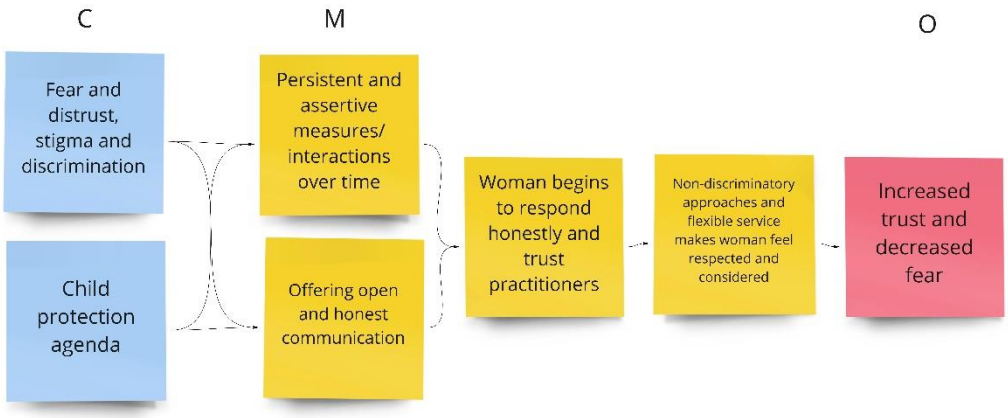
> *everything ok?" and you could see over the time that she did start to relax and she was coming in here all the time just to have someone to speak to.*
>
> (Practitioner Interview 3.)

This practitioner mentions several key differences in the service compared with standard services especially the approach to put the service user first. These include the use of text messaging to communicate with service users, persistent attempts to engage with service users and an innumerate amount of appointments offered. An "assertive outreach model" (Practitioner Interview 5) was employed specifically to optimise maternal and fetal health.

> *We do a very assertive outreach model, for substance use treatment for this service, it is completely different how we do substance use treatment for other people, I think that is right I think we do, we are much more hands on, we will pursue people, not chasing them down the street, but if they do drop out if they don't make the phone calls, someone will get in touch with them, someone will keep, keep going until we get them back into antenatal care and we establish that they are going to the chemist, they are getting their prescription, if that is what they are on. Standard care if someone doesn't make contact yeh we will get in touch but if they keep not attending we don't pursue them. You know but this service is completely different, we will keep going and keep going, as long as they, you know she's not delivered and baby is still there, she is still pregnant we, you know keep going keep going keep going, to try and so someone is always on their phone you know texting, knocking on doors, which is great, I think it is a really great model.*
>
> (Practitioner Interview 5.)

This highlights the awareness the practitioners have that pregnant women are fearful and distrusting of services and in order to engage service users at any level; persistent and assertive measures must be taken in a friendly and non-discriminatory approach. However it must be noted that these assertive measures can also be interpreted as defensive practices to ensure the safety and wellbeing of the fetus, further highlighting the child protection agenda overshadowing the woman centred approach.

Figure 57. PT2. CMO 2.



Evidence of trustworthiness

Trust building between practitioner and service user increased over time however this trust also strengthened when women and practitioners saw evidence from one another of trustworthiness. Once women started to see evidence in the actions of the practitioners, they began to trust them more. Women who were engaging with some parts of the service, found it easier and quicker to trust other practitioners. One woman explained that the first staff member she met was "friendly and supportive" (Rachel) and by the time she met the final staff member she found it easier and quicker to build up a relationship with them because she knew they were there to support her. She had received support from previous service practitioners, felt supported by practitioners meaning this evidence made her able to trust in the individual practitioners. She also knew the practitioners worked together and reported the fact there had not been any miscommunication between staff members, also strengthening the evidence that the team were working together to support her resulting in her trusting in the team approach.

> ***Was that [relationship building] easier to do because you were already in the service?***
>
> *Yeah, I would say so, yeah.*
>
> ***Okay. And can you think why that might be?***
>
> *Just because I know they're all there to support me and help me and they're there to help (baby) thrive and stuff, yeah…To give me advice and stuff how to look after her, yeah.*
>
> ***Okay, so just knowing that the staff are there to help you.***

Yeah.

So this new staff member coming in is there to help me as well, that's not going to change is that how you felt?

Yeah, yeah.

(Callie.)

Again, for women who were engaging on some level with practitioners there was first hand positive experiences of support. Service users often described what practitioners said they would do and how this was then experienced.

(Early Years Officer) and that just made it really easy, and they were always there if I wanted to chat or that, she said if there's anything, ring me or text me and I will ring you straight back, yeh so it's been all positive.

(Louise.)

Another example of this was reflected on by one service user who initially had distrust in the service, however when she was rewarded for clean drug tests with more parenting responsibilities, her belief and trust in the process increased.

I think it was all that time I was getting supervised contact and I didn't feel like it was going anywhere and as soon as I had a couple of clean tests I got to pick him up from the carers, and that's when I realised they will give me him back if I dae what they ask, cause I thought at first even if I dae that I will not get him back cause I have had bad experiences before ken what I mean so.

(Emma.)

I think as well, cause I said to them what's the point in me changing my drug use if you're not going to give me him back, so once I noticed that they were giving me the chance.

(Emma.)

Other women described practitioners as "straight up", "no beating around the bush" (Louise) and laying their "cards on the table" (Rachel) which helped evidence to the women that they were respectful and could be trusted.

Always straight up with me and there was no like beating around the bush or you know what I mean, I liked that because it was not hiding anything or talking, everything they said or put in reports you know they would say to my face which was really nice… like everything was straight up and you knew where you were, that's what I liked and I found that like really good.

(Louise.)

Although trust could be built over time and strengthened by evidence, it could also be broken. Some women experienced situations when the trust they had started to build, was damaged by the actions of the practitioners. Women reflected on their confidentiality being broken, and their parenting capacity being assessed. These different experiences had similar effects on the women who felt disrespected, let down and distrusting of specific practitioners impacting their TR.

Did you feel you could trust them?

Well after that incident I was a wee bit, aye, by that person, I was like would you like me to send that in a text and send it to your (family member). Do you know what I mean? But aye everyone else, no problem.

(Jess.)

Jess' trust in the practitioners faltered when confidential information was shared via text message with a member of her family. Instead of the information being sent to Jess, someone else received the information. During discussion surrounding the incident, Jess expressed her disappointment and sense of disrespect as she felt it inappropriate for the information to be shared via text message. In this case the practitioners' error weakened Jess' trust as did the disrespectful practice.

I didn't much like her…

What was it about her that wasn't what you liked?

Just I was still pregnant and she was talking about my baby being taken away, and then after I had my baby, she, it was her who did the assessment and it was a really damming assessment so…It was just it was really misinformed.

The assessment that she produced?

Yeh, and so now I'm trying to […] get rid of [the service].

(Jo.)

Over time these actions of practitioners mounted to instilling more distrust in women who felt the service was working against them instead of with them. For Jo the actions taken by practitioners after the decision was made for her child to be permanently accommodated, made her feel practitioners had given up on her and she could no longer rely on them for support.

And once [they] did the report to say I couldn't look after my daughter [they] just came and took the workbook back [they] wouldn't even let me finish the course

Right ok so [they] didn't give you that opportunity to finish it

Nah [they] just stopped

And did you want to continue?

Well yeh cause it would help, cause I still want to get my daughter back…And it would have helped…But [they] just stopped and so [they] didn't want to, [they] stopped working with me but [they] still wants to go to panels to bad mouth me.

(Jo.)

In Jo's case, the decision for her child to be permanently accommodated was met within the strict timescales of child protection guidelines (Scottish Government, 2022). In many cases to ensure timings are adhered to, social work will commence Parallel Planning; a process by which both child plans, one for return to parental custody and one for permanent accommodation, are followed simultaneously. Practitioners appreciated women's concerns when Parallel Planning was commenced, however within the child protection agenda it was considered essential to have contingencies in place to ensure decisions about baby's living accommodation would not be prolonged. The impact Parallel Planning could have on women's motivations and engagement were clear to practitioners who had to deal with supporting the woman after the decision was confirmed by social work.

> *We always see [Parallel Planning] as slightly negative because you know if we are parallel planning, that's us fearing the worst and if you are doing that actually a lot of parents take that as "well it doesn't matter what I do, you have made your mind up" we are doing parallel planning and they don't really understand why we are doing it.*
>
> (Practitioner Interview 6.)

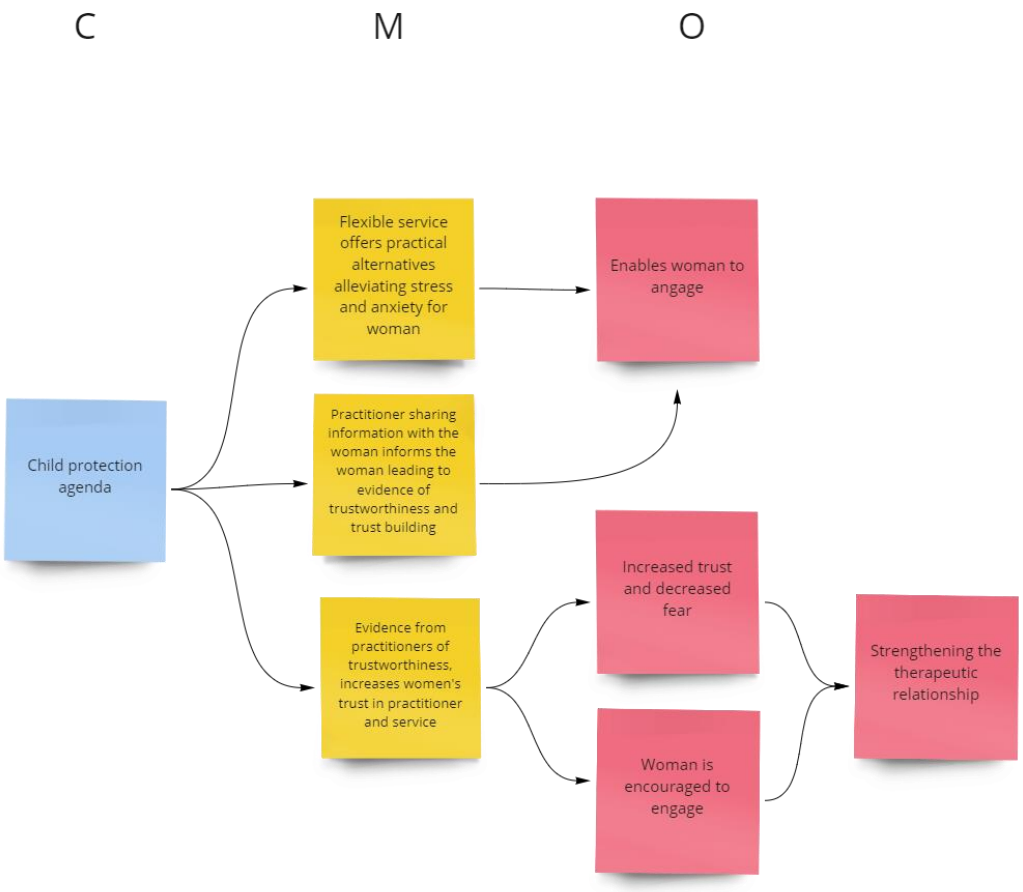
Flexible service

All women discussed the flexibility in aspects of the service delivery however this varied to the extent in which women felt this helped. Practitioners highlighted the differences in their own specialist service which would go the extra mile compared with standard service. This may involve taking women to appointments, shopping, or for their prescription. There was also flexibility in where their appointments took place. Often women would be seen at home instead of in a clinical area. This was helpful for practitioners to see their living conditions and was important for the child protection assessment, which follows an ecological model as highlighted in Chapter 1. However some women felt this led to a lack of privacy and heightened the surveillance they were experiencing. The flexibility of the service in relation to the TR is discussed further in IPT 3 as this key aspect of tailoring the service impacts on outcomes including "reducing woman's stress", "meets the woman's individual needs", "increases longer term engagement" and "improves satisfaction with the service".

Many women alluded that the service was different during their pregnancy then after their pregnancy; this was down to the context of where the child was placed. If the baby was at home with the parents, then a continued supportive approach was taken. However, if the baby had been placed in foster care, then the supportive approach was not as previously experienced. There would be more expectations on women to get themselves to appointments for contact with the child. This was seen as a way of testing women's ownership and encouraging accountability, encouraging women to meet service expectations. Women experienced this as having to prove themselves to the service and prove they were dedicated to their child and a commitment to parent effectively. These aspects are further explored in IPT 3, as they relate to Meeting the

needs of women within a child protection context (Emergent component) and Goal setting.

Figure 58. PT2. CMO 3



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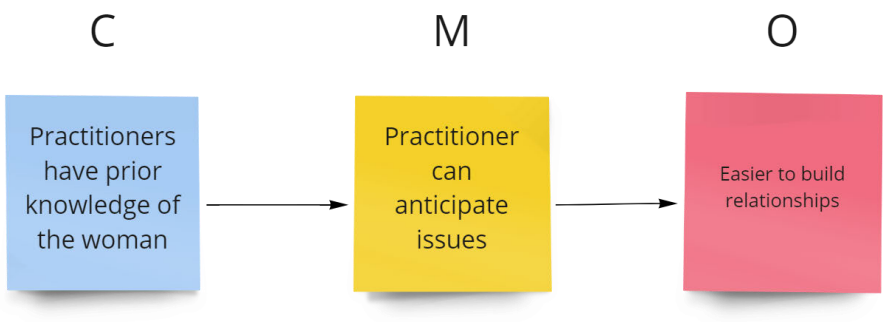
"Being known" and "Feeling known"- (Emergent component)

At the early stages of IPT development there was an acknowledgement that if practitioners knew their clients this would aid relationship building and anticipation of client's needs.

"If staff have a good knowledge of the individual then they can anticipate issues, build on the knowledge they have, build relationships easier."

Figure 59. PT2. CMO 4.



It became clear through interviews with women and practitioners that continuity of practitioner throughout the woman's journey through the service aids the development of a TR and allows practitioners to get to know the woman over time. This sense of "feeling known and being supported" by practitioners which most women expressed is an outcome of the TR practitioners and women build over time as they get to know one another.

Practitioners highlighted the importance of getting to know women, their past history, present circumstances and underlying issues in order to provide flexible and individualised interventions. Practitioners had many different "tools" in their bag and by getting to know the woman they could identify the main areas which could be addressed.

> *So it's a bit of pulling information from all different roles that I have had in the past but really respecting clients in the sense, you know that we are a supportive team and we want to have the best outcome for both, ultimately baby but for the parents. You can only do that by engaging with them on a regular basis and really getting to know them and being respectful. So my role I see as just really getting to know them as people, both if its mum and dad then I meet them together and meet with them separately. Just getting to know them getting to know what their past experiences were like, what that meant for them. Have they had children removed from their care before?*
>
> (Practitioner Interview 4.)

Women also appreciated being known; having a practitioner show they knew them and understood them, instilled trust in the practitioner and the TR they were building. For one woman, her painful and traumatic past was something she avoided discussing however, the practitioner worked patiently with her to manage issues from her past. This illustrated the respect the practitioner had for the woman and resulted in evidence that the woman could also trust in the practitioner.

> *(Practitioner) she was amazing, she actually got my contact with my son increased and started back up because she wanted to talk about (son) and at first I was really going mad, it's got nothing to do with (son) and I wouldn't let my brain go there cause it's so painful but she did and now I am speaking with him again and seeing him not regularly enough, but I am still getting to see him, so yeh just really just helped.*
>
> (Morven.)

In this passage Morven expresses the practitioner's sensitivity towards her and demonstrates the practitioner going the extra mile to look beyond the immediate (unborn child) and approach a more holistic view of the situation.

Building on the evidence from practitioners, women had trust in them and could rely on them for support. Knowing someone was there to support the women helped manage the stress and fear of child protection meetings.

> *I didnae like going to big meetings like the child protection ones with them all, cause its quite intimidating but cause I'd got used to them (practitioners) and being with them (practitioners) I would just look at whoever was there that I knew, to get through the appointment.*
>
> (Rachel.)

> *So you're no sitting there on your own you know you had someone there to support you and do what's best for your baby and that was nice too.*
>
> (Louise.)

Rachel and Louise describe a sense of working together with practitioners and the feeling of being supported, relying on the emotional support offered by practitioners in times of vulnerability.

> *Just talking, and like I seen someone every week and (name) or the midwife come to every other appointment, if it was social work or if I needed them to be there for anything, I could just ring and they could be there. Like so if I want, like they were really supportive that way if I wasn't sure about anything they would come along and sit in on anything that I wanted to.*

(Louise.)

Over time women were able to get to know practitioners and understand how the service was positioned to support them. With evidence of trustworthiness and experience of support, the fear of social work and their child being removed was more manageable as the benefits of having the service practitioners became more evident.

> ***Was there a fear that if you didn't, (achieve sobriety)***
>
> *Oh aye course, it's just like with the social work*
>
> *Yeh*
>
> *Ken what a mean but like I said when I started getting to know them I was like actually its good having them…so its good cause you've got [the service] to back you up so you're doing the right things, social work cannae, ken what I'm saying?*

(Emma.)

As Emma expressed, many service users viewed the service as a support mechanism between themselves and social work services, a middleman to help advocate their perspective. Unfortunately, this wasn't the perception of all service users as further discussed in subsequent theory areas.

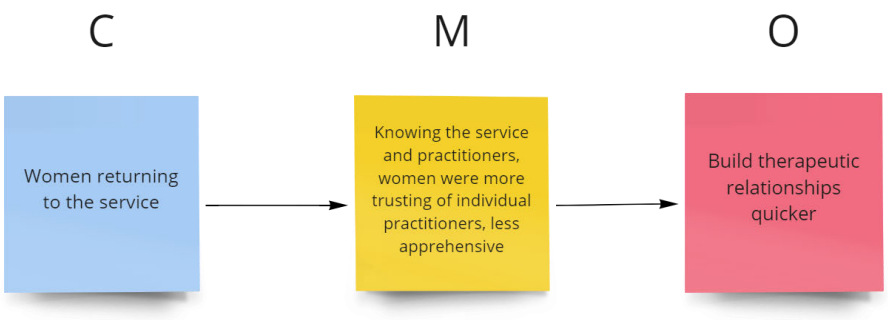
For women returning to the service, knowing the staff and having them know them was very reassuring. This reassurance made it easier for women to engage with the service from the outset because there was some level of trust already present. This was true for both women who had had successful interactions with the service which

resulted in their baby going home with them and for women who had lost custody of their children previously. There was also an awareness that practitioners already knew the woman's case which made the woman feel more at ease and not apprehensive about disclosing information. However not knowing which practitioner would be allocated to their case made the women apprehensive.

> *So that's why, but [practitioner] is the one I knew from before and that's why it's made it easier because I knew her so when I had my first meetin' with all of them, she was there so it was like it was fine I could just bounce fae [practitioner] I needed tae. It's good…*
>
> ***So it's been good for you because you already knew [practitioner] you can kind of get back into it a bit easier this time?***
>
> *Aye cause I can relax a bit mare cause she sortae knows me so, she knows like my past, cause she's been at every other meeting, she's been at the child protection meeting so she knows any [thing] that needs to be known.*
>
> ***Yeh***
>
> *So it's a bit easier to settle in*
>
> (Rachel.)

These interconnected elements of the practitioner "knowing the woman", the woman "feeling known" and the evidence from practitioners which made the woman "feel known and supported" all contribute to the trust building of a TR.

Figure 60. PT2. CMO 5.



Professional's role influencing TR — (Emergent component)

Both professionals and women described how TR encouraged them to engage with elements of the service. However, TR differed for each professional and woman dyad depending on the role the professional had within the overall service. These differences were noted by professionals due to the nature of their work. The different roles also influenced the length of time it took for trusting TR to build between women and practitioners. Practitioners used the building of TR at certain points in the woman's time in the service to influence specific agendas.

Practitioners who were more involved in the parenting aspects of the service noted the importance of being friendly and approachable to ensure parents would reach out and communicate concerns they had about themselves or their child. These practitioners also embraced the emotional and practical supports women required, offering to take them to the shops or out for coffee. Whilst practitioners used these informal and friendly practices to get to know women, women reflected on how these interactions helped them in some of the most difficult times, showing them that the practitioner was understanding, empathetic and respectful.

> *She was just really helpful and understanding, the fact that you're pregnant or you've just had a baby, she was really understanding and very helpful, more so than other ones.*
>
> *She also waited on me one time when I was getting my medication, just to make it that bit easier, rather than me having to like waddle along the road when I was*

heavily pregnant or when I just gave birth and I was still really sore. That's why that makes a difference, somebody just helping in that way.

(Katie.)

However, for practitioners involved with mental health and substance use the purpose of TR was more focused on the service user's clinical needs.

Sometimes you have to work with mums who, where you don't have much of a therapeutic relationship and I wonder if certain disciplines within [the service] have got different understandings of therapeutic relationships, so for me a therapeutic relationship means that the client is engaging on some level with me.

(Practitioner Interview 1.)

This was also reflected on by women who found it more challenging to build TR with substance use staff because of the role they played within the service.

Ok and you said it was a bit difficult, more difficult to building the relationships with the CPN (mental health nurse) than it was the other members of the team.

Because that was my problem, was the drugs…yeh well that was it from day one was the challenge, everything else they were happy with, that was the, yeh that was the one thing,

Ok so was the CPN (mental health nurse) the most difficult trusting relationship to build?

Yeh.

(Emma.)

At what point did you start to feel like you were building up trust with them or did you?

> *Eh aye eventually with [practitioner] and that aye, I think when he was about six month I started to build up trust with (practitioners) and then it was only about a couple of months ago that I started to build trust with the drug worker.*
>
> (Rachel.)

Practitioners understood different members of the team were seen by women in different lights. Maternity staff were assumed to be the easiest to build TR with because women would be more likely to engage with staff directly caring for the health of their baby.

> *Most of her parents do meet with [midwife] she builds up a good relationship with them all, you know she's got, and there is never any conflict of stuff because she's doing the nicer bits so you know…booking scans, doing the heart beat and you know its bits about their baby so they really engaged with that part, with addiction nurses its more difficult because they are doing toxicology and their having to tell them it's come back positive for this or that and having to really do some work on their emm recovery journey and again with [Early Years Officer] […] doing more of the conversations regarding the parenting and about child protection about with the social work looking at if baby's not coming home.*
>
> (Practitioner Interview 2.)

However, for practitioners with a substance use role, women were less willing to engage due to the nature of conversations they would need to have and the punitive approach of regular toxicology samples which constructed evidence to social work. Having difficult conversations about child protection or substance use were barriers to relationship building which needed to be overcome with time and effort on both parts.

> *All the drug worker things, alright, it's maybe helping me a wee bit, but at the same time it is going against you as well, like alright, it's there to help you, but a lot of that's evidence for them, like to be quite honest, with the social work, for taking your bairn off you and that. So I mean, aye, and it is hard to sit and sort of speak about it all.*
>
> (Katie.)

Practitioners appreciated that their role addressing parenting concerns could be upsetting, challenging and often distressing if discussions about the woman's own past was required however, when these roles were discussed with women it was clear for some that the role and relationship dynamics influenced women's engagement.

> ***When you think about the role that the CPN has, and the role that the parenting officer has, you said the parenting officer's really like approachable and takes you to things, and it sounds like really quite friendly, but it sounds like the CPN takes a different role. How would you see if they switched, do you understand what I mean, if your CPN was the really friendly one and your parenting officer was the really strict one, how do you think that might change how you're getting on?***
>
> *I couldn't…I wouldn't like a parenting officer to be quite strict, just given the sort of thing they're doing. I have had drug workers before that are open, approachable and friendly, and that's been fine, but maybe just at this point in time, I need somebody that's a bit…as I say, it's not that she's strict, it's hard to explain. She's just no nonsense, like she'll not really put up with my excuses or that, basically, do you know what I'm saying?*
>
> (Katie.)

As Katie expressed in this passage, the approach taken by different practitioners are appropriate to their role. Despite the differences in practitioners' roles across the service, many women identified that the practitioner's *professional* role was key to building trust in the individual and the process. Women had more belief in the practitioners because of their professional experience and their professional identity. Seeing evidence of their knowledge or receiving feedback from them, increased women's faith in practitioner's ability to help them.

> *As I said, I don't feel like I've got a massively great bond with the drug worker or anything like that, but I think she's alright, so I mean, aye, and I feel like she is helpful and she does know all this stuff. So aye, I think on that basis, and I think*

if anybody knows about stuff like that, it would probably be her, because she does seem like she knows an awful lot. She does seem very knowledgeable and like she can link stuff up and all that. She doesn't sound like she's just talking crap, she sounds like she actually knows what she's talking about, so…

So you think that you have confidence in her, in her abilities as a drug worker.

Aye, more so in the past few weeks. As I say, I know it sounds bad, but it was literally when she told me about her [previous work experiences], but even before that I did think, oh, at least she's sort of…even my mum said that, and my mum's never even met her, but the social worker had said, oh aye, the drug worker explained that it's something to do with your brain, and your brain rewards you, your brain still sees you to do all that or something like that. My mum even said, oh, the woman does sound really knowledgeable and all that, so aye.

(Katie.)

They just make you feel, cause I dinnae really speak to anybody that much cause I like to keep myself to myself so hearing it from them being professionals gives you that "oh well maybe I am daeing something right", just makes you feel a bit mare, dinnae know the word, but it makes me feel better when I speak to them.

(Rachel.)

When comparing practitioners roles within the service it was evident TR developed differently and resulted in different interactions between woman and practitioner. As explored further below in IPT 3 "Meeting the needs of women within a child protection context" CPNs used TR to engage women whilst maintaining professional boundaries. CPNs kept a clear clinical lens and long-term view of substance use recovery by laying out expectations e.g., encouraging women to attend clinics and not always seeing them at home, to prepare women for mainstream services. This differed from EYO and HV who provide more practical support "enabling engagement" and "hand holding", to

ensure engagement in pregnancy and then reducing support during postnatal period to encourage more “accountability” from parents if children are in LACC. However, CPN’s looked for more evidence of commitment throughout pregnancy and the postnatal period to encourage motivation to engage throughout.

Figure 61. PT2. CMO 6.

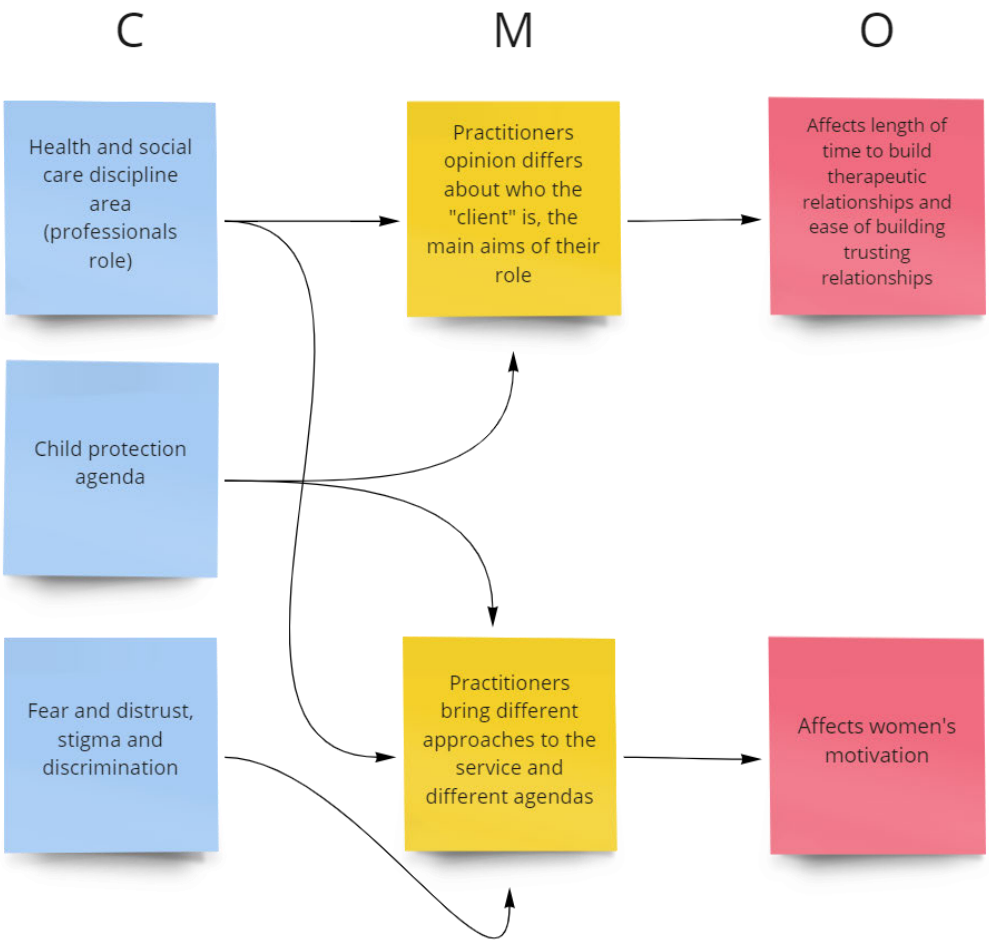


Table 22. Tested PT2 Context, Mechanism, Outcome Developments During Testing (Phase Two)

Context	**Mechanism**	**Outcome**
Child Protection Agenda	Flexible service offers practical alternatives (resource) Alleviates stress and anxiety for women (response) Practitioner sharing information with the woman (resource) Informs the woman leading to evidence of trustworthiness and trust building (response) Continuity of practitioners overtime (resource) Provides opportunity to get to know woman (response) Evidence from practitioners of trustworthiness (resource) Increases women's trust in practitioner and service (response)	Enables woman to engage Practitioners knows the woman Flexible and individualised interventions Woman feels known Increased trust and decreased fear Encouraged to engage Strengthening the therapeutic relationship
Fear and Distrust, Stigma and Discrimination Child protection agenda	Persistent and assertive measures/interactions over time (resource) Offering open and honest communication (resource) Woman begins to respond honestly and trust practitioner (response) Non-discriminatory approaches and flexible service (resource) Makes woman feel respected and considered (response)	Increased trust and decreased fear

Context	**Mechanism**	**Outcome**
Health and social care discipline area (Child protection agenda) (Fear and distrust, stigma and discrimination)	Flexible service offers practical alternatives (resource) Practitioners opinions differ about who the "client" is, the main aims of their role and the approach depending on their discipline (resource) Practitioners bring different approaches to the service and different agendas (resource)	Affects length of time to build Therapeutic Relationship and ease of building trusting Therapeutic Relationship Affects women's motivation
Women returning to the service	Having previously built Therapeutic Relationships and knowing practitioners and the service (resource) Women are more trusting of individual practitioners, feel more at ease and less apprehensive (response)	Build Therapeutic relationships quicker

Tested Programme Theory 2.

The service delivery model for pregnant women with problem alcohol and drug use works because specialist practitioners offer relational based practices (Intervention) to encourage trust building with women who are often distrusting and fearful of services due to previous experiences. **This approach helps to make women feel respected, considered and more trusting of the service supporting engagement**.
However, practitioners' disciplinary background can alter the development of trusting relationships, affecting motivation and engagement due to differences in practice agenda and approach.

Relational based practices (Intervention)

As the service is founded in the child protection agenda and aims primarily to reduce risk to the child, women with drug and alcohol problems are more likely to be cautious in their interaction with practitioners for fear of losing custody of their child. Therefore relational based practices are employed by practitioners, including:

1. Sharing information with the service user informing them and showing evidence of trustworthiness.
2. Offering continuity of practitioner overtime providing opportunities for service user and practitioner to get to know one another.
3. Flexible services offering practical alternatives to alleviate stress and anxiety in service users.

These approaches enable and encourage engagement between service user and the service practitioners, strengthen a therapeutic relationship and offer flexible and individualised interventions.

For women who have fear and distrust in services, and have experienced previous stigma and discrimination, practitioners demonstrate relational based practices through their interactions with service users. This approach increases women's trust in the practitioner and service as a whole and reduces women's fear of practitioners and the wider service by:

1. Taking persistent and assertive measures and interactions overtime.
2. Offering open, honest communication to which in turn women respond more honestly.
3. Practising non-discriminatory approaches and taking a flexible, holistic approach making women feel respected and considered.

For women returning to the service, previous relationships with practitioners support women to trust practitioners sooner and be at ease with practitioners encouraging therapeutic relationships to build quicker.

However as practitioners within the service are from different health and social care discipline areas, there are disparities in opinions as to who the "client" is and what the practitioners' aims and roles are. Practitioners also bring different approaches and agendas to their practice and with wider team, leading to:

1. Differences in length of time it takes to build and extent of the therapeutic relationship between woman and practitioner.

2. Affect the individual woman's motivations.

Figure 62. Tested Programme Theory 2 Concept Map

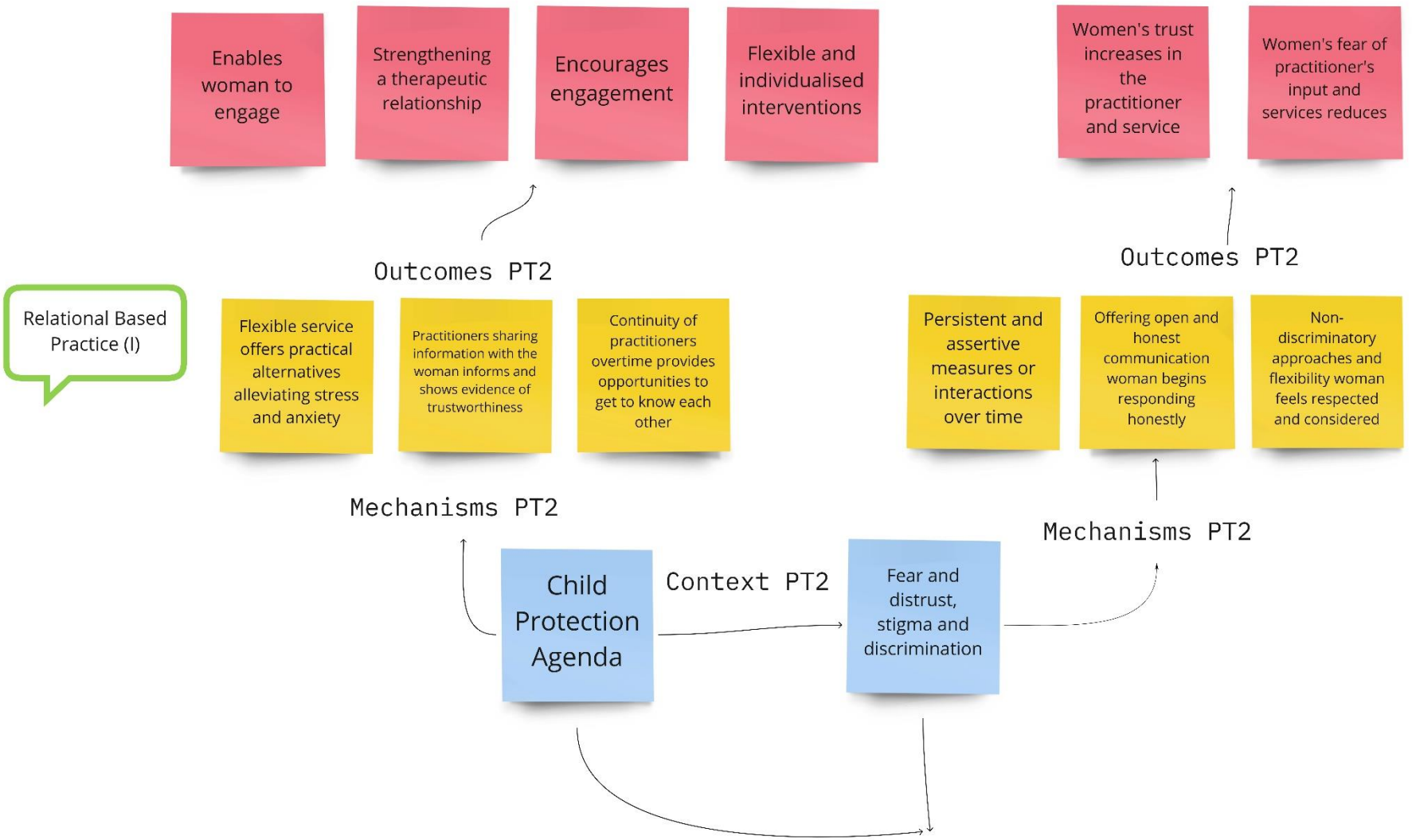
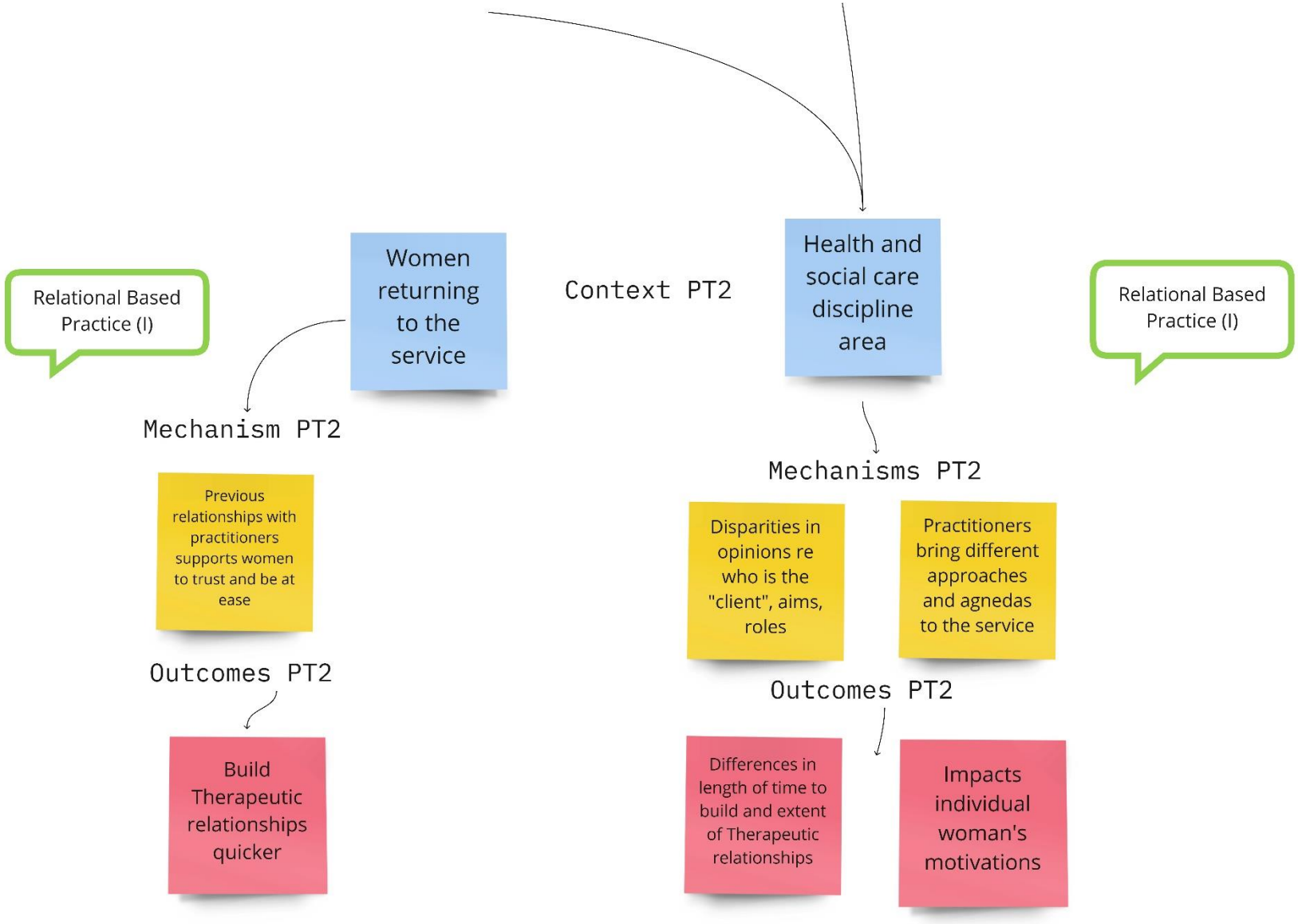


Figure 62 continued.



Testing Initial Programme Theory 3

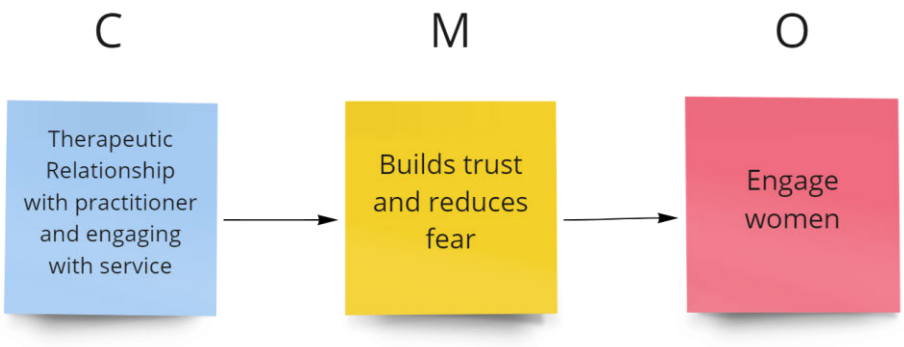
The following section will present IPT three as a concept map (Figure 63) which was developed during Phase One. The concept map presents the Context, Intervention, Mechanisms and Outcomes being tested in theory 3. IPT three focuses on the intervention element of tailoring the service. Through a series of mechanisms: increasing value, improving autonomy and empowerment, and giving women hope which leads to longer term engagement and behaviour change. However, this is dependent on one key contextual element depending on the therapeutic relationship which is already established and engaging the service user. Figure 64, Figure 65, Figure 66, Figure 67, Figure 68, and Figure 69 outline the developments of the concept map throughout testing, whilst Table 23 outlines the final tested CMOs and Figure 70 displays this as a final concept map.

Figure 63. Concept Map IPT 3. Original.

Therapeutic relationship with practitioner and engaging with service (Context)

Therapeutic relationships (TR) are key to engaging women (outcome) in services. As explained above TR help build trust between woman and practitioner and reduce fear, which is present due to the personal experiences of social work and trauma and the overarching policy agenda of child protection.

Figure 64. PT3. CMO 1.



Engagement (Context)

Essential to this theory is the context factor that women who had already started to build therapeutic relationships with practitioners and were engaging with the service on some level would be able to gain more from the flexibility of the service. Although the practitioners aimed to work in a flexible way offering services to women, those not engaging in the service would not benefit from the tailoring of the service. I did not successfully recruit any women to the study who were not engaging with the service however the narratives of those who did participate made this clear.

> ***So they have tailored it a bit more to your needs this time, did they tailor it at all the first time?***
>
> *Well I dinnae know cause I hadn't worked with them the first time so I didn't know what to expect…From them the first time…So it was like, I didnae know how they were going to be, what they were going to dae, what they were going to put in place basically…But like once they got to know me a bit mare I felt like they were workin' to benefit me, benefit me a bit mare, but when I first met them nut [no] I felt like they were just daeing their job basically and but, when I got to know them, I realised they were actually there to help, but this time I feel*

> *a bit mare like they are mare mainly there to help me…cause it's just me and my son now so it's like, so I feel they are a bit mare this time but the first time nut no until I got to meet them then a wee bit but this time I feel they are mare, definitely.*
>
> (Rachel.)

This woman explains that in her first pregnancy she didn't know what to expect from the service. She felt practitioners were just doing their job and she didn't see the service as tailored towards her or meeting her needs. It was not until she started to engage with the service and developed relationships with practitioners that she could see it was tailored to her and meeting her needs. Now during her second pregnancy she feels it is more tailored to her needs and the service is working to benefit her. This second time round her partner is not involved and she therefore feels the service is more focused on her individual needs.

Meeting the needs of women within a child protection context (Emergent component)

Once considering the context of the child protection agenda the service is only flexible to the extent to which the child protection service allows. Women whose newborns have been accommodated by foster or kinship care reported experiencing differences in the level or perception of support they received from practitioners. This flexibility of the service was still available to those whose babies were being cared for at home by parents. In fact, practitioners described this as being the most risky period, when baby was at home under child protection regulations as seen here in my conversation with Practitioner 7:

> *It's...well, it can be really...the most risky time, is when the baby is home with the parents.*
>
> (Practitioner Interview 7.)

This demanded a lot of practitioners' time and resources to offer substantial support for women caring for often unwell withdrawing babies at home. However, practitioners also had the demand of supporting foster carers with their care of the newborn and managing the relationship with the birth parents.

> *I have to support the foster carer, which can come with massive challenges...some of them really struggle with the babies and struggle with how they manage their relationship with the parents and how they communicate with that.*
>
> (Practitioner Interview 7.)

Child protection timeframe (Context)

The strict time frames outlined by the child protection guidelines meant practitioners only have a set number of months to support parents to reach their goals. A LACC review was carried out when the baby was one, three and seven and half months old to determine the progress made by the parents. At the final review the decision would be whether or not for the child to go "through permanency" (Practitioner Interview 2) which describes the court order regarding removal of parenting responsibilities (Adoption and Children (Scotland) Act 2007, 2011). These expectations, as explored further below, were agreed by social work, the team and the woman.

> *If a child is accommodated then we have to follow the child protection guidelines and that's a process, so it tends to be a six week LACC review, a four to six week LACC, then a three month LACC and then there is a seven and a half month LACC, we have to make a decision by the seven and a half month, so our parenting assessments normally done for that, round about that time or within that time frame. So it's more the babies that are accommodated that we would do that assessment for, so there is evidence if baby is going home or if baby's to go through permanency.*
>
> (Practitioner Interview 2.)

Practitioners were clear that women who had their babies in LACC were expected to show their commitment to parenting in many ways and that this was assessed during pregnancy and whilst the baby was in LACC. However, practitioners explained this was a tall order in what was a short time frame.

> *The timescales that these ladies have got is tiny. You know, this pregnancy, nine months, it seems like forever, but, actually, it's not, it's really quick. In particular,*

> *when we get [referred] them, and they can be quite late on in their pregnancy, and there's all sorts of child protection stuff. I think it's really difficult and it's a big ask for them to make the changes that is required…I'm not saying it's not what people need to ask of them for the children, but, actually, it's huge.*
>
> (Practitioner Interview 8.)

The overlap of support and expectations blurred the lines for some women who felt the service was not as supportive after their baby was born and placed in LACC. Certain processes and structures contributed to the way women perceived the support they received. Supervised contact visits which were arranged for the parents to spend time with their baby were also opportunities for parenting officers to assess the parents' capacity to parent. This formed part of the decision-making process required at the LACC reviews. Whilst the terms of the contact visits would be agreed prior, women often felt the terms disadvantages them. Women were very aware that the purpose of supervised contact was to meet the expectations outlined in the Child's plan however this often-required women to travel across the city on public transport to attend the contact visit.

> *They tell you where it is, the time, cause I think it's like an expectation that they want to see that you will get up out your bed and get moving, have everything ready for the bairn so, they are meant to make it [like] that.*
>
> (Katie.)

Women generally accepted these expectations and all women spoke openly about the determination and commitment they had, to be able to spend the little time available with their baby. However, these expectations made women feel they were proving themselves to practitioners or the wider service and reflected on feelings of being under surveillance especially during contact visits.

> *I felt like I had to prove myself first, do you know what I mean, that is how I honestly felt, but I feel I have now, I feel like they are all backing away from me now though.*
>
> (Jess.)

> *Obviously with any contact you do get a bit nervous because somebody is watching you with your bairn… I dinnae want to feel like somebody is totally watching every single move that I make…I think anybody would be like that, if somebody is sitting in a contact you do feel like they are watching every single move you make and get paranoid what if you make the simplest mistake and they are going to write that doon and go back and say, and that'll get used against you, but thankfully I have never done anything like that.*
>
> (Katie.)

Most women had more than one child and some could be attending contact visits for more than one child on multiple days each week in different parts of the city. The contact visits were arranged for a mutual location, which took into consideration the needs of the baby. Practitioners would aim to hold contact visits near the home of the foster carer to reduce travel time for the baby who could be suffering from Neonatal Abstinence Syndrome (NAS). Whilst women accepted the reasons for the visit agreement, they were clear that the additional stress they experienced from other aspects of their life contributed to challenges they faced in trying to meet the expectations of practitioners, social work and themselves. This illustrates the child centred approach to service delivery versus woman centred approach.

> *It's alright saying, aye, you should be able to go anywhere for your bairn. A lot of us do, I do go anywhere, I would go anywhere, I go to all my appointments and stuff, but I think you've still got to be a wee bit realistic in the sense that it's alright for all you, because you are all driving, so it's alright for you to all sit and say that. But I don't see one single one of you leaving to go to a bus stop, you are all jumping in cars. Especially when it's bad weather.*
>
> (Katie.)

Women who experienced contact visits reflected on the challenges of relying on public transport which was also highlighted as a possible barrier to meeting expectations by practitioners. Practitioners acknowledged the practical issues such as lack of funds to pay a bus fare or the risk of meeting drug using associates on public transport as it was

widely accepted that buses were known locations for drug activity. Katie however reflected on the shame and stigma she experienced when using public transport such as having an empty buggy on a bus.

> *In my early pregnancy [I had] … my own hand bag and then you've got all the bairn's stuff, like if lugging that on buses, not only is it embarrassing cause your walking about with a buggy without a bairn in it. It's a lot for like one woman to carry sort of thing.*
>
> (Katie.)

This fed into the associated feelings of guilt worsened by the shame and stigma and added to the emotional stress women were experiencing.

> *I think just trying to keep in mind aye it's no easy being pregnant as it is and when you've got the stress of not getting the bairn hame, and whatever else, I think they should just keep everything in mind.*
>
> (Katie.)

Practitioners were reflective on how their practice differed during a woman's pregnancy and postnatal period**.** Whilst the woman was pregnant, practitioners would work as a team to ensure women were attending appointments. However, for women whose babies were in LACC, once baby was born, the experiences were very different and women were expected to be able to get to appointments themselves and on time.

> *When they are pregnant our main priority is engagement, engagement with the mums to make sure that baby is safe,… that's our priority you know working in child protection, making sure we have a live birth...They have no mode of transport and they can't get there [to an appointment] because well you know that, this baby needs to be seen, then we will work it within the team, that somebody will take them up [to hospital]...There are some that expect lifts all the time to places and would quite happily take that from us as seeing us as a taxiing service however it is explained along the way that yeh we can help with this because of the baby and we will support you but I am supporting you to the point that you are able to manage this yourself.*

(Practitioner Interview 2.)

Practitioners were realistic about the challenges these women posed to meet the expectations, however from a child protection point of view the child was the focus of the service and the vulnerability of these babies needed to be protected by the service to minimise harm and risk. Practitioners acknowledged the dilemma this raised when trying to support a woman to reach the expectations of the Child's Plan (discussed further in section Goal setting) however they were clear in their view that the service was structured around the safety and security of the child.

> *(Some agencies say) "Of course mum's going to take substances she's upset and worried", yeh well we understand that but you know, "and her turning up for contact, well what if she is late and contact is cancelled"? Yeh we do do that and they said "well why do you do that? Yeh she might not be able to get of bed, she might not be" and I get all that, but we have to shift, and this is where there is a dilemma in our role is because if you've got a baby with withdrawals and they [baby] are sitting crying and waiting and they are not coming or they are running late, unfortunately that is seen as not being organised, not being up and not being responsible and they [woman] have to keep that baby in mind all the time.*

(Practitioner Interview 4.)

Professional's role influencing TR

Practitioners working on women's drug use and mental health had a longer-term focus on recovery and tried specifically not to set a precedence which could lead to women's expectations of the service being vastly different to that of standard services. These practitioners spoke of asking women to "meet them half way" (Practitioner Interview 1.), sometimes arranging home visits and sometimes asking them to attend a clinical setting. However, the intensive outreach aspect of the service and the importance placed on the main outcome of a healthy live birth meant practitioner intentions and practice itself often differed.

> *And I think that is quite tricky, because I think we have built an expectation or you know, mum's when she is pregnant, you know kind of, has become reliant*

on that or doesn't understand exactly why there is suddenly a switch to 'oh no if you're not coming to appointments we are not going to drop your prescription off today and drive round to the other side of town to find you' and stuff, which we very much do when they are still pregnant.

(Practitioner Interview 5.)

Practitioner's focusing on the health and wellbeing of the baby supported women to improve their own health and wellbeing however, as mentioned above this was to ensure the outcome of a healthy live birth.

I would hope that she does still feel really considered. To have a well baby we have to have a well mum so I would say that she is paramount to our work and how we keep her well and I suppose that's the bit about if she can't make appointments we will help them get to appointments. Some of them have really high anxiety, some of them are really anxious about meeting other people so, so [to] keep baby well, we have to keep mum well, but that is not to say actually after baby is born you know we will not manage to support you anymore. No I see it as a whole big picture, and I would hope the mums don't.

Yeh so like as a family sort of holistic needs?

Yeh yeh,

For the whole family, for the welfare of the child but also for the family members?

Yeh yeh.

(Practitioner Interview 4.)

Context of child placement affecting women's TR (trust, self-awareness, openness).

Whilst practitioners tried to maintain a holistic family approach to support women in the postnatal period, the child centred approach often left women feeling they had to prove themselves to practitioners. All women felt they were proving themselves to practitioners however, the structure and processes made women with children in LACC feel they were under surveillance whilst the majority of those with baby at home felt they received more support. This affected the way women interacted with

professionals and their own self-awareness. For women who were under surveillance they did not feel able to acknowledge to professionals their weaknesses and struggles. However, those who felt more supported by practitioners were more confident in expressing or identifying their needs to professionals. Women experiencing contact visits with both the service practitioners and routine social work without practitioner support did reflect that the service was able to support discussions with social work to advocate for the woman and her needs. Katie reflected on these experiences and how she didn't want to share her concerns for fear of appearing unable to meet expectations. This highlights how fearful women are of expressing their needs in case this is evidence against them.

> *They know it's not like me to ever ask for help, (laugh) cause you never want to, to be honest but I just like get on with stuff, so recently they've moved my contacts to this end of town but I think, sometimes they need to remember as well, the midwife remembers but unfortunately she's no in charge of everything that goes on.*
>
> (Katie.)

In comparison one woman who successfully stopped her drug use during pregnancy and succeeded at having her baby remain in her care spoke of working with the service acknowledging what she could gain from the service as well how she met the expectations of social work:

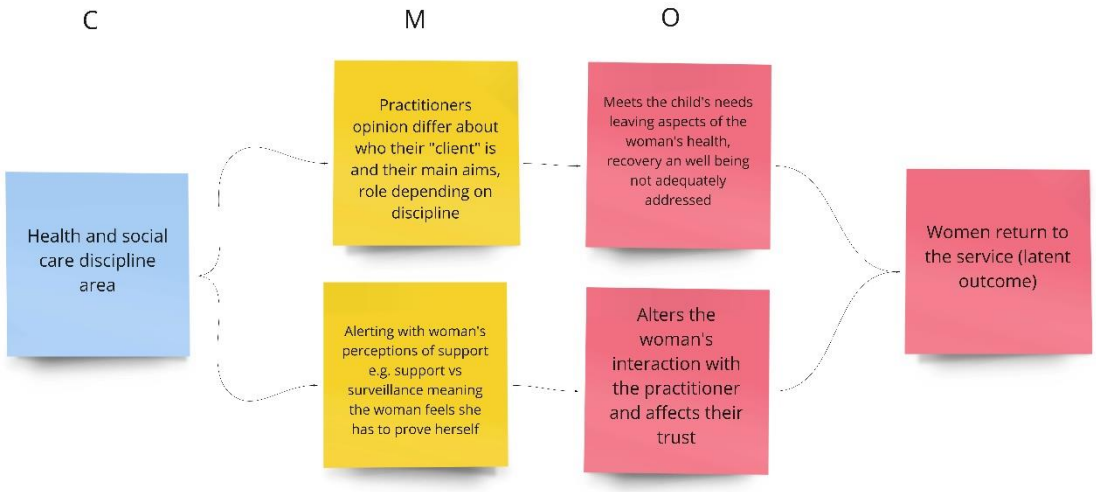
> *Yeh we were both very clear from each other what I needed from the service and what they could provide, and it worked really well.*
>
> (Morven.)

This example highlights the difference between women who have started to be more self-aware and communicate honestly with the service and those who continue to fear the repercussions of the service. The differences between these two women may have been the ownership and accountability they took for their actions and behaviours. Both had experienced trauma in their lives and both had previously had children removed from their care. Yet Morven was honest and open with professionals, was able to advocate her needs and dealt with some of the underlying reasons for her drug

use. Whilst Katie remained reserved in her discussions, did not let down her guard to show her vulnerabilities and did not seek the help she needed, instead played the game of trying to meet the expectations whilst not addressing the underlying issues. Practitioners who outlined the functions of the service including communication, goal setting and resources, further highlighted this could only help if women and families took responsibility for their own behaviour and needs.

> *I think just having conversations, we do that regularly having meetings with them. Taking kind of, set clear goals, I think we have done that from the outset and sign-post them to everything that they can access, if they need to but also it is on them.*
>
> (Practitioner Interview 6.)

Figure 65. PT3. CMO 2.



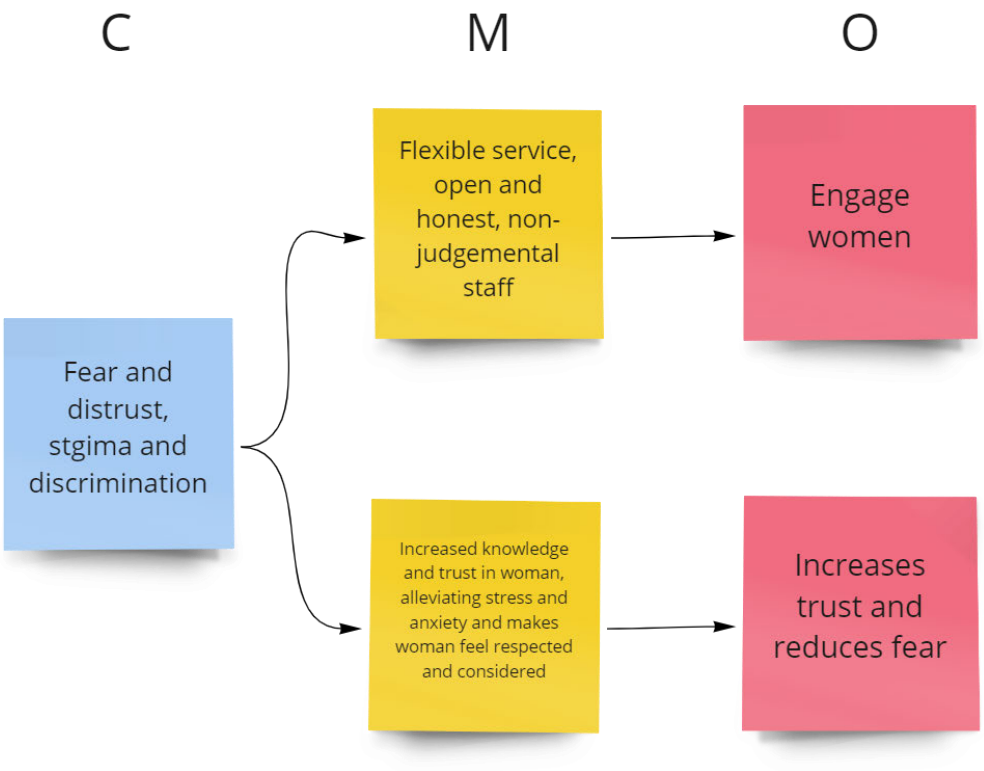
Tailoring of service to individual need

During early interviews with women, it was clear that women appreciated the flexibility of the service which tailored aspects of women's care to suit their individual needs. This personalised approach to their care was welcomed by women as they reflected on how this reduced stress and anxiety for them. This developed a hunch:

"Resource: Practitioners are open, honest and share info, are non-judgemental. Offer flexible service e.g. attend social work meetings,

Response: Woman has increased knowledge, trust, alleviated stress and anxiety and feels respected and considered."

Figure 66. PT3. CMO 3.



Practitioners aimed to support women through tailoring the service or being flexible, prioritising an individualised service to meet the needs of the women. These tailored aspects varied on an individual basis but predominantly included the methods or circumstances in which the service was received by women.

> *Cause at first like when they come like you've gotta do like the book, they have… where you've got to like work through the [work] book, but (Practitioner) said "your minds kind of different", n' like a lot of it, [I] didn't need to do it, so instead of going through we spoke through it which I found really helpful.*
>
> (Louise.)

Many women and practitioners reflected on the tailoring of the interventions to meet

the literacy level of the woman. For some elements of the service, practitioners would talk through workbooks or tasks verbally. They would later show the woman the work they had achieved in the workbook helping them feel a sense of achievement and recognition, improving self-esteem and confidence.

> *The book at first, I'm bad at writing things ken like looking at things I said I cannae dae it, it's too much information but (Practitioner) the way she does it is she talks to you and goes through it and then months later she shows you the book and you've done this this and that…I thought that was really good, instead of giving someone this book to do[…] she would go through it and you wouldnae realise you'd done it.*
>
> (Emma.)

Although several women and practitioners discussed tailoring aspects of the service to the individual woman, this was not the case with all. Some women had a different experience with a different practitioner from the team. Emma explained that she had received a workbook to look through however she had expressed to the practitioner that this had been challenging for her.

> *It's just a book at the end of the day. I said to [Practitioner] I find it hard to just think about, you need to go over it with me, so she's started going over it with me.*
>
> (*Emma.*)

Emma reflected that she had found it difficult to develop a good relationship with this practitioner therefore highlighting the importance of the process of TR building which allows for both woman and practitioner to get to know each other allowing for tailoring of the service to meet the woman's needs. Emma had the ability however to identify her own needs having experienced this with the first practitioner and confidence to discuss this with the practitioner to ensure the service was tailored to meet her needs.

Practitioners supported women in individualised ways**,** attending appointments with them to offer emotional support and help advocate for them.

> *If they miss appointments...generally, if they miss appointments or they feel like 'I went to the GP, or I went to the housing, and I wasn't even really able to tell them how I felt' I've said, 'right, well, come on, I'll come along with you the next time, and I'll, kind of, support you'.*
>
> (Practitioner Interview 8.)

Previously highlighted in IPT 2, women reflected on the feeling of being supported by practitioners at meetings and linked this to reducing their stress and anxiety. Offering flexibility in the service aimed to meet the needs of the women, and to do this, women were encouraged to voice their opinions about the service and make decisions about how they received support. Practitioners would include women in decisions about their own care by asking them what their own priorities were.

> *It's about, again, adapting to what they want and them vocalising, "no, I'd rather have Monday and then we'll have Tuesday and we can just spend Tuesday doing our thing, go shopping, do, whatever," or sometimes they want to...they're scared, so they want to keep busy….And it is really individual. You'll get a lot of patterns that are similar…But they're all individual and will have their highs and lows and good days and bad days in, you know, their life [is] going up and down, I suppose.*
>
> (Practitioner Interview 7.)

> *I always, sort of, say that to clients, that I've asked you all these questions, what about you, is there anything that you feel that I need to be doing for you, or...*
>
> ***Like reflecting back with them...***
>
> *Yes. Yes, yes, yes.*
>
> ***...and getting that back.***
>
> *Yes.*
>
> (Practitioner Interview 8.)

By being able to offer a flexible service which is meeting the individual needs, women

experienced an array of emotions and responses. For some women being able to express their concerns and have an emotional and practical support available increased their own confidence, self-belief and reduced stress.

> *[Speaking to practitioners] just makes you feel a bit mare, dinnae know the word, but it makes me feel better when I speak to them, if I am feeling a bit rubbish or that or if they help me with something, that's a weight lifted off me so aye, they make me feel a bit more confident if I am feeling shit and down and depressed so.*
>
> (Rachel.)

Being flexible in the approaches practitioners applied; enabled a more holistic view of the woman often including many aspects of their life and supporting the woman to address them. This approach helped support the woman by including her in leading aspects of her treatment. By having some control over the direction of their care, women like Morven had positive experiences of the service.

> ***So the way you say "helped me," did you feel like they were on your side?***
>
> *Eh absolutely, they were there for me. With [previous son] initially, my CPN almost every meeting we were talking about [previous son] and working with my feelings with that, like how he was feeling as well.*
>
> ***And did that feel like you were talking about more than just this pregnancy, they were looking at you and your [family]***
>
> *Yeh and if I wanted to talk about childhood trauma that I have had then I was able to with her, it was basically sessions, the sessions were round me, apart from I got drug tests (laugh), and I did a wee bit of relapse prevention but she said I was doing really well on the drug front so she didn't really have to go there so it was more about sort of my anxiety, the trauma that I have had.*
>
> ***Ok so they sort of like discussed all these things with you and then they let you kind of roll with how you wanted the sessions to go?***

> *Yeh, and with my first [child] died…I hadn't really dealt with that and then I was really worried with having a [baby], how I was feeling. They were just brilliant they let me work through everything I needed to do.*
>
> (Morven.)

Tailoring services encouraged further engagement with services as practitioners who had developed these therapeutic relationships worked with the women to prioritise the foundations required to encourage longer-term engagement. One practitioner explained how by being flexible and carrying out home visits, over time the woman had been engaging with her and has gone on to work with third sector services. Although the changes in her drug use and life style may not alter the outcome of the child's placement, the woman progressed by increasing her confidence during her time with the service and is now able to engage with other services.

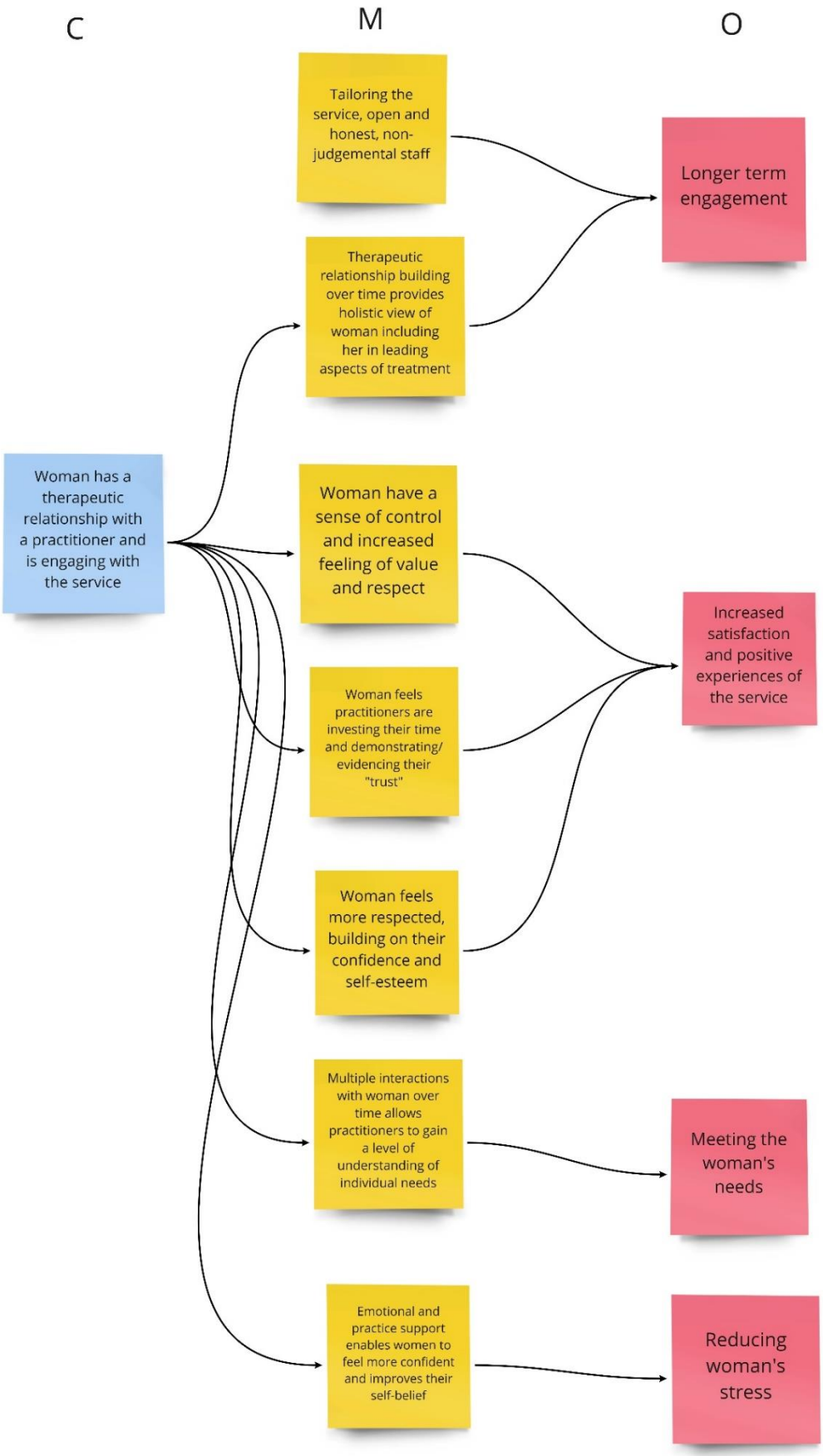
> *I've been working with one [client] I've done so many home visits, but, actually, it's been really good now because she's now coming to see me at the health centre appointments, which is huge. It doesn't seem like a lot, but it's, actually, huge, because she never engaged with any services before...and now I am trying to get her...she is now engaging with another service. She's working with a third sector service. She's been to about three or four appointments, which, again, is pretty huge, and it's whether she'll continue that, but I, actually, do feel like a lot of my work was...there's lot of things I would have liked to have been doing with her, but, actually, she wasn't at that point and it was, actually, just about, kind of...I feel like it was like getting the foundations in place so that, actually, she could carry that on, and work with other people, because I don't think...I mean, she has been making some changes, but it won't...which is fantastic, but, actually, its maybe […] going to be years of work before, actually, she really gets to where she wants to be.*
>
> (Practitioner Interview 8.)

Testing of this aspect of the programme theory has led to a general appreciation that practitioners who are working well with women, get to know women over time, gain a

level of understanding of their individual needs will therefore offer a more tailored service.

By offering this tailored service, women who are engaging with practitioners feel more respected, and build on their confidence and self-esteem as practitioners demonstrate to them their investment in individualising the service and improve the woman's sense of value. For some women who build TR they begin to trust the service, working together with practitioners, relying on them for support and feeling more empowered in being offered choices e.g., home visits, visits near place of work, and being shown evidence of their commitment e.g. practitioners trying to meet their individual need. In combination these lead to reducing woman's stress, meeting the woman's individual needs, increasing longer-term engagement and improving satisfaction with the service.

Figure 67. PT3. CMO 4.



Goal setting

All women discussed the expectations they were expected to reach or the changes they needed to make in order to be allowed their child home with them. These expectations were outlined in the "Childs Plan" which was formulated by social work from the information and agreement of the team practitioners. The "Child's Plan" would be discussed and agreed with the woman and her partner (if involved) at the core group meetings which involved social work and the service practitioners.

For some women these expectations worked like goals and showed them the path to achieving their ultimate goal. This was motivating and gave them clear direction and a sense of hope that they could achieve the aims. "I had hope so I started daeing it [changed drug use], cause if you don't have hope you're not going to change are you." (Emma.)

> *Yeh but at the same time I could talk to them and like they would tell me straight how it was like if you don't stop [Heroin] that's no going to be happening, this is what you need to do, so then do you know what I mean?…yeh obviously the drug use and everything, yeh they sat down and said like right that's gotta be zero like there's gotta be zero tolerance for that…they said like obviously if you do it then this is going to happen and...I did everything they said, you know what else could I have done?*
>
> (Louise.)

For some women the fear of their child being removed from their care was a motivation itself. This fear made some women more likely to engage with the service.

> ***And was there anything about that fear that motivated you to then get involved with the service?***
>
> *Yeah, just the fear of her being taken away and being (Partner's) first child I just knew I had to go to my appointments and stuff, which made me go to my appointments. And I didn't want to lose another child.*
>
> (Callie.)

However, for others this threatening pressure from social work had the opposite effect. For Katie who had been in the service previously with her children, the threat of social work had previously made her use drugs more as a result of guilt and stress. Facing the same situation for a third time, she was unsure if the fear would motivate her to change her drug use or if it would make it worse again.

> *[Fear] can go two ways. It is hard to say, because in a way it can get you on board, but in another way, it can just make you be like, oh no, and then go and use, because you just think, 'oh my god, there's this other bairn, oh no, they're going for the same thing (permanency), oh no, what if I end up losing both of them'.*
>
> (Katie.)

> *You know what if the baby doesn't come home, you know that is a hard thing to do, and that might bring up other issues, what issues have they faced? Have they [been] abandoned as children? Do they have family support? That is enough to lead anyone to think 'oh I might go off the rails and to take something to calm myself down'.*
>
> (Practitioner Interview 6.)

Both practitioners and women reflected on times when outlining expectations gave women a sense of false hope. Women were encouraged to prepare for baby as if baby was going to be going home. This meant buying or borrowing baby items, preparing a Moses Basket for baby to sleep in and ensuring there were clothes etc. Even in the cases when it was understood that their baby would not be going home with them from the hospital, preparing for baby was seen as making an effort and evidencing good parenting. If women didn't prepare for baby in this way it was seen by practitioners as losing hope and giving up.

> ***Do you still expect them to prepare the house and things, for baby to come home?***
>
> *Yeh, and that is a really tricky one, because I have had clients who are really keen to do it and get baby's room all ready, they get all the items- the pram. I*

> *have had other clients who said, 'I am not going to spend a penny on that baby until I get baby home'. And there are two ways to that. If you have no money, and you have no hope and you think this isn't happening for us, would you in all honesty think, the little money I've got I am going to buy that for baby? Or think emm or actually let's not, but it's probably deemed as them giving up if they don't…But that is so unfair, I always think that is so unfair because you can't afford a loaf of bread and a pint of milk but actually we are asking you to get all this ready for baby.*
>
> (Practitioner Interview 4.)

Women experienced emotional turmoil from preparing for baby and not returning from the hospital with their baby, feeding into a sense of lost hope.

> ***How did it make you feel when [the service] gave you these sort of expectations, these things that they said you have to do, to ultimately ensure your daughter came home to you?***
>
> *It gave me a lot of false hope…They always said there was a chance [baby would be accommodated] but because I was doing what they said I thought she would be coming home…And they said still go and buy a mosses basket, go and buy everything, then I get discharged from hospital without my baby and I've got to come back to all this baby stuff.*
>
> (Jo.)

For Jo it was at this point her turbulent and abusive relationship also broke down and she began using illicit substances again.

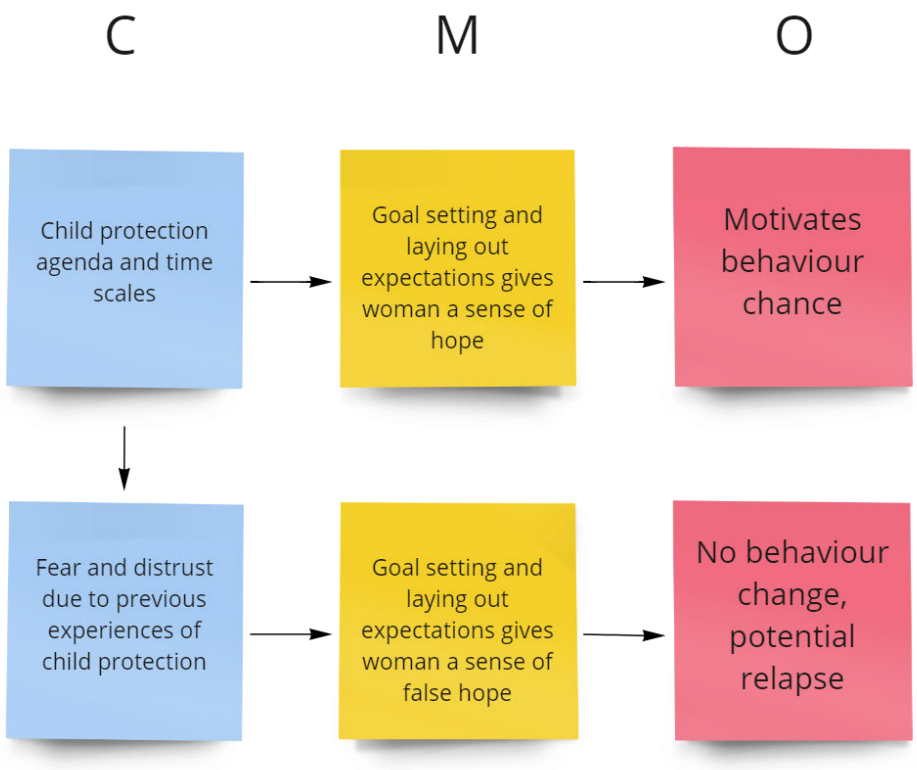
Practitioners where certain communication was clear and honest with women and that women should not receive false hope. Practitioners viewed the clear expectations outlined in the Child's Plan as a method of referencing a woman's progress and a resource to evidence to women when they had not met the expectations.

> *I think they know when they have not [achieved the Child's Plan], I think it's, and I do build up really good relationships and I can say, but you've no cause we said to you, you know you have to be stable, you know you agreed with that,*

> *you had to hand in clean toxicology, you had to engage, you haven't done any of that[…], so it's always made clear along the way when we have met at core groups or home visits, we are always reviewing the child's plan, and what they have to do.*
>
> (Practitioner Interview 2.)

This highlights how even in the most intimate and normalised aspects of women's lives such as preparing their home for their baby, the agenda and driver from the service was for the needs and care of the newborn baby over the emotional needs of the woman. By using the "Child's Plan" as a resource to show women where they had not met the expectations of the service, the practitioners protected themselves, their role and defended their decisions. These role-like behaviours are further explored through refinement in Phase Three in Chapter 6.

Figure 68. PT3. CMO 5.



Accountability

Practitioners continually expressed the need for parents to be accountable for their actions or take responsibility for their behaviour. For some women there was a sense of ownership or accountability over their decisions, actions and behaviours. Practitioners saw this self-awareness as evidence of change or steps towards recovery. Practitioners were always highlighting to women the importance of "keeping baby in mind" and living and behaving responsibly as if baby was in their care even when baby was in LACC. By being able to "keep baby in mind", responsibility and accountability was demonstrated by women. Some women who had successful outcomes and were living with their baby at time of interview spoke openly about how they were responsible and accountable for their actions, decisions and behaviours.

> *We were sort of being held accountable, and for me I needed that emm, cause if it wasn't for them I don't know if I would have got custody… I said hold you accountable as well, emm, and you don't want to let them down because you make a bond with these people, well I did cause I don't have friends and family so it was really good support for me at the time. And you like don't want to (let them down), when they are putting faith in you.*
>
> (Morven.)

However, women whose children were in LACC at the time of interview were more adoptive of a defending role, often blaming other people, services or process for their actions, decisions and behaviours.

> *Well it looked like I was getting her home and then when she was four weeks old, her dad eh, he took, I found out he…wanted to try to get custody of her and he gave me drugs and I relapsed.*
>
> (Jo.)

Linking back to Jo's previous comments, illustrates a spiral of events, which contribute to her inability to break the cycle of her vulnerabilities and addictive tendencies. Despite being enrolled within the service, competing forces in the wider social context remain too powerful for Jo to overcome. Further exploration of these interactions

between aspects of the wider social context and the individual are discussed in chapter 6 to demonstrate the power they hold.

All women expressed their strong will to continue fighting for custody of their children and appeared determined to achieve this however, this undercurrent of victimisation meant some women did not appear to be expressing accountability as other women did. This raises the questions does ownership and accountability need to be activated in order for women to take some control over decisions and actions and longer term behaviour change? And if this is the case, what context trigger these mechanisms?

When reflecting on the data and exploring the cases with the demographics included, the women who had support from a partner were more likely to express accountable statements in their interview. The two women who did not appear to be expressing accountability were not currently in relationships or had recently experienced separation from a partner. Interestingly the women who openly expressed their accountability during interviews were also the women who appeared to be most on board with the service from the outset, engaging from an early stage or even seeking out the service for additional support at the start of their pregnancy. These women felt the most supported by practitioners and particularly expressed the support the service had offered them in relation to working with social work. It could be assumed that these women were most ready to make changes in their drug use although this was not explicitly tested.

The two women included in the study whose children were in LACC had differing perceptions of the service to one another. One was very reluctant to engage with the service as a friend had told her the service would revoke custody of her child, whilst the other had previously experienced the service and was willing to engage in aspects of the service.

Personal support (Context)

Women had varying degrees of additional support outside the service. Four women had partners who were also involved in the service and received support from practitioners including either the dedicated Father's worker or an Early Years Officer. These women reported the support they received from their partner was vital as they worked in conjunction with their partner to meet the expectations of the service. For

some women this was different to previous experiences when they had children removed from their care and did not have the additional support of a partner.

> *I had (partner) this time, I wasn't on my own and he was like you have to be honest, folk can't help you and it will only look bad, so yeh my approach was different this time as well.*
>
> ***And was he quite trusting of the service as well then? Do you feel like together you were?***
>
> *Yeh, yeh emm yeh, in a way it was harder because we were both drug users and if one wants then the other wants obviously, but at the same time we came together for (daughter) and he's been brilliant throughout the pregnancy and he is a brilliant dad to her, it could have gone either way, we could have both jumped off the deep end or we could have both got our heads together and we did. But yes at the beginning I was like oh this is going to be so hard I don't know if I am going to be able to do it.*
>
> (Morven.)

For some women their partner was one of the barriers to their own behaviour change as partners were often the source or resource to the woman's own drug use, e.g. domestic violence, manipulative relationships, sex work, substance use.

> *Because I knew everything that they were saying to me I couldnae argue with them it was me who was in the wrong, ken what I mean it was me I was in denial at first and I wanted his dad to dae it with me, and I'm thinking I will just wait on him and eventually he will come off [drugs] and we will dae it together, but I would have never got him home, if that if I [had] believed (Partner) cause (Partner) kept on saying he was going to dae it but then he said to the social work that he couldnae do it, so he was saying and doing different things.*
>
> (Emma.)

As previously outlined above some women were able to reflect on their partners influences and become more self-aware demonstrating accountability, whilst others continued to blame their ex partners for their drug use.

It was also assumed that most women would have little family support due to their extensive chaotic substance use however more than half the women interviewed discussed support they received from their families. This support varied between daily emotional and practical support, to infrequent but reliable communication. Although family support was considered valuable, it was also a fragile relationship for some women who often made decisions based on family influences or to protect the wider family unit. During the Eco-mapping exercise with Katie, key stressors and supports were explored. Unfortunately the stress and pressure she was under from the expectations of her parents was adding to the expectations of the service and her own guilt, which increased her reliance on drugs.

> ***Anything that's a stressor at the moment anything that is inhibiting at the moment for you?***
>
> *Number one is (daughter), my middle daughter, the whole [situation] is she? isn't she going to end up getting adopted?.*
>
> ***Ok so that will be a real stress for you at the moment.***
>
> *It has been since I started it, the whole pregnancy has been overcome by it, fortunately aye I do have the most supportive family I could ask for but I cannae blame my mum for saying like basically I am going to be out the family if (daughter) gets adopted, she cannot bear the thought of (daughter) getting adopted so that's hard to think that like I have had that [supportive mum] all my life and then if my daughter gets adopted that's going to be hard enough but then I won't even have a mum to, aye so, (Katie becomes tearful).*
>
> (Katie.)

Longer term engagement (Outcome) influenced by discharge from service

Practitioners aimed to discharge women from the service in a gradual and step wise approach to ensure women could be referred onto other services as required. Practitioners were aware that the timing and process of discharge from the intensive service needed to be approached on an individual basis depending on the circumstances. Women experienced leaving the service in different ways depending on the outcome of their involvement with the service. Those who had their child in their

care were discharged to mainstream services depending on their support needs at the time. This was influenced by their stability of drug use as those managing well would return to their GP for their continued prescription whilst those requiring additional support would be discharged to a CPN at a local community drug hub. Some women who were on a Drug Treatment and Testing Order (DTTO) received their drug services support through local DTTO and not the team service. Some other women whose children were going for permanency or continued in LACC chose to stop engaging with the service and tried to seek support through other services.

> *Yeh so when we discharge we never all discharge at once, so who needs to remain involved, who doesn't, so the health visitor will discharge to a community health visitor, the substance use to the hub or GP and…(early years officer) it's usually [third sector] if baby's at home or an early years centre, so we are not leaving them without that support, cause they have had all this support and then if you were to withdraw it all its like whoa, so we introduce other support.*
>
> (Practitioner Interview 4.)

For women who had felt well supported from the service there were feelings of apprehension about being discharged to new practitioners. The relationships built with practitioners took time to establish and the thought of starting again with practitioners made women nervous. Practitioners were also very aware that standard services would not be able to provide the level or flexibility of support that the team service offered.

> *Emm a bit nervous I know I will be ok, it's just cause I have got to know them all and now I have got to get a new health visitor and its scary cause you get to know them and they know you and now I have got to go through it all with someone else, his new health visitor is coming tomorrow with (practitioner), I have met her a couple of weeks ago but emm its just different, it's just scary but I know it's got to happen like I can't keep them forever.*
>
> (Louise.)

Practitioners were concerned about the discharge process and the effect this could have on women, especially those with limited additional support from family and friends. To manage these concerns practitioners often kept women in the service longer than would usually be expected, or they would keep in touch with them informally over and above their caseload.

> *But also it's just, I think we all just empathise with them, it is just so difficult for any parents, never mind parents who have substance use and no support. You know, then to just say here is your baby, don't use drugs don't drink, see you later. That is just setting them up to fail. And I think that is what we need to look at and try to address.*
>
> (Practitioner Interview 6.)

Practitioners reflected on the structure and agenda of the service and how the processes and practices focused on the child protection agenda. This meant at point of discharge there were still aspects of the woman's health, recovery and wellbeing which had not been adequately addressed. It was well accepted by practitioners that some women would be likely to return to the service in the near future for support with a subsequent pregnancy. This was also shown in the annual reports that many women returned and of the nine women interviewed four had previously attended the service during a pregnancy.

> *It's not going to go away. We've not fixed everything. Everything is not great.*
>
> (Practitioner Interview 7.)

For some women who had not identified with the service at the outset and had felt overwhelmed by the service at times, were impatient by the time they were being discharged. They expressed they were ready to "get on with life" and accepted the service had "done everything they can". Whilst others reflected on being discharged as their final step in proving their abilities and achievement to practitioners.

> *We were kind of ready to be trusted and go out there and show you we've got this covered…Happy really happy that we had completed the programme and ready to move on.*

(Morven.)

Practitioners also reflected that at point of discharge, some women would relapse or "sabotage" (Practitioner Interview 10) their progress because of their issues with insecure attachment and sense of loss. Women would want to feel in control of the parting of the relationship they had built with practitioners and therefore would relapse. This highlights the complexity and how therapeutic relationships can have such a significant impact on women's motivations and experiences.

> *So when they've been coming and have a relationship and get a good level of support, and the CPN's a good example of that actually, and then they start incrementally working towards discharge and even if it's really positive because they've done brilliantly often the women will sabotage it because actually they'd rather make that decision that it's ending than you because that's less painful.*
>
> (Practitioner Interview 10.)

Practitioners raised concerns that because the service demanded so much intensive support to engage women early in their pregnancy, the women exiting the service did not receive adequate support. Concerns about "setting women up to fail" (Practitioner Interview 7) and an awareness that several aspects of women's lives were not yet addressed highlighted the potential short term support the service was actually capable of.

> *There's so much focus on the child that they have no time to focus on their own recovery.*
>
> (Practitioner Interview 8.)

These two potential theories on the reasons for relapse suggest either could be plausible however, limited data testing these aspects means this theory component regarding longer term engagement was deferred as opposed to refined at this stage.

This highlights the difficulties of addressing the interconnected aspects of the woman and her baby's needs to ensure a longer term positive outcome and it is not a surprise that women fall through the extensive gap between intensive outreach service and mainstream services at point of discharge and end up back in the service again.

Figure 69. PT3. CMO 6.

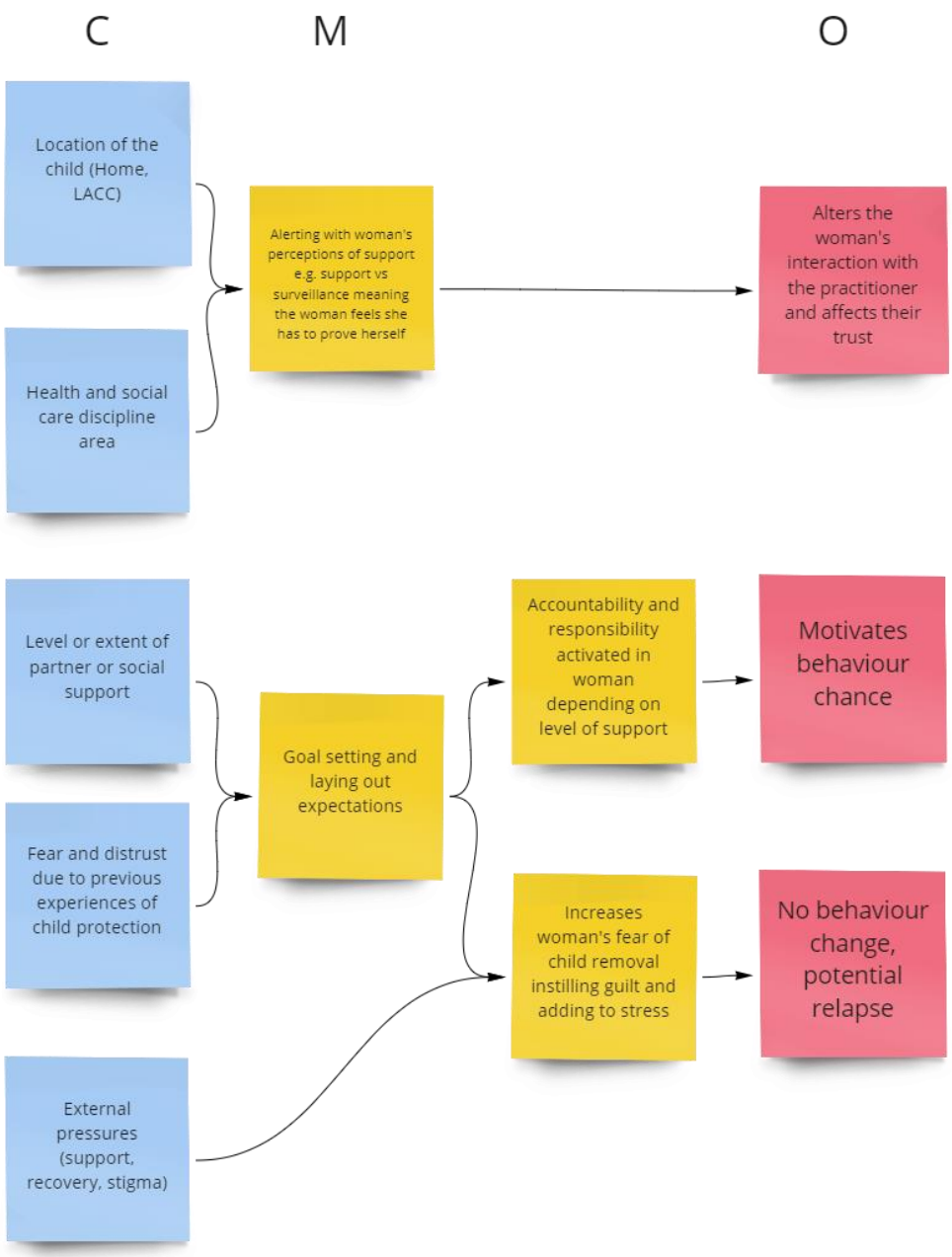


Table 23. Tested PT3 Context, Mechanism, Outcome Developments During Testing (Phase Two)

Context	**Mechanism**	**Outcome**
Woman has a Therapeutic Relationship with a practitioners and is engaging with the service	Therapeutic relationship building over time (resource) Holistic view of woman, including woman in leading aspects of treatment (resource) Allows practitioners to prioritise the foundations of engagement (response) Gives woman a sense of control and increased feeling of value and respect (response) Women feel practitioners are investing their time and demonstrate/evidence their "trust" (resource) Women feel more respected, build on their confidence and self-esteem (response) Multiple interactions with woman overtime (resource) Practitioners gain a level of understanding of individual needs (response) Emotional and practical support (resource) Enables women to feel more confident and improves self-belief (response)	Longer term engagement Leading to satisfaction and positive experiences with the service. Meets woman's needs Reduces woman's stress

Context	**Mechanism**	**Outcome**
Health and social care discipline area (Woman has a Therapeutic Relationship with a practitioners and is engaging with the service)	Practitioners opinion differ about who their "client" is and their main aims, their role and approach depending on their discipline (resource) Alters women's perceptions of support e.g. support vs surveillance (response) Woman feels she has to prove herself (response)	Meets the needs of the child Aspects of woman's health, recovery and wellbeing are not always adequately addressed Women return to the service (latent) Alters the woman's interaction with practitioners and affects trust.
Child protection agenda and timescales (Woman has a Therapeutic Relationship with a practitioners and is engaging with the service) (Location of the child (Home, LACC))	Goal setting and laying out expectations (resource) Gives woman a sense of hope (response)	Motivation and behaviour change
Fear and Distrust due to pervious experiences of child protection (Child protection agenda and timescales)	Goal setting and laying out expectations (resource) Gives woman a sense of false hope (response)	No behaviour change or a potential relapse
Location of the child (Home, LACC) (Practitioner's opinion differ about who their "client" is and their main aims, their	Goal setting and laying out expectations (resource)	Alters the woman's interaction with practitioners and affects trust.

Context	**Mechanism**	**Outcome**
role and approach depending on their discipline (resource))	Alters women's perceptions of support e.g. support vs surveillance (response) Woman feels she has to prove herself (response)	
Level or extent of Partner support (Fear and Distrust due to pervious experiences of child protection) (Woman has a Therapeutic Relationship with a practitioners and is engaging with the service)	Goal setting and laying out expectations (resource) Accountability and responsibility activated depending on level of support (response) Increases woman's fear of child removal (response) Fear instils guilt and adds to stress (response)	Motivation and behaviour change OR No behaviour change or potential relapse
External pressures (support, recovery, stigma)	Fear instils guilt and adds to stress (response)	No behaviour change or potential relapse

Tested Programme Theory 3

The service delivery model for pregnant women with problem alcohol and drug use works because specialist practitioners employ relational based practices to offer a flexible service (home visits, transport, informal communication, advice, practical support) (Intervention) to women who have built trusting relationships with a practitioner and are engaging with the service (context). **Flexible services reduce women's stress, meets their holistic needs and leads to satisfaction as:**

Relational based practices and flexible service (Intervention)

Building relationships over time allows for a more holistic view of the woman's needs and provides opportunities for the woman to be included in leading her own care. In turn, this produces a sense of control and increases her feeling of value and respect.

Relational based practices over time allows for practitioners to:

1. Prioritise the foundations of engagement and support these foundations to encourage a longer-term engagement.
2. Gain an understanding of the individual and holistic needs of the woman and in turn more successfully meet these needs.

As relational based practices instil women's trust in practitioners, receiving emotional and practical support from practitioners enables the woman to feel more confident and improves her self-belief, reducing her overall stress.

Offering Flexible services through relational based practices over time lead to higher satisfaction with the service and positive experiences as:

1. Women feel practitioners are investing their time in them and demonstrate their trust.
2. Women feel more respected, building on their own confidence and self-esteem.

Integration (Intervention)

The service delivery model for pregnant women with problem alcohol and drug use works differently for women depending on the practitioners' disciplinary background as practitioners bring different aims, goals, and ethos of practice.

These differences affect the relationships women and practitioners build and often fall short of addressing the woman's holistic needs as:

For women who are engaging with the service and have built relationships with practitioners, disparities in practitioners' aims, and ethos of practice, alters women's perceptions of support (e.g. support vs surveillance). Therefore, women feel they have to prove themselves to varying degrees depending on the practitioners with whom they are interacting. This strategizing has impacts on both the actions of practitioners and woman including:

1. Alters the woman's interaction with practitioners and affects her level of trust.
2. Meets the needs of the child primarily not always achieving the needs of the woman.

3. Inadequately addresses aspects of women's health, recovery and wellbeing.
4. Ultimately can increase the woman's likelihood of returning to the service (latent outcome)

Goal setting (Intervention)

The service delivery model for pregnant women with problem alcohol and drug use works differently for women depending on their social support and where their child has been placed as:

Goal Setting, (Intervention) **fosters motivation differently depending on how practitioners support, family support and Goal Setting are perceived by the individual woman herself**.

Goal setting and outlining expectations through assessments and "child's plan" produce diverse outcomes due to the service users' wider context and support. For instance, Child Protection time scales can motivate behaviour change depending on location or proposed location of the child and external support from partners and family members.

For women with supportive families and partners, goal setting:

1. Gives women a sense of hope and supports intrinsic motivation, as women feel accountable to their supporters and the practitioners with whom they have built connections.
2. This accountability supports the service user's capacity to commit to and develop behaviour change practices.

However, for women who are lacking support or feel pressure from family members, goal setting:

1. Can foster false hope adding to their stress, and lowering self-esteem.

When women have previously experienced outcomes of child removal and face external pressures (lack of support, stigma, and recovery), further fear and guilt manifests causing goal setting to:

1. Feel unachievable and a further barrier to face.
2. Reducing the capacity the service user has to change their behaviour and can result in potential relapse.

Depending on where the child is placed, goal setting can:

1. Alter the service user's perceptions of support as service users' feel they are either being supported to meet their goals or are being surveyed to meet their goals.

Overall, because of the child protection agenda, service users continually feel they are proving themselves to practitioners and the wider service however, the perception of support vs surveillance alters the service user's interaction with practitioners and can affect the trust they have in them.

Figure 70. ***Tested Programme Theory 3 Concept Map***

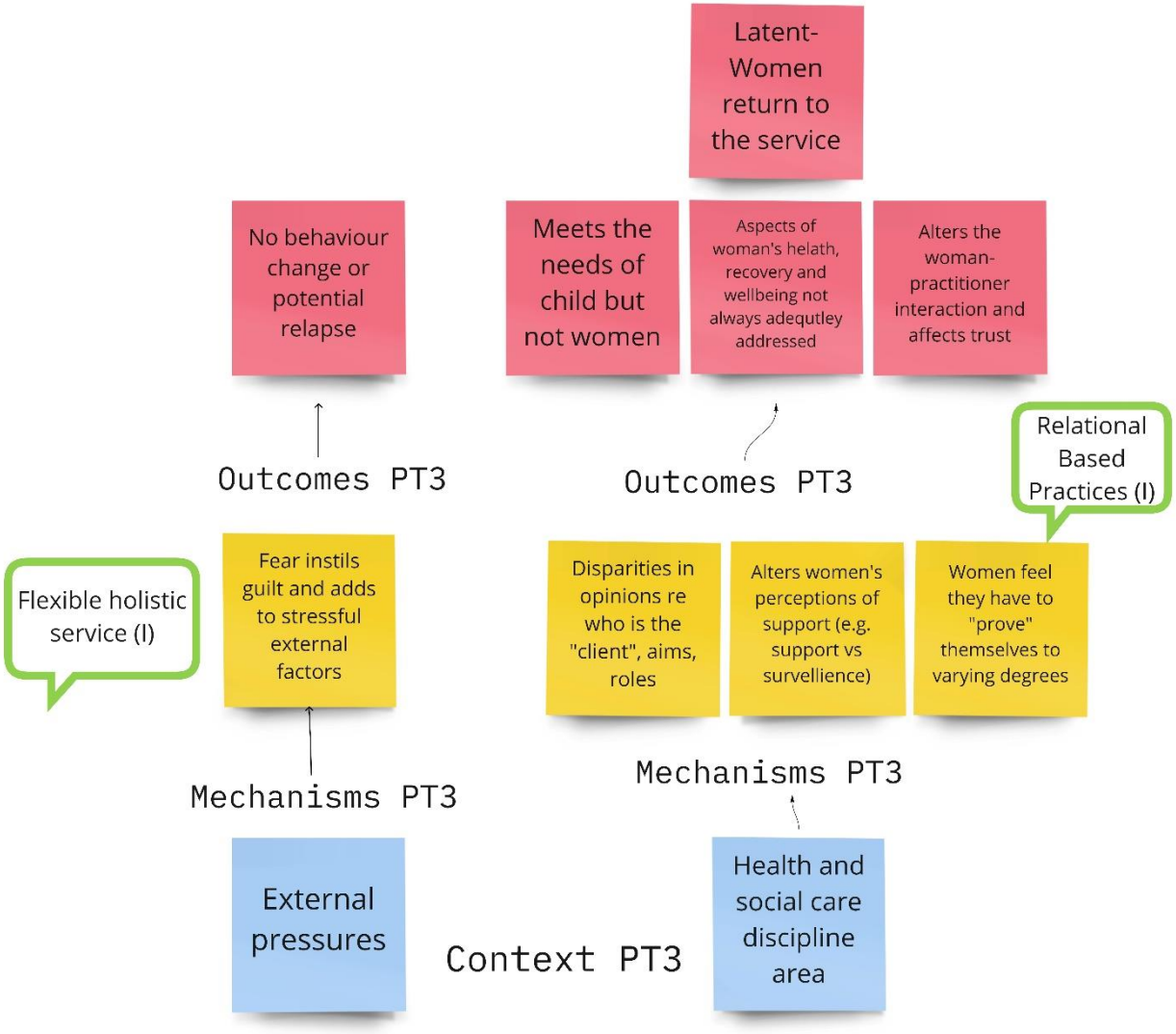


Figure 70 continued.

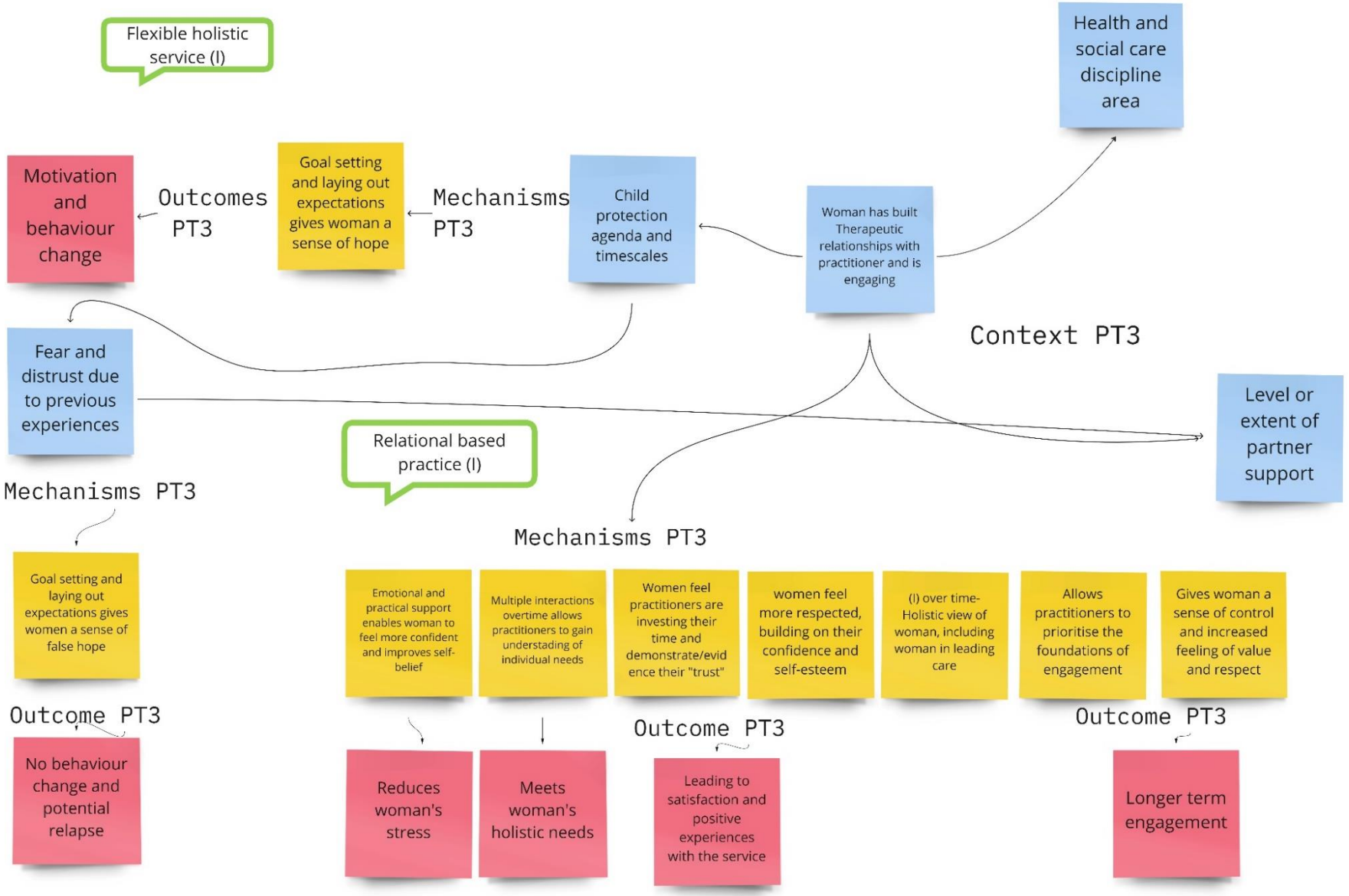


Figure 70 continued.

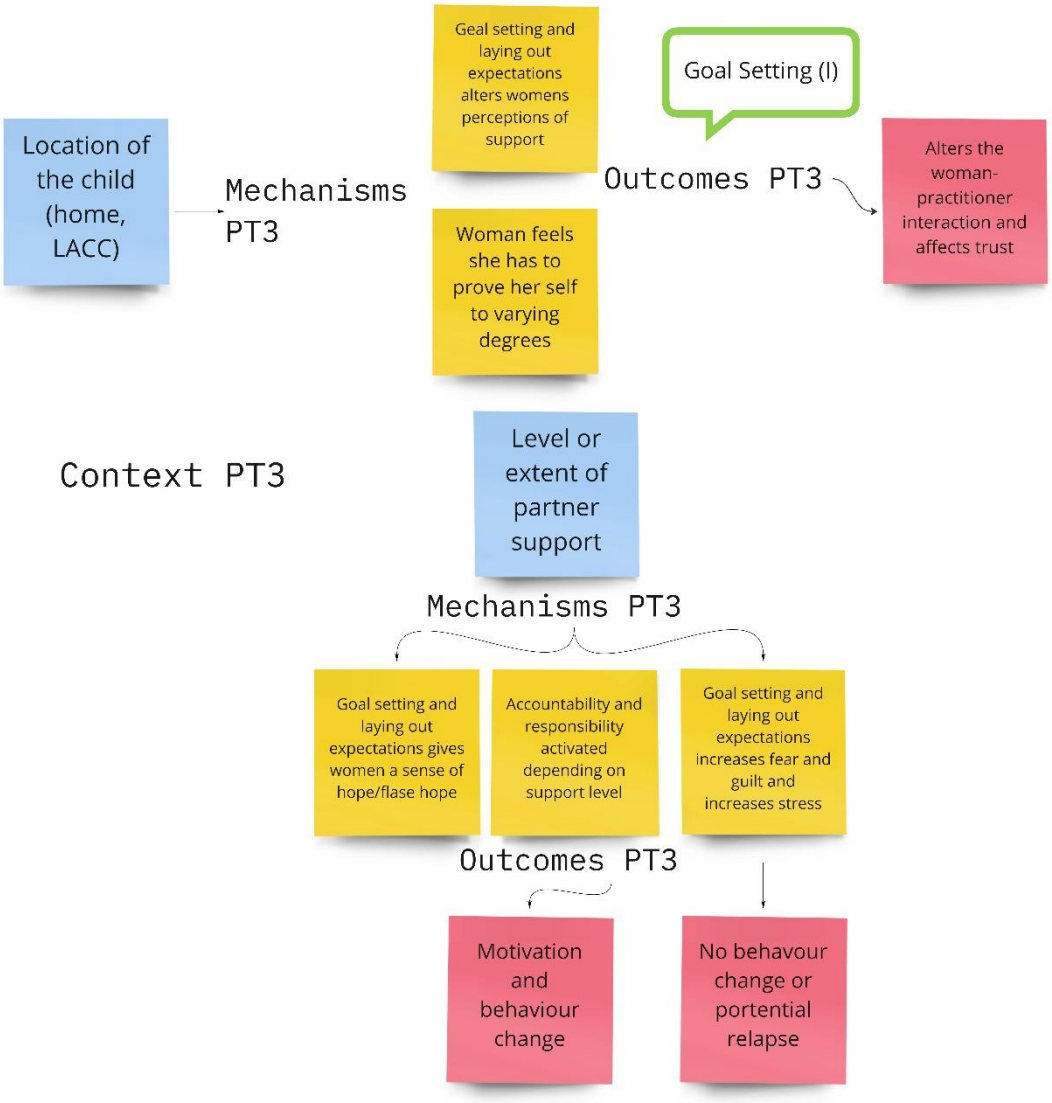


Table 24. IPT Refined, Refuted or Deferred

IPT 1	**IPT component**	**Data source**	**Refute/ Refine/ Deferred**
The service model for pregnant women with problem alcohol and drug use works because specialist practitioners work as a multidisciplinary team in a co-located service, and the range of specialist expertise in combination with daily staff interaction serves to strengthen coordination, understanding of roles and problem solving. Within a challenging and "gruelling" practice area (Context) the service (MDT, Co-located, specialist service) (Intervention) with mutual goals and team ethos (Context) introduces…	Mutual goals and team ethos (Intervention)	Observations of practice. Team meetings. Interviews	Refined
1. The opportunity for (formal and informal) communication (resource) which builds respectful, trusting inter-professional relationships (response) leading to improved communication about cases (outcome).	Co-location (Intervention) leading to relationship building and communication	Observations or practice. Team meetings Interviews	Refined

IPT 1	IPT component	Data source	Refute/ Refine/ Deferred
2. The opportunity for (formal and informal) communication (resource) improving practitioners understanding of responsibility and accountability (response) resulting in timely action (outcome).	Co-location (Intervention)	Observations of practice. Team meetings. Interviews.	Refined
3. Skilled staff (resource) who bring an understanding of responsibility and accountability (response) and motivation and dedication (response) resulting in improved staff morale and retention, reduced burn out and timely action (outcome).	Specialist practitioners (Intervention) leading to accountability, motivation and dedication	Observations of practice. Team meetings Interviews	Refined
4. Peer supervision (resource) which improves motivation and dedication (response) and an understanding of responsibility and accountability (response) resulting in improved staff morale and retention, reduced burn out, improved communication about cases and timely action (outcome).	Peer supervision (Intervention) leading to accountability	Interviews	Refined
5. A case co-ordinator (resource) which improves each practitioners understanding of responsibility and	Case-co-ordinator	Interviews	Refute

IPT 1	IPT component	Data source	Refute/ Refine/ Deferred
accountability (response) leading to improved communication about cases (outcome) and timely action (outcome).	(Intervention) leading to accountability		

IPT 2	**IPT component**	**Data source**	**Refute/ Refine/ Deferred**
The service model for pregnant women with problem alcohol and drug use works as the practitioners use open, honest, non-judgemental approaches to encourage trust building with women who are often distrusting and fearful of services due to previous experiences. This approach helps to make women feel respected, considered and more trusting of the service. If the service aims to build therapeutic relationships (intervention) with a woman who has previous experience of social work (who have fear and distrust of services) (context)…	Therapeutic Relationships (Intervention)	Observations of practice. Team meetings. Interviews	Refined
1. Then a non-judgemental approach and flexible service (resource) makes the woman feel respected and considered (response) and therefore more encouraged to engage (outcome)	Non-judgemental approaches (Intervention)	Observations of practice. Team meetings. Interviews	Refined

2. The flexibility of the service (resource) offers practical alternatives (resource) alleviating stress and anxiety (response) (because of “hand holding”, “takes pressure off”) enabling women to engage (outcome)	Offering Flexibility (Intervention)	Observations of practice. Team meetings. Interviews	Refined
3. Then offering open and honest communication (resource) the woman begins to trust the practitioner (response) leading to therapeutic relationships (outcome).	Open and Honest Communication (Intervention)	Observations of practice. Team meetings. Interviews	Refined
4. Then the practitioner sharing information (resource) with the woman will inform the woman and will lead to trust building (response) and strengthening the therapeutic relationship (outcome).	Sharing information (Intervention)	Team meetings. Interviews	Refined

IPT 3	**IPT component**	**Data source**	**Refute/ Refine/ Deferred**
The service model for pregnant women with problem alcohol and drug use works as it offers a flexible service (home visits, transport, informal communication, advice, practical support) (intervention) to a woman who has a therapeutic relationship with a practitioner and is engaging with the service (context).	Offering flexibility (Intervention) within a Therapeutic Relationship (Context)	Interviews	Refined
1. Then the tailoring of the service (resource) makes the woman feel more valued (response) as it meets her needs (outcome) leading to satisfaction and positive experiences with the service (outcome) and longer term engagement (outcome).	Flexibility- leading to increased sense of value	Interviews	Refined and partially deferred
2. Then the tailoring of the service (resource) offers choice (resource) strengthening woman's autonomy and improving her self-efficacy and empowerment (response) leading to satisfaction and positive experiences with the service (outcome) and longer term engagement (outcome).	Flexibility- leading to choice	Interviews	Refined

3. Then goal setting or laying out of expectations (resource) gives women a sense of hope (response) leading to motivation and behaviour change (outcome).	Goal setting- leading to hope	Interviews	Refined

Chapter 7 Phase Three Findings

Phase Three, Refine programme theories

Objectives – Refine these programme theories to unearth a deeper understanding of how the programme works and identify middle range theories to explain how the programme works in a broader sense.

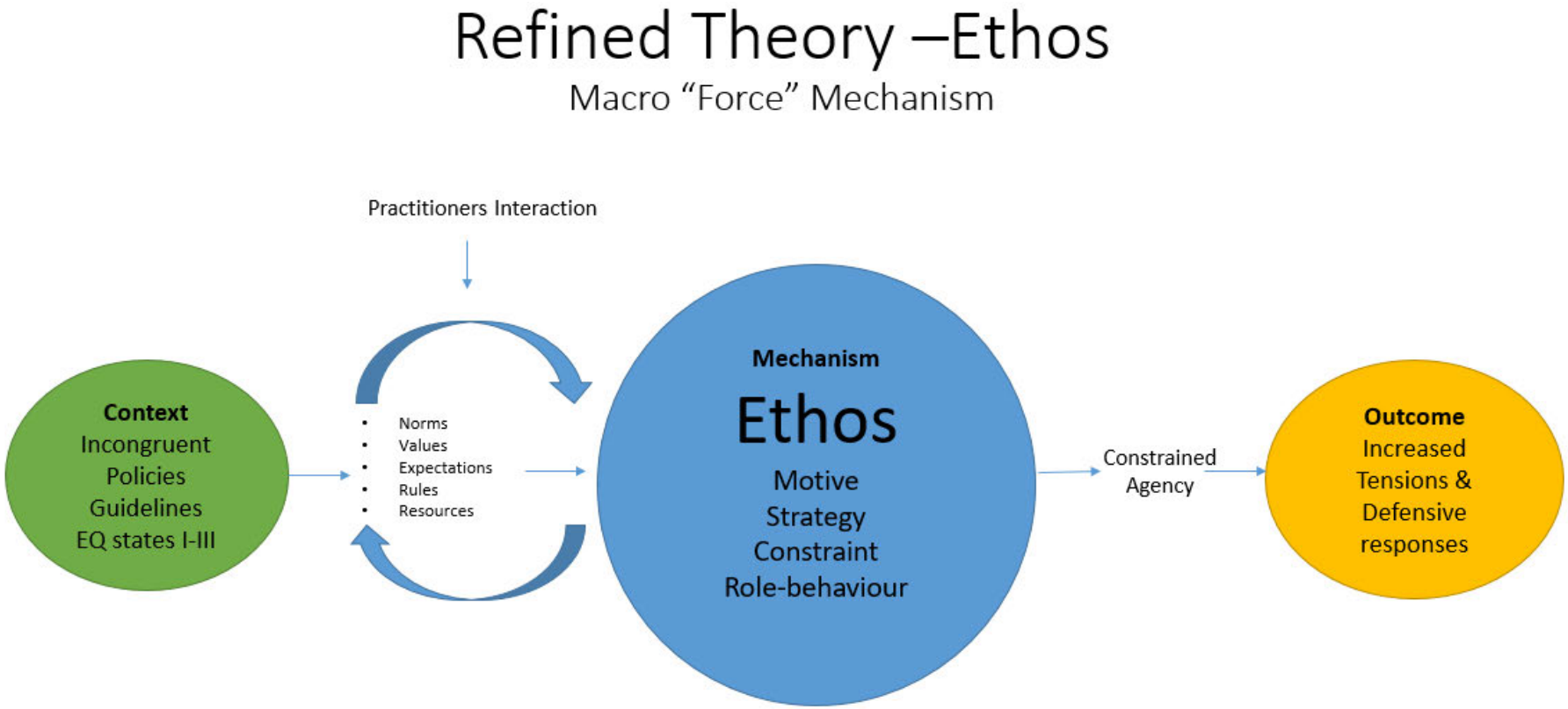
In this section, I will present the findings in relation to the four core mechanisms identified through the testing and refinement process presented in Chapter 6 Phase Two Findings. The methods of this refinement process as explained in Chapter 4, Phase Three methods – Refine programme theories, utilised the theoretical perspectives of Trust Level Theory (Gibb, 1991), Critical Interactionism (Burbank and Martins, 2019) and Feminist Symbolic Interactionism (Kleinman and Cabaniss, 2019). Concepts from these theories are referred to throughout this chapter including Environmental Quality Phases (Gibb, 1991) previously described in Chapter 4, Trust Level Theory. Additionally, recognition of a new perspective on mechanisms as discussed in Chapter 4, Core mechanisms – new understanding of mechanisms, has been applied throughout the refinement process and is evident in the four presented mechanisms. Westhorp's (2018, p.50) description of mechanistic behaviours: "Mechanisms operate only when the circumstances are suitable, and always in concert and in competition with other mechanisms," were closely considered to understand the overall functioning of the four mechanisms. Descriptions and examples of mechanisms working in concert and competition with each other will be outlined further in section Interactions of four key mechanisms. Each mechanism is presented with a figure to illustrate its component parts. Following the figures from left to right, Interactionism (Burbank and Martins, 2019 and Kleinman and Cabaniss, 2019) and Trust Level Theory (Gibb, 1991) lenses have been applied to programme specific examples to demonstrate the mechanism functioning. In the final section, I will demonstrate evidence and understanding of how the four key mechanisms presented in these findings interact to produce a vehicle of mechanisms contributing to workings of the service.

Mechanism 1: Ethos – force mechanism at the Macro level

Construct of mechanism

The following description (depicted in Figure 71) outlines the components and functions of Ethos as a core mechanism. Ethos is based on higher-level system influencers or context, including policy, guidelines and the broader Environmental Quality (EQ) states described in Chapter 4, Trust Level Theory. These influencers provide social norms, values, expectations, rules and resources, which through joint action are interpreted, reinforced and magnified producing the social force of Ethos. Ethos works as a force as it drives forward strategy, motivation and behaviour within the service contributing to outcomes. Ethos is also the main mechanism, which interacts with all the other mechanisms affecting their outcomes.

Figure 71. Ethos – Force Mechanisms on the Macro Level



As previously discussed in Phase Two, programme level data and substantive theory (San Martin-Rodriguez, 2005) suggested Ethos was a key element to ensure adequate, focused teamwork was successful in a multi-agency team. During IPT development in Phase One, Ethos was conceptualised as a shared approach to MDT; which directs the service and helps the integrated service work collectively as one unit to meet the needs of the clients. This was explicit in the discussions with stakeholders and evident in the literature regarding teamwork (San Martin- Rodriguez, 2005). However reviewing the underpinning policies and guidelines suggested there were disparities across the agencies included in the MDT, which could create tensions in practice. Testing Ethos in Phase Two highlighted the differences in practice depending on practitioners' discipline. Different approaches to practice affected the relationships practitioners and service users built over time, and produced barriers to integrated team working.

Initially I considered Ethos in this sense to be part of the context in which the service was placed and therefore influencing other mechanisms. However when I considered my new understanding of the different constructs of mechanisms I began to realise Ethos was in fact working as a mechanism. Understanding the function of the mechanism and the outcomes it produces is an essential part of the mechanisms construct.

Norms and values

Norms and values are constructed by the overarching policies and guidelines that underpinned the service and had evolved from a multitude of resources. Tracing the service back to its evolution, it was clear the service was framed by a risk-averse position after the response to the Report of the Caleb Ness Inquiry (O'Brien et al., 2003). This Inquiry found that systemic failure across services, with siloed working practices and poor communication had implications in the protection and subsequent fatality of Caleb Ness at 11 weeks of age. Similar findings from the Lamming report (Lamming, 2003) which was carried out after the death of Victoria Climbie, aged seven, at the hands of her guardians, recommended integrated approaches to child protection services.

This foundation for the service encouraged integration of partners across health and social care services to support open and necessary communication with a goal of preventing further adverse outcomes. In addition, awareness of the underpinning norms and values associated with child abuse and neglect created an Ethos with motivation and intention. Interpretation of these norms and values by policy leaders and programme architects contribute to the strategic approach to interventions, such as the service being evaluated. This initial building block in the force of Ethos grounds the service in EQ state Punitive, Autocratic and Benevolent (Gibbs, 1991) (see Chapter 4, Table 10).

Motive and strategy

With motive comes strategy, control and power. This strategy hinges on the risk-averse nature of policy and practice and forces a series of ripple effects through the service structure, implementation and outcome.

An example of this strategy was identified in discussions with practitioners regarding access to opioid substitution therapy. Practitioners described the service as an "Assertive Outreach Model" (Practitioner Interview 5), which ensured pregnant women were able to access their prescription for opioid substitution therapy because this was known to be essential to reducing risk to the fetus.

> *We will keep going and keep going, as long as… you know she's not delivered and baby is still there, she is still pregnant we, you know keep going keep going keep going to try and so someone is always on their phone you know texting, knocking on doors.*
>
> (Practitioner Interview 5.)

However, this assertive outreach model changed once the baby was born and women were expected to independently manage their needs within the realms of standard care.

> *Suddenly a switch to 'oh no if you're not coming to appointments we are not going to drop your prescription off today and drive round to the other side of town to find you' and stuff, which we very much do when they are still pregnant.*

(Practitioner Interview 5.)

These two opposing practices to opioid substitution therapy highlight strategy of the service to control risk to the fetus during pregnancy, whilst fostering accountability in women during the postnatal period. As the service Ethos functions with Motive to prevent risk and Strategy by holding control of the prescription, the practice aims to make changes in service users behaviours to meet safe parenting expectations. However, the dominance produced by this power imbalance between practitioner and service user, constrains the actions or response in the service user and subsequent actions of the practitioners.

> *When push comes to shove if you need to maybe go over somebody's prescription (review dose) then, you know, that's me having a, sort of, an element of, kind of, control over them, but we have to be safe in our prescribing, so sometimes we just have to do that, but I try to say to people I want to try and avoid that.*

(Practitioner Interview 8.)

Practitioners reflected on the necessity to act on their powers in light of the potential risks as seen here in the example of safe prescribing. Despite the practitioners' awareness of their motives and strategy they continue to hold power over the women, constraining her use of agency.

Offsetting the risk-averse Ethos of the service, was a nurturing woman-centred ideology embedded in the maternity guidelines (NICE 2010, Scottish Government 2016) and core global principles of Respectful Maternity Care (WHO, 2018). These guidelines focused on the importance of empowering women to make informed decisions about their maternity care whilst advising against judgemental and disrespectful practices. These guidelines sit within the EQ scale Participative, Emergent, Organic and Holistic (Gibbs, 1991), and are vastly different to those practices of risk aversion in the child protection agenda. Embedding practices of woman centeredness, structured the focus around relationship building with women, which is known to be a key factor in increasing women's self-worth (Hanmer and

Statham, 1999). Supporting open communication and respectful practices were key to building these relationships.

> *I need to be friendly and compassionate and listen to them.*
>
> (Practitioner Interview 7.)

> *It is about giving them a voice, emm yeh. That was a section that I added to the group because I didn't feel the women had a voice and I felt they needed a safe place to just sound off, and see when you gave permission to do it, oh could they do it.*
>
> (Practitioner Interview 4.)

These opposing woman-centred versus child-centred ethe affected the ways practitioners approached their focus, who they believed their client was and the relationships they built with them.

> *I'm meant to be supporting the woman, and my goal is to try and support her for her to have a better life, and then if she's got children for the children to, kind of, reap the benefits from that… I'm not, sort of, coming at it like I want to make her life better so that it's better for the kids. That's great, but I, actually, am...I want your life to be better so then that'll be good...better for your family.*
>
> (Practitioner Interview 8.)

This often raised tensions between practitioners who referred to the balancing of women and child approaches to "walking a bit of a tightrope" (Practitioner Interview 8). Yet practitioners continued to hold the power and control in the relationship, steering the direction through their motive and strategy**.** Relationship building became the resource to ensure the motive of child protection was achieved.

> *If they don't think they have a voice and they don't think that I will listen to what they say they're not going to come to me and that increases the risk for these really really vulnerable children, so the relationship is key.*
>
> (Practitioner Interview 7.)

Rules and expectations

Rules and expectations are a further layer within the structural context that are interpreted by the practitioners within the service and are given power relative to their agenda and purpose. These are significant because of their interaction with the practitioners' disciplinary background. For instance, practitioners who are embedded within substance use services have specific expectations of their clients, based within their understanding of addiction, relapse and recovery. These expectations were consciously considered in practitioners accounts of recovery work, which they explained was particularly challenging within the context of child protection agenda.

> *It's hard for people to...I…sort of, visualise it that people are spinning all these plates and they're just running around, you know, trying to spin them all and it's a huge amount of work and energy and they're just trying to do everything to try and get to where they need to be so that people can say, yes, okay, you can have your baby home…there is so much focus on the child that they have no time to focus on their own recovery.*
>
> (Practitioner Interview 8.)

In contrast, the child protection agenda powered on through with its own rules and expectations in the form of time scales that were constructed based on the needs and development of the child.

> *So mothers are expected to abstain from using substances and then evidence that they have been able to do that, what then tends to happen is that the mental health side of things then comes to the fore front because the substances have been masking… the mums can't abstain and then you know it makes things really difficult for them because there are lots of timelines with the case conferences or the child protection proceedings have to stick by…so once they are in that cycle it is really difficult to get out of.*
>
> (Practitioner Interview 1.)

Constraint

These opposing agendas created further strategy, counter strategy, constraints, motives and role like behaviour among practitioners, as outlined in Figure 71.

Constraint is a byproduct of the interaction between the context, and practitioners' agency, which results in reification of Ethos. When practitioners interpret others' responses to norms and values, they attribute meaning which evokes a personal response. Schwalbe (2019, p. 35-36) terms this "affective constraint" as the action within the interaction is to be constrained.

For example, when practitioners challenge the decisions or practices of others, the person interprets the meaning and responds with *constrained* action. This was evident in the practitioners' discussions of the use and benefits of toxicology screening, which had implications for women's Opioid Substitution Therapy, and evidence of child protection risk. Many women wanted toxicology screening carried out when they were stable on their Opioid Substitution Therapy in order to evidence to their social worker their changed behaviour. However, practitioners, whose role it was to carry out toxicology screening, advised against this use as toxicology tests were primarily for managing prescription dose. Practitioners within the service also faced conflict with some social workers who wanted the toxicology results to inform actions regarding child protection proceedings.

> *It's such a, sort of, grey area, but, I think, it's really a wrong thing to…just focus on the drug screens…some social workers totally get that and then you can have that conversation and then they just say, 'yes, so what were the drug screen results?' And you think, oh, we've just had this big conversation. You can see how clients really get tied up in knots about it as well.*
>
> (Practitioner Interview 8.)

In this example, the practitioner has their own understanding for the use of toxicology screening which, from a disciplinary background, has evidence for practice. However, within the interdisciplinary setting the expectations of other practitioners and service users need to be met. As the child protection agenda holds power over the recovery agenda due to it's interpreted risk and opposing time frames, the actions of the practitioner are constrained.

Role-behaviours

Contrasting norms and values, motives and strategies, and rules and expectations dominate interactions between practitioners, services and women, contributing to tensions in practice and motivate adoption of role-behaviour. Role-behaviours activate the defensive process (see Chapter 4, Table 12) and are naturally assumed in response to challenge. Role-behaviours allow practitioners to feel the security of their own rules, responsibilities and expectations.

> *I see it as part of my role to teach them that [parenting skills] and to help support them get that [parenting skills], so if it means I have to hold their hand to start with that's what I will do however, I wouldn't be doing that right through because you know there has to be some responsibility on them.*
>
> (Practitioner Interview 2.)

As seen here there is strategy and motive in the practitioner's behaviour which provides safety and limits to their practice. Outlining their "role" shows the other team members what the practitioner is willing to be accountable for, and where their boundaries lie. In turn, the approach removes relational aspects of woman-centred care (which is also demonstrated in the following quote), which should principally be person specific as opposed to service specific. This practice breaks down the integration of the team, which becomes factionalised by structure instead of process. Role-behaviour is not overt, yet practitioners are aware of their own actions and reasons for these actions. Practitioners reflecting on their role behaviour, show there is constraint in their actions because of the Ethos of the service.

> *I do think there is a lot of pressure on parents and it kind of sets them up to fail, because I think there should be more of an onus on working with them and trusting them …instead of [saying] 'I am staying outside your house and watching you seeing what you get up to'. For me it is about trust.*
>
> (Practitioner Interview 6.)

Tensions, noted in practice through role-behaviour, constraints and motives, are examples of practitioners' agency being affected by the overall structure. Agency as described in Chapter 3, and further elaborated in this chapter, refers to the individuals'

capacity to act within boundaries of social structures which influence them. In the case of practitioners, as with service users, agency is affected by the influences of resources such as “interprofessional relationships, policies, management directives” as described by Purkis and Ceci (2019, p.19). Practitioners do not function in a vacuum, their individual identities, experiences, values and beliefs in conjunction with social and organisational structures contribute to affective constraint as described above.

> *We are advocating that mum shouldn’t have stress, and shouldn’t be anxious and we are in a case conference effectively telling them we might take your baby into care. So you know that is a contradiction itself.*
>
> (Practitioner Interview 6.)

Practitioners were aware of the impact Ethos’ had on women’s experiences with the service and it was not overlooked, however they appeared restrained by the force, which caused barriers in their practice. This is an example of practitioners’ agency being influenced by the power the child protection agenda holds over the recovery agenda, leading to constrained actions and incongruence. Ethos’ social force moved through defensive practices producing tension among the Multidisciplinary team (MDT), and raising barriers.

As outlined above, norms and values, which are the contextual basis of Ethos, were incongruent across agenda and practice. The underpinning agenda based on EQ 1.Punitive and 2.Autocratic (Gibb, 1991) contradicted the relational-based practice process, and benignly benevolent approach, practitioners inherently wanted to provide through EQ 3. Benevolent, 4. Advisory, 5. Participative and 6. Emergent (Gibb, 1991). This context is essential in understanding the function of Ethos as a force producing primarily negatively framed outcomes. If the context had been *congruent* norms and values, the force of Ethos could contribute to positively framed outcomes.

Figure 72. Mechanism 1: Ethos

Ethos – This theory explains the benefits and drawbacks to interagency working within the service, highlighting the importance of congruent principles across the multiple agencies working within the service.

If norms, values and expectations are incongruent across agenda and practice (polices, guidelines,) in the integrated MDT (C), then tensions and subsequent defensive responses rise among practitioners (O) because competing ethe force: motives, strategy, constraint and role-behaviours, as practitioners' autonomy is constrained by their personal and professional allegiances (M).

As the service has a fixed agenda rooted in child protection, partner agencies are forced to manage their own professional identities and practices within this environment. These principles are not all aligned and can raise tensions within the team.

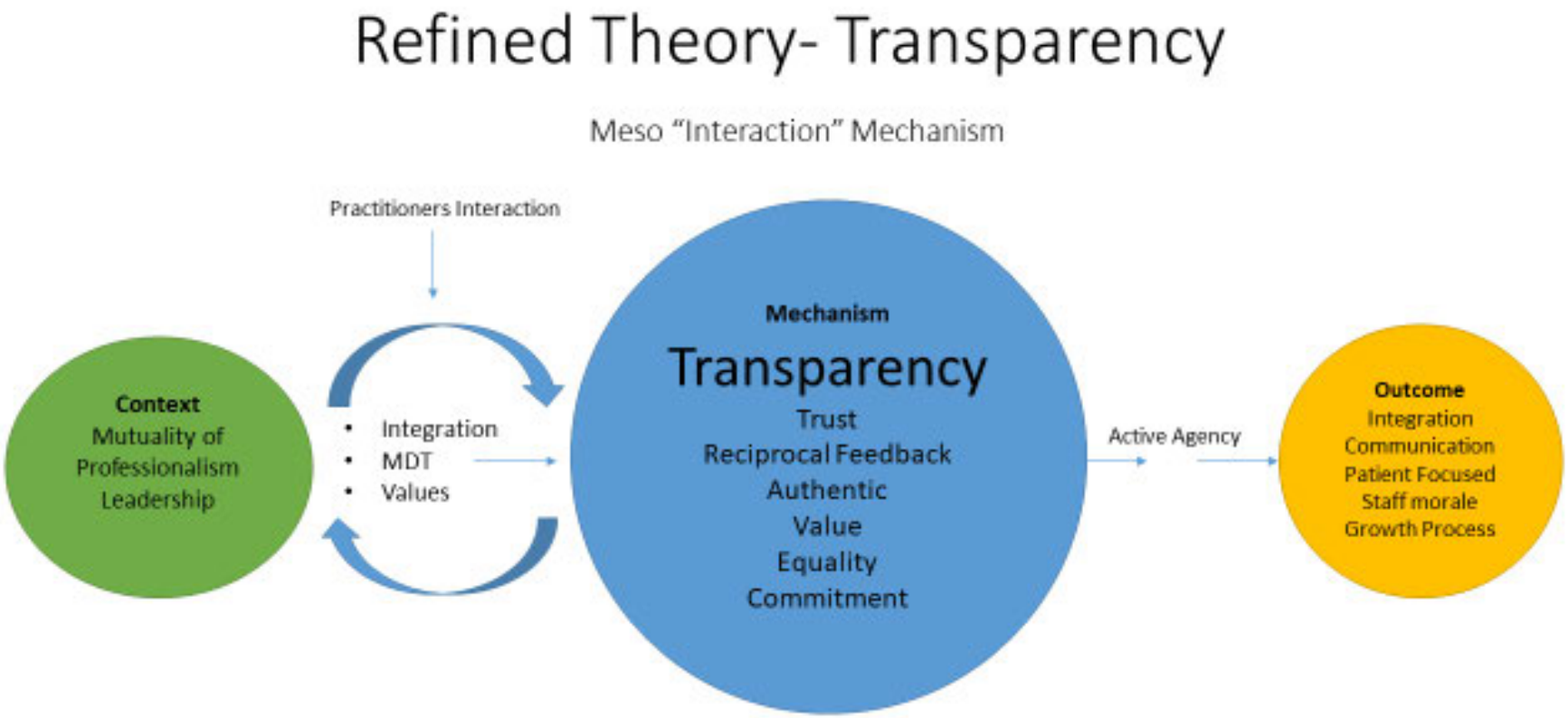
Practice Point: To improve synergy across interagency working, the service requires congruent principles and practices, which align with the services mutual aims. This requires equal buy in from partners at organisational and practitioner level and relevant resources in terms of funding

Mechanism 2: Transparency – interaction mechanism at the Meso level

Construct of mechanism

The following description (depicted in Figure 73) outlines the components and functions of Transparency as a core mechanism. Transparency is an interaction mechanism, which works from a contextual platform of mutuality. Transparency is present at the Meso level where it interacts with the Macro context and produces outcomes at the Micro level. This mechanism grows organically through its internal interactions fostering a climate that contributes to outcomes.

*Figure 73. **Transparency — Interaction Mechanism at the Meso Level.***



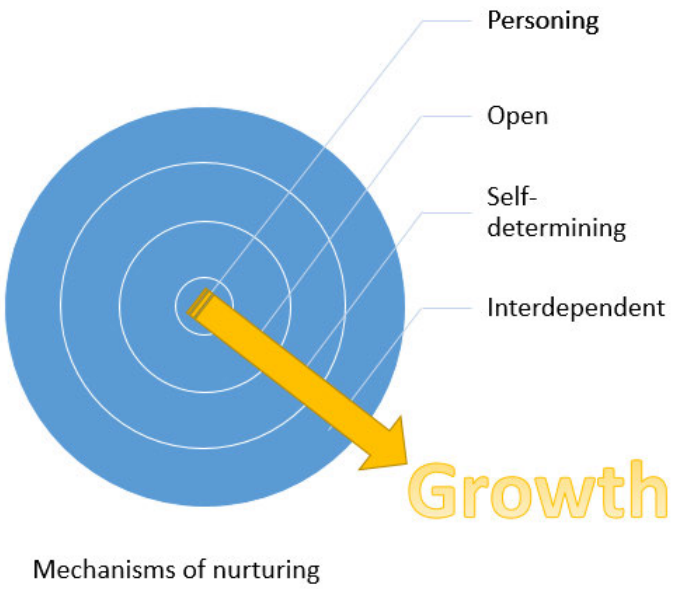
Values

Based on values and assumptions of multidisciplinary team working and integration of services; practitioners find themselves to be likeminded in professionalism, interpersonal communication and commitment. One of the driving forces behind Transparency is the personable leadership which supports the intrapersonal development of individuals and the team itself.

> *[Team manager] knows exactly what's happening. She's in…you know, she's in control. She's very supportive. And like I say, just even taking interest of…really wanting to learn about each role I think is massive. And I think it's what makes a difference. And I think she has encouraged us over the years to really be aware of what each other's role is.*
>
> (Practitioner Interview 9.)

This investment in each individual, supports the internal growth process (Figure 74) which is required to support further organic growth of the Transparency mechanism itself. This springboard lays the foundations for trust, openness, authenticity, equality, value and commitment, which are evident functions of the mechanism of Transparency.

Figure 74. Inner-outer Growth Process



Note. Adapted from Gibb (1991)

Trust

Practitioners have trust in themselves, each other and the leadership of the team. This trust is mutually responded to by other's evidence of trust. As practitioners trust each other their self-belief and confidence grows.

> *I know if I speak to any of my colleagues I will get the right information, the right advice and the right support regarding whatever I have asked them.*
>
> (Practitioner Interview 3.)

Based on the personable approach, trust is meaningful and unqualified (Gibb, 1991, p. 236), and brings with it responsibility and opportunistic actions. This builds on the practitioners' agency and allows practitioners to acknowledge responsibilities, feel respected and respond with commitment.

Reciprocal feedback and authenticity

As members of the team work together with respectful interactions, communication becomes open and free flowing. There are no barriers or motives as team members embrace their "authentic self" (Gibb 1991 p. 224) based on the intrinsic motivations to work together for the same purpose. This is both a conscious and subconscious process for practitioners as transparent relationships grow.

> *You've got to have confidence in yourself, you've got to have sensitivity amongst your team so that if you have concerns you can share them without people getting defensive.*
>
> (Practitioner Interview 10.)

Being authentic and entering into open communication allows for reciprocal feedback and critical reflection (Gibb 1991). Practitioners are confident in their own practice and manage scrutiny from their colleagues. This confidence requires critical self-reflection when assessing their own practice within the team. Being in a multidisciplinary team brings different opinions to the table and results in colleagues challenging each other's practice and approaches as evident in the mechanism Ethos. This was considered by practitioners as an opportunity for reflective practice, to ensure clients received adequate and appropriate care.

> *It's good that there is different disciplines…so it's really...looking at hopefully…every aspect as a team and then as a team be able to go out to that mum or that family and offer whatever resources that we have…me as a practitioner I suppose it's just good experience to work with because we don't all see eye to eye, so it's quite good to sort of have the differences of opinion and to kind of look at like 'why I am I doing that' and yeh I do agree why I am doing that actually so it just sort of can help you to really challenge yourself and make sure you're doing what you're doing and why you're doing it really.*
>
> (Practitioner Interview 1.)

Value and equality

Practitioners show their understanding of the value of teamwork as they embrace the value of their peers whilst appreciating the new value of the team as a whole. The individual team members treat each other equally and are in turn treated as equals.

> *I think we are really good at knowing each other's skills and knowing who to go to for certain things …I think the team make you feel really valued… everybody has their own skills and knowledge, I think everybody is good at making you feel that you know something specific in that area. And I think when they come to you asking your advice it makes you feel good, like oh I am glad I was able to help my colleague regarding a certain question or situation.*
>
> (Practitioner Interview 3.)

All these functions of Transparency interact with each other when present within the nurturing EQ scale V. and VI. Participatory and Emergent (Gibb, 1991) (see Chapter 4, Table 10). These states embrace loyalty, collaboration and sharing, developing deeper connections than seen in Benevolent and Advisory phases which are more surface level relations. For example in the challenging practice area, which can cause emotional labour for the practitioners, peer support and supervision, is offered. A mutual understanding of each other's experiences and need to support each other, encourages further collaboration, consensus and loyalty.

> *We always encourage folk, if you've had a really difficult day and you've been out all day, kind of, on your own, doing visits and you're going home, to pick up the phone and talk to somebody.*
>
> (Practitioner Interview 7.)

This level of transparency within the team also allowed for a deeper integration of the team and movement towards EQ Organic (Gibb, 1991). Through transparent communication, practitioners can focus on the needs of the client through sharing information and working together to problem solve issues.

> *I think having a culture within the team of knowing that you don't always get things right and that's okay. So having a culture within the team that encourages different people to come forward with different ideas and different strengths and being able to share their knowledge.*
>
> (Practitioner Interview 10.)

Commitment

It was clear in this highly complex practice area, competent practitioners brought skills in reflective practice allowing for self-reflection and awareness. These skills, in conjunction with informal and formal supervision supported motivation and dedication and improved staff morale.

> *You have to take responsibility for [your own] debriefing, you have to. So there's a lot of ownership and responsibility taking as well …But we've got a competent workforce and they're really good at that and they're really good at picking up when they see their colleagues as well need that extra support, so there's a lot of mutual support as well.*
>
> (Practitioner Interview 10.)

On reflection, this awareness was more likely to be present in skilled, competent practitioners who were confident in their practice and their abilities but who were willing to show vulnerabilities.

> *In order for the mutual support to work you've got to have folk that aren't guarded and feeling confident in their role and able to put their hand up and say, I struggled with that meeting, that was really distressing actually.*
>
> (Practitioner Interview 10.)

This is an example of practitioners' agency affecting their ability to be authentic and engage in transparent behaviours and further highlights the importance of the context of mutuality.

> *And that is why we are all involved we want to work to make things better, but it's about the patient focus.*
>
> (Practitioner Interview 1.)

Practitioners held a set of values, which enabled the Transparency mechanism to build on the growth process (Figure 74) within each team member and generate a compassionate model of teamwork.

Figure 75. Mechanism 2: Transparency

Transparency – This theory highlights the importance and value of compassionate team working which the service practitioners foster in light of barriers to integration.

If practitioners' norms, values and expectations in professionalism and commitment are mutually aligned (C) and there is supportive leadership for the team (C), then *Transparency* will foster collegial practices resulting in: integration, effective communication, patient focused agenda, increased staff morale and intrapersonal growth process (O). This is achieved as *Transparency* offers building blocks within the team, including: trust, reciprocal feedback, authenticity, value, equality and commitment; developing interpersonal relationships and increasing practitioners' autonomy (M).

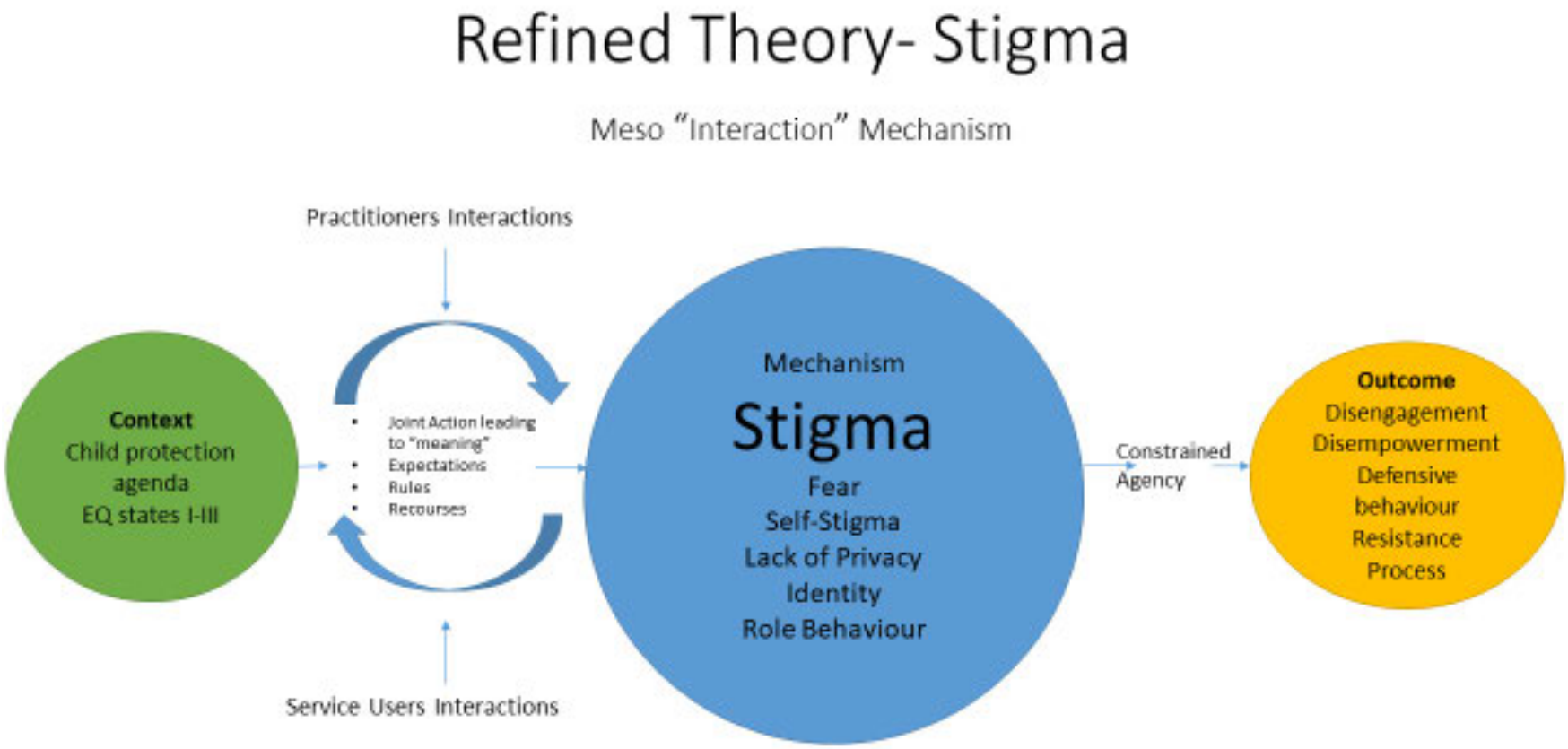
Practice Point: Transparency among team members supports growth of the individuals, the team as a whole and improves services for service users. Opportunities to cultivate transparency must be offered by leadership and commitment from experienced skilled practitioners.

Mechanism 3: Stigma – interaction mechanism at the Meso level

Construct of mechanism

The following description, (depicted in Figure 76), outlines the components and functions of Stigma as a core mechanism. Stigma is an interaction mechanism working at the Meso level as described by its interaction with both the Macro and Micro levels. It is influenced by social structure at the Macro level, which through interactions with persons creates meaning, rules, resources and expectations. These symbolic resources are created through "Joint Action" (Blumer, 1969) or interactions which synergistically create meaning and recreate meaning. Meaning is interpreted by someone, and based on their agency, they take action. These "actions" create outcomes at the Micro level, which places Stigma as a mechanism at the Meso level impacting outcomes at the Micro level in line with Westhorp's (2018) description of mechanisms above.

Figure 76. ***Stigma — Interaction Mechanism on the Meso Level***



Stigma is a construct determined by the social world, and early interpretations by Goffman (1963) suggest it is a relationship between “attribute and stereo-type”. This implies persons attribute meaning to that which identifies differences between people and categorise people by type based on these assumptions. It is not then the difference, that is stigmatising, but the meaning implied by those ascribing difference. Goffman (1963) goes on to explain the importance of two types of social identity; virtual and actual. Virtual social identity is assumed based on the relationship between attributes and stereotype; for example, the identity of “bad mothers” (Hanmer and Statham, 1991). This differs to the actual social identity of someone who proves to hold certain attributes (woman, mother, substance use dependant) and belongs to certain categories such as a “mother who has a substance use problem”.

Expectations

Social identities are what the social world base expectations on and work cyclically creating and recreating meaning, rules and expectations through social interactions. When expectations are not met or deviate from the norm, attributes are allocated in the process of stigmatisation.

Critical interactionism accepts that interaction between two people are both influenced by social structure of stigma and are influencing social structure of stigma, which impacts the interaction between people. Several interactions have been identified by Goffman (1963) which are also evident in the interactions between the Macro, Meso and Micro levels in the study data.

Fear

Starting with a commonly experienced emotion, Fear is experienced in the interaction between woman and practitioner. Goffman (1963) explains there is prior fear of the interaction due to anxiety regarding the unknown experience of the social interaction about to happen. However, there is also fear of the known from prior experiences which lay the foundations of the expectations. This was clearly evident in the interactions between women and practitioners. Women spoke of many prior experiences when they have been stigmatised due to their substance use. This anticipation of stigma made them fear the interactions they would experience when engaging with the service.

> *I have had experiences in the past with social work, social workers can be good, but you can get ones that are wrong, that kids go in care that shouldn't be in care because they don't like you, I've been in care myself so I know this.*
>
> (Emma.)

Role-behaviour

Starting from a fearful position puts the person in the defensive cycle instead of the growth cycle and produces defensive behaviours in order to protect or shield from the stigma.

> *They referred me on somewhere and I ended up walking oot I ended up having a bit of an argument with the woman, she was just being pure patronising towards me, eh like so I just walked oot, they were trying to get me to go back but I've just been asking them to send my prescription back to my doctors.*
>
> (Sylvie.)

Sylvie's argumentative reaction is a response to feeling stigmatised and as a result, Sylvie rejected the support from this third sector recovery service. Assuming role-behaviour, or being "on" or "in action" compensates for feeling self-conscious and uneasy (Goffman 1963). It is easier to be defensive and play the game than to let down their guard and feel the implications of the stigma. Those who are doing the stigmatising also assume role-behaviour as this position of safety is constructed of rules and expectations they can rest on to play their side of the game.

Self-stigma

As stigma is a social construct of meaning and expectations, the person being stigmatised also holds constructed values. People use these measures to assess their own identity and can cause them to become shameful or "self-stigmatise" when they do not meet the social constructed expectations. An example of this was clear from the way women described being "a good enough" or "fit mother". These terms were referring to the stigmatising and socially constructed expectations of "fit mothering" (Hanmer and Statham, 1999).

> *This woman was quite cheeky the way she was sort of saying ken like "what a silly young girl you are getting involved in all these things" and she kept asking probing questions,*
>
> ***Right ok and how did that make you feel?***
>
> *It was just embarrassing like I was absolutely mortified cause (sigh) it's just really embarrassing…it's still embarrassing having to say it all, I have done this whilst I have been carrying a child, like I have used drugs or anything like that, it is degrading to start with.*
>
> (Katie.)

In Katie's case the experience of a mainstream midwife probing and patronising her about her identity as a mother with substance use issues made Katie feel embarrassed and shameful as she evaluated her behaviours against those expectations of fit mothers.

In addition to fear of stigma, and self-stigma, women also experienced other strains on their identity. Shame and low self-esteem were common, as practises of goal-orientated interventions, parenting capacity assessments and experiences of surveillance were all used within the service.

> *I felt I had to prove myself, like prove my kids were my number one, that I was going to go to every single appointment that was put my way and that I was going to keep clean and that, emm it was like I had to prove, prove that point.*
>
> (Jess.)

A byproduct of stigma is "othering", a further example of people's interpretation of values and meaning. This was clear when women reflected on their own drug using habits and how this positioned them as better or worse than others.

> *I just don't think all the people that are on drugs deserve to lose their kids… there are some people that are just doing it recreationally…then I do know loads of druggies who I wouldn't even leave my bairn even when they've got clean, and I know people that have never took drugs in their life, and they shouldn't have their bairns.*

(Katie.)

> *I hadn't been in that lifestyle with any of them or that but I just know by experience that some people are further on in their recovery than others.*

(Jess.)

Othering highlights how women identified themselves separate to the stigma they were experiencing and how they reached a self-determined moral standard, higher than other mothers. However, in return what this does is further create a socially acceptable yet stigmatising view of women with substance use issues. This lays blame on the individuals' morality and creates standards to be reached, therefore reproducing practices such as surveillance as experienced by women. This rhetoric embedded self-assessment and comparison and in some cases allowed some women to identify with aspects of stereotype at their discretion.

> *Yeh apparently women seem to come out [of drug use] in their early thirties and male forties and that is our ages so…we kind of fit the stereotype in that way we were sayin'.*

(Callie.)

Callie reflected on her identity in recovery and takes comfort in a sense of belonging. Goffman (1969) explains this as development of the stigmatised persons "moral career" and contributes to the development of their identity. This is highly relevant as Callie had taken accountability for her drug use and was given custody of her child as discussed below in Inter-being mechanism (Mechanism 4).

Lack of privacy

Stigma also causes a lack of privacy, endured by the stigmatised person. In terms of clients in the service, all women are identified because of their flaws and failures to reach the social expectations of motherhood. Because of these failures they are categorised as high risk and perceived as deviant, leaving their identity exposed. This continued lack of privacy is highlighted above in the form of surveillance, which is continually executed to manage the "risk".

> *They know what our house is like, they know how chilled out relaxed like, it's no an unstable environment emm, aye I felt like nothing was allowed to be private, do you know what I mean?*
>
> (Jess.)

Women's experiences of lack of privacy were expected and reluctantly accepted. Reflecting on the needs of their child and framing the risk with a wider societal view made some women accept the limitations they had within the situation.

> *I dinnae like daeing [toxicology screening] obviously cause it's like well why should I?...But I understand like I'm pregnant they have got to make sure…[no] drugs are in my system… so I dinnae mind daeing it now cause I've got nothing to hide, but if I had something to hide I would be…stand offish, and no[t] trying to meet them and cancelling my appointments and that but I've got nothing to hide.*
>
> (Rachel.)

Others felt strongly about the injustice they experienced however played the game to move forward in the process:

> *I have jumped, I have basically danced to the beat of your drum for months and months now, go 'n just give me a break and let me get on with my life.*
>
> (Jess.)

Agency

Identity is created based on these experiences, meaning and expectations of self and others. Internalised self-stigma, shame and othering create an intrapersonal environment to affect each woman's agency. Based on this stigma, agency is highly controlled by the victimised interpretation women have of themselves. This brings with it lack of control, power and options for action. Kleinman and Cabaniss (2019) raise the question: "What are people using their agency for?" (p. 125)

This is a valid question which I would add to: What *can* people use their agency for? Blumer (1969b, p. 85) argues that structures created through interaction, confront individuals with both opportunities and constraints, "The things which [have to be

taken] into account: tasks, opportunities, obstacles, means, demands, discomforts, dangers." (p. 331)

Therefore, in the case of mothers with substance use issues, each move and counter-move are laden with predetermined outcomes with the *game* stacked against them, there are obstacles at every turn.

> *Emm I didn't really want to [attend antenatal classes] but I was trying to do everything I could to look good to social work, hoping that I might get to keep my baby.*
>
> (Jo).

In Jo's case her fear of losing custody of her child forced her to attend antenatal classes. It was at these classes that she was offered drugs from a peer and subsequently relapsed. In further discussions with Jo, it transpired her abusive partner had been against her attending the classes. Therefore, Jo's actions were both constrained by power held in her relationship and power held by the service, implying her use of agency was significantly affected by obstacles, demands, discomforts and dangers. It is therefore no surprise that women employ defensive behaviours in response to this stigma. As highlighted by Gibb "Most people don't like to be dependent, to clutch, to be hungry, and to ask," (1991, p. 126.).

Therefore, survival tactics take over as women respond to a lack of self-esteem and self-worth (Hanmer and Statham, 1991). Goffman (1963) perceived defensive behaviour such as "bravado" and "cowardliness" in interactions as a result of unexpected or unpredictable interactions, however I would argue these behaviours are a result of use and capacity of an individual's agency. This is evident in Gibb's (1991) defensive process in strategizing, coercing and rebelling (Chapter 4 Table 12) of which many examples were noted in discussion with practitioners and women.

> *Sometimes mums just give up before it gets to that point [parenting capacity report]…So it's almost like they sabotage any chance of, because that's easier to deal with than actually being told that they can't have the baby.*
>
> (Practitioner Interview 1.)

What did you feel the other staff were like with you?

Treated me like I was just a random drug user and not like her mother

And how did that make you feel responding to that?

Just made me, didn't want to engage with them.

(Jo.)

In practice, service users' defensive behaviours were viewed as "sabotage" (Practitioner Interview 1) whilst in reality Jo's agency is constrained by stigma allowing her little choice but to respond by disengaging with the service. From both perspectives, the service user exerts defensive behaviours attempting to take some control over the situation.

Overall Stigma is a series of interactions based on meanings and values, which are experienced and internalised resulting in constrained agency producing defensive behaviours. This mechanism does not work alone and additional mechanisms attempt to counteract the process and outcomes of stigma which will be discussed in Interactions of four key mechanisms.

Figure 77. Mechanism 3: Stigma

Stigma – This theory highlights the reality of substance use and parenting and the unfortunate reality that despite practitioners' awareness, service users continue to feel stigmatised.

If women with drug and alcohol problems (who have low self-esteem and low self-worth due to histories of trauma), experience interactions with programme components, practitioners and the wider social context embedded in punitive and moralistic perceptions (C), then service users will be further disempowered and will respond with defensive behaviours and disengagement (O). This is due to service users' underlying interpretations of expectations, rules and resources, which produce meaning and experiences of Stigma: fear, self-stigma, lack of privacy, identity and role behaviour, contributing to constrained capacity to make free choices (M).

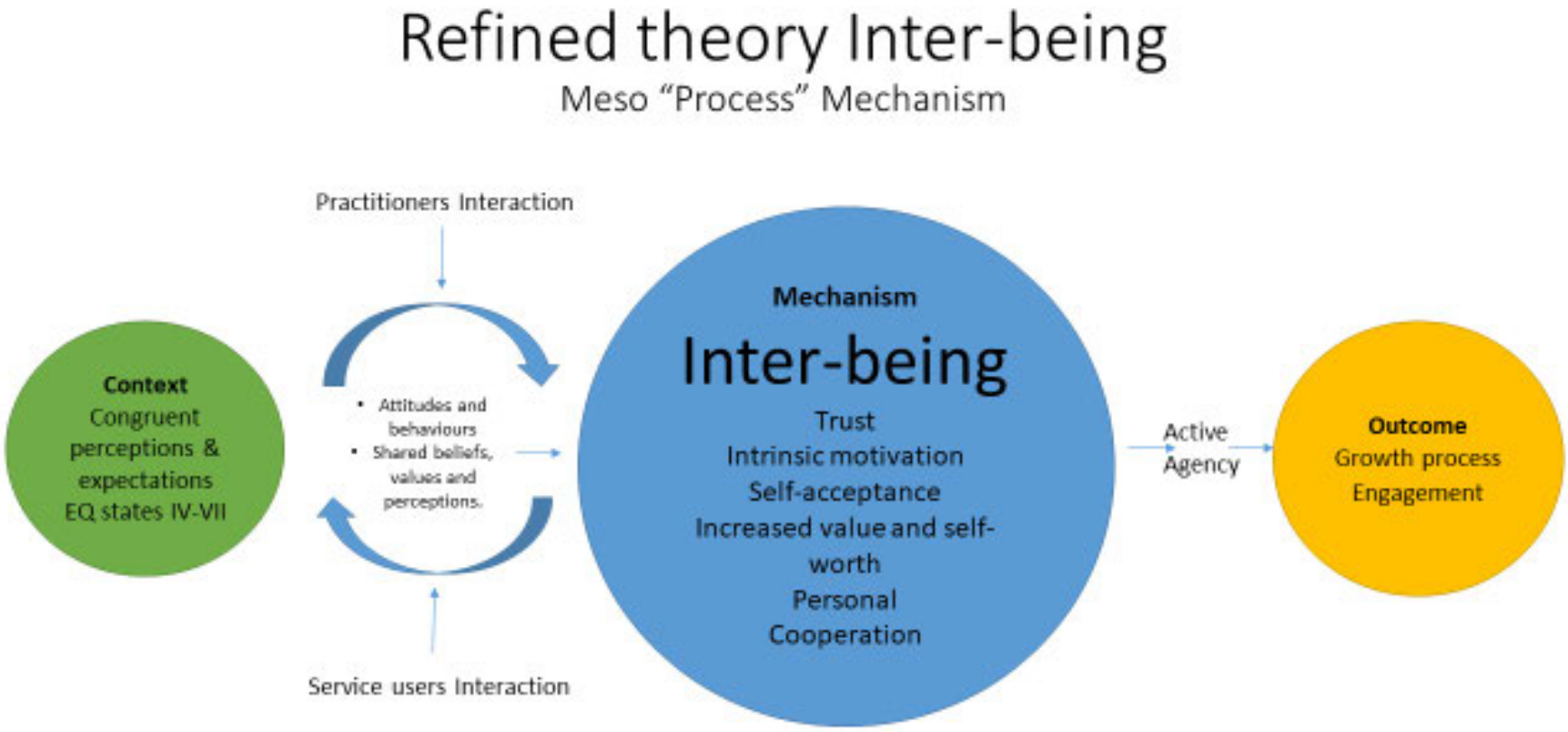
Practice Point: An overview of the fundamental principles and practices of the service should be considered from a service users' view point to reduce opportunities that may produce stigmatising or discriminative experiences for service users.

Mechanism 4: Inter-being – process mechanism at the Meso level

Construct of mechanism

The following description, (as depicted in Figure 78), describes Inter-being, as a process mechanism that works at the Meso level between the building of feedback and feedforward processes between practitioner and woman. The mechanism relies on previous elements that lay the foundations for subsequent process. Inter-being is highly dependent on high congruence between attitudes and behaviours, shared beliefs and values. Both attitudes and behaviours have to match and match that of the other person to build trust (Gibb, 1991). Inter-being is based on the EQ Participant and Emergent (Gibb, 1991) and requires Transparency mechanism to support its power in the overall service.

Figure 78. Inter-being — Process Mechanism at the Meso Level



This relational-based mechanism was evident in some form from the outset of theory building. Building therapeutic relationships (TR) was highlighted in the initial stakeholder interviews as key to engaging women in the service. During meetings with practitioner's the importance of open, and honest communication with clients and sharing information was considered essential first steps to building trust. Practitioners highlighted engaging women was a priority in order to provide a prescription of methadone to initiate harm reduction measures and attempt to stabilise the woman's drug use to reduce risk to the fetus in pregnancy. Although, because of fear women had of the service, building the relationship was a slow and sensitive process.

> *You have already overwhelmed her she is already really scared. You need to just go in and do a bit of that hand holding and saying look what, what do you need just now? What would help you just now to make things feel better and less scared? And just that very small step can sometimes lead to a more positive step in the future.*
>
> (Practitioner Interview 3.)

The term "therapeutic relationship" held different meanings for different practitioners depending on their practice area. However, women were clearer about the basis of relationships with staff.

> *I find it hard to trust people as well and I was always a bit scared to let people in but like [practitioner] and that just made it really easy, and they were always there if I wanted to chat or that, she said if there's anything, ring me or text me and I will ring your straight back, yeh so it's been all positive.*
>
> (Louise.)

Trust was continually raised as a key concept in the interactions between practitioners and women. Women reported starting to *trust* practitioners over time, or began to *trust* practitioners if they had reason to. However, there were also situations when *trust* was lacking between women and practitioners or *trust* was broken.

> *There was issues that came up… about health stuff, and it was put in a text and it was sent to the wrong person and it was sent to somebody else and it was*

> *meant for me, and I know who it was who got the text and it was really intimate stuff.*
>
> (Jess.)

Jess describes an incident when her trust in the service was broken due to the actions of a practitioner. This experience resulted in a cautious response to the service and a feeling of overall disrespect. Trust Level Theory explains that the EQ scale is directly related to the motivations or abilities someone has to build trust. It was clear EQ was related to the individuals' level of trust and therefore the extent to which their relationship with the practitioners would contribute to the outcome of engagement.

> *I think she knew having someone there to speak to, cause she had no family, she had no one, she was isolated, so I think just having that person she could come to.*
>
> (Practitioner Interview 3.)

In this example the practitioner used open communication, dedicated time and evoked active listening building a safe and encouraging environment for trust building and subsequent engagement.

Engagement as a first outcome has subsequent linked outcomes of behaviour change. Engagement itself, required elements of behaviour change or "personal growth". I use the term "personal growth" as I interpret behaviour changes as a growth process dependent on prior experiences, beliefs and values. This growth process is the conceptual mechanism of Inter-being which relies on feedback and feedforward processes. Triggering the growth process (Figure 74) depends on certain contexts and certain procedures. As highlighted by Gibb (1991) Inter-being is the process or exchange in trusting relationships between persons based on congruent perceptions and expectations.

> *Explaining our role and saying yeh we have a job to do but also we are here as a support for you and to make sure you're ok and I think its building that trust and building that relationships, I think you get so much from that.*
>
> (Practitioner Interview 3.)

Shared beliefs, values and expectations

Beginning with a perception of support whereby practitioners approached women in a non-discriminative way, women perceived this support as genuine, felt accepted, and began to accept and present their own authentic self, stepping away from the surrounding stigma.

> *It was hard for me, cause it was facing myself for what I was daeing, I was blaming everyone else when it was really me, so it was hard at first but when I opened up to them and was honest saying look I'm still taking but I'm not taking as much as you think , cause at first I wasn't telling them how much I was taking but they were just getting dirty tests all the time.*

(Emma.)

Following expression of self by the service users, practitioners responded and communicated in open and honest ways, were transparent in their information sharing and were open to listening to women. These actions from the practitioners resonated with women who interpreted them as personal (non-stigmatising) and empathetic, increasing their sense of value and self-worth. Therefore, their response was also to be more open in their communication, show more of themselves to the practitioner and let their guard down. This rapport building through interactions is how trust builds over time and through actions of trust.

> *If they're struggling. I don't want them to be alienating me. I don't want them not to like me. I need to…you know, I need to be friendly and compassionate and listen to them and give them a voice. I think that's really … key, because if they don't think they have a voice and they don't think that I will listen to what they say they're not going to come to me and that increases the risk for these really really vulnerable children, so the relationship is key.*

(Practitioner Interview 7.)

Self-acceptance

Reaching a further level of relational-based interaction in the growth process involves realisation of "wants" (Gibb, 1991, p. 15). This assertive awareness is evident in some of the women's accounts of their experiences with the service. Accountability is the

term used by both practitioners and women when describing a shift in perception and behaviour. Those who describe being "held accountable" (Morven) demonstrate their position within the growth process. Those with accountability were more likely to make changes in their behaviour which was aligned with the expectations of the practitioners and the wider service.

> *[Practitioners] hold you accountable as well emm and you don't want to let them down because you make a bond with these people, well I did cause I don't have friends and family so it was really good support for me at the time. And you like don't want to, [let them down] when they are putting faith in you.*
>
> (Morven.)

These interactions were markedly different to those in the defending process (Gibb, 1991, p. 19) as defensive actions and behaviours are expressed in the form of Depersonalising, Closing, Manipulating and Depending behaviour (see Chapter 4, Table 12). Those not making this shift in the growth process became stuck or retracted from growth process into resistance process (Figure 79).

Figure 79. Outer-inner Resistance Process

Note. Adapted from Gibb (1991)

> *I suppose it's good just to have these other…these workers, knowing that they're to help you and listen to you and there to support you, but as I said, I've not started the relapse prevention yet, but that's not one person's fault, that's actually my fault as well, because obviously there's been a couple of appointments that I've not turned up at, so that couldn't be blamed on the drug worker or anything, that's my fault. I maybe would have started it by now, and as I said, although it is down to like me, so it's like, I can't totally pin it on them, can I, but I suppose it's good to just have them and know that that is what they want for me and stuff like that, so aye.*
>
> (Katie.)

Katie began to build relationships with practitioners and appreciated the support knowing someone was there for her however, she had still not reached a sense of *actualising* (Gibb, 1991) where she took action. Katie begins to show accountability through her reflections on her actions such as missing appointments and recognises her responsibility, whilst she remains stuck in the growth process, failing to foster intrinsic motivation to change her behaviours.

Intrinsic motivation

An intrinsic motivation is released through the relational interaction between the practitioner and the woman and results in an interdepending relationship. The relationship itself becomes a propeller for increased self-esteem, self-belief and ultimately trust. An example of this was noted in women who had custody of their child at point of interview and were engaging in third sector groups to support their recovery and parenting.

> *I suppose they're just like supporting me with anything that I need supported with. They do stuff on depression, anxiety and stuff – they do quite a lot of courses so I can get involved in them if I want when like I'm ready to get involved.*
>
> (Callie.)

Callie showed low self-esteem and lacked confidence however through building trusting relationships with practitioners her self-esteem increased and at point of

discharge from the service she was attending toddler groups. Emma and Louise who also had custody of their children at point of discharge were actively involved in the recovery community attending SMART groups.

> *So I started [going to recovery groups], instead of being in the hoose taking drugs all the time I started going out and daeing stuff so I gradually started doing things and it changed the way I was thinking.*
>
> (Emma.)

Goal setting was a large part of the service approach to encourage behaviour change. Goals were outlined in planning meetings with social workers, parents and practitioners and recorded in the Child's Plan. These related to drug use, life style, and even administrative tasks such as registering with a GP. These goals were used to encourage women's commitment and accountability to themselves and the process of preparing to be a parent. For those who had built trusting relationships with practitioners, intrinsic motivation was activated as outlined above however for those who were struggling to progress through the growth process, goal setting did not have the same effect. Gibb (1991) explains how the significance of the motive behind goal setting can impact on the activation of intrinsic motivation: "Work that is arbitrarily assigned…unrelated to inner goals…given punitively is resisted by most people" (Gibb 1991, p. 236).

For women who are not fully immersed and committed to the goal setting itself and felt the goals were not aligned with them, did not succeed in reaching them. This however is related to their interpretation of the motive behind the goal setting itself, such as in the case of Parallel Planning.

Due to structural elements, the EQ state is not always prepared for nurturing mechanisms evident in the "Emergent, Organic and Holistic" state as described by Gibb (1991) in Chapter 4, Table 10. For instance, if the process of relational interactions started with the perception of surveillance instead of support; women would believe practitioners to have predetermined roles and motives. Actions would be interpreted as strategic and controlling and not genuine or personal as seen in the mechanism Stigma.

> *It's not like I've lied about it [childhood trauma], I've just not mentioned it, it's a really personal big massive thing, so I just feel like maybe just telling them that, because I always feared they would use it against me, but the social worker assured me no, so maybe just opening up a bit sort of thing might help. I suppose it's worth a try really, eh?*
>
> (Katie.)

An example is EQ II. and III. Autocratic and Benevolent states where role-behaviour is commonplace to exert control and power. Role-behaviour was present in many aspects of the service across both practitioners and women, however the circumstances around this behaviour altered the power it held to affect the growth or resistance processes. Whilst practitioners tried to maintain a holistic family approach to support women in the postnatal period, the overarching child protection agenda left women feeling they had to prove themselves to practitioners. All women felt they were proving themselves to be "good mothers" however, the structure and processes involved for women with children in care settings made them feel they were under surveillance whilst the majority of those with baby at home felt they received support. This affected the way women exerted agency, interacted with professionals and their own self-awareness. Women who perceived they were under surveillance, did not feel able to disclose to professionals their weaknesses, instead of being open and honest about their limitations (Figure 74), they would distance or mask as illustrated above by Katie's quote (Figure 79). Practitioners explained this as a contentious issue as practitioners perceived women asking for help as positive examples of self-awareness and accountability however, women avoided this in case of child protection repercussions.

> *It is ok to ask for help and that is the bit we are trying to focus on and it is not a weakness and I think we are all, well I do emphasise the importance of being honest and if you need help it is ok to ask for it. And the child protection side of things yeh things do come in, I would like to think, working openly and honest with professionals is key to what we do and I think parents should be really empowered to take ownership for their feelings and not rewarded but be respected and we should take that into account.*

(Practitioner 6.)

However, those who felt more supported by practitioners were more confident in exposing or identifying their needs to professionals remaining open to disclosing their limitations. This is an example of the effects of genuine trust versus contingent trust (Gibb 1991). For women experiencing contingent trust, the power held by the child protection agenda directly related to the woman's abilities to seek support, highlighting ways in which woman's agency is influenced by structure and further impacts inequalities.

Inter-being is a process mechanism of co-ordinated, responsive relational interactions which are wholly personal. In the right nurturing conditions or context, Inter-being can play out over time generating personal growth and evidence of behaviour change. However if the conditions are not right, Inter-being may be stuck in process or reverse due to its feedback, feedforward process.

Figure 80. Mechanism 4: Inter-being

Inter-being – This theory demonstrates the significance Relational Based Practices have on trust building, engagement and personal growth of the individual.

If a practitioner and a service user hold congruent perceptions and expectations (C) then Relational-Based Practices will build trust between practitioners and service users through a process of *Inter-being*. *Inter-being* is a process of connection between two people (practitioner and service user) which fosters: trust, intrinsic motivation, self-acceptance, increased value and self-worth, sense of being personal and co-operation (M). This supports both practitioners and service users' capacity to make free choices. Trust building over time and demonstrations of trustworthiness supports engagement and intrapersonal growth processes (O).

Practice Point: To support service users to engage in services, priority must be placed on Relational Based Practices and practitioners should be encouraged to be personable in their interactions, and not mask behind their professional

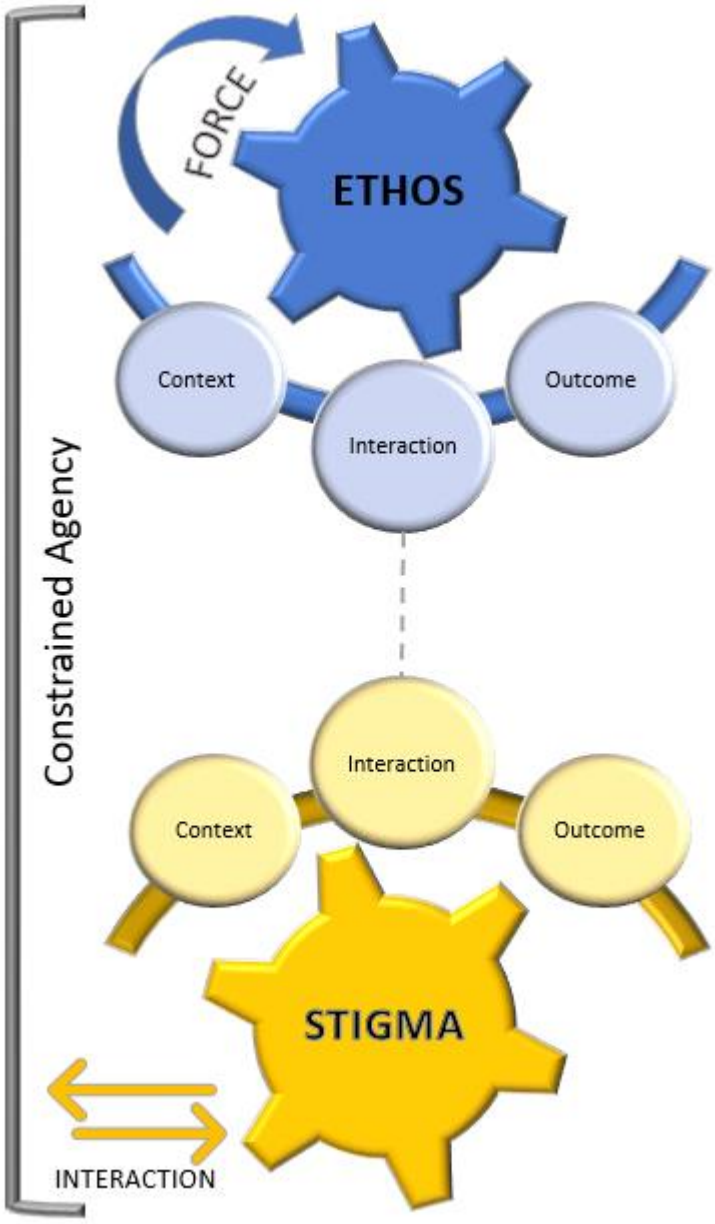
Interactions of four key mechanisms

In the following section the four key mechanisms outlined above: Ethos, Transparency, Stigma and Inter-being, will be discussed with examples from the IPPSS to illustrate in what ways they work in "concert and competition" (Westhorp, 2018. p.50) with each other. Mechanisms do not function individually; they interact with each other further contributing to intended and unintended consequences.

Ethos interacting with Stigma

Ethos and Stigma, produce constrained agency within practitioners and service users (Figure 81). As outlined above in the descriptions of these two mechanisms, both produce defensive behaviours in practitioners and service users. Ethos functions as a force mechanism channelling motives, strategy, constraint and role-behaviours in individual practitioners and practice. These elements of Ethos impact the interactions between practitioners and service users as they affect the meaning, expectations, rules and resources which trigger Stigma as an interaction mechanism. Ethos continues to function as a force on the Macro level of the service producing outcomes at the Meso level. Whilst Stigma functions at the Meso level producing *situational constraints* within the service: a form of constraint laden with external factors and power.

Figure 81. ***Ethos Interacting with Stigma***



Ethos and Stigma interacting with Inter-being

When practitioners then interact with service users they may be unaware of the situational constraints which are affecting their own agency as experienced in Ethos (producing motive, strategy, constraint and role-behaviour), and enter into interactions with service users unaware of the power these constraints have on the individual service users' agency. Ethos' functions then interact with the service users' experience of the service and the abilities they have to begin to form relationships with the practitioners. In this case, Inter-being cannot be activated as the context is incongruent perceptions and expectations as service users perceive practitioners to have motive and strategy controlling their actions.

When the dominant response is constrained agency through the interactions of both Stigma and Ethos, counter pressure of Inter-being may be lacking in order to change the outcomes. As seen in cases of service users who face multifaceted problems, the situational and emotional constraints, influence engagement in relational based practices (Figure 82). An example is of this interaction is outlined by case study 3 (Figure 83 and Figure 84).

Figure 82. ***Ethos and Stigma Interacting with Inter-being***

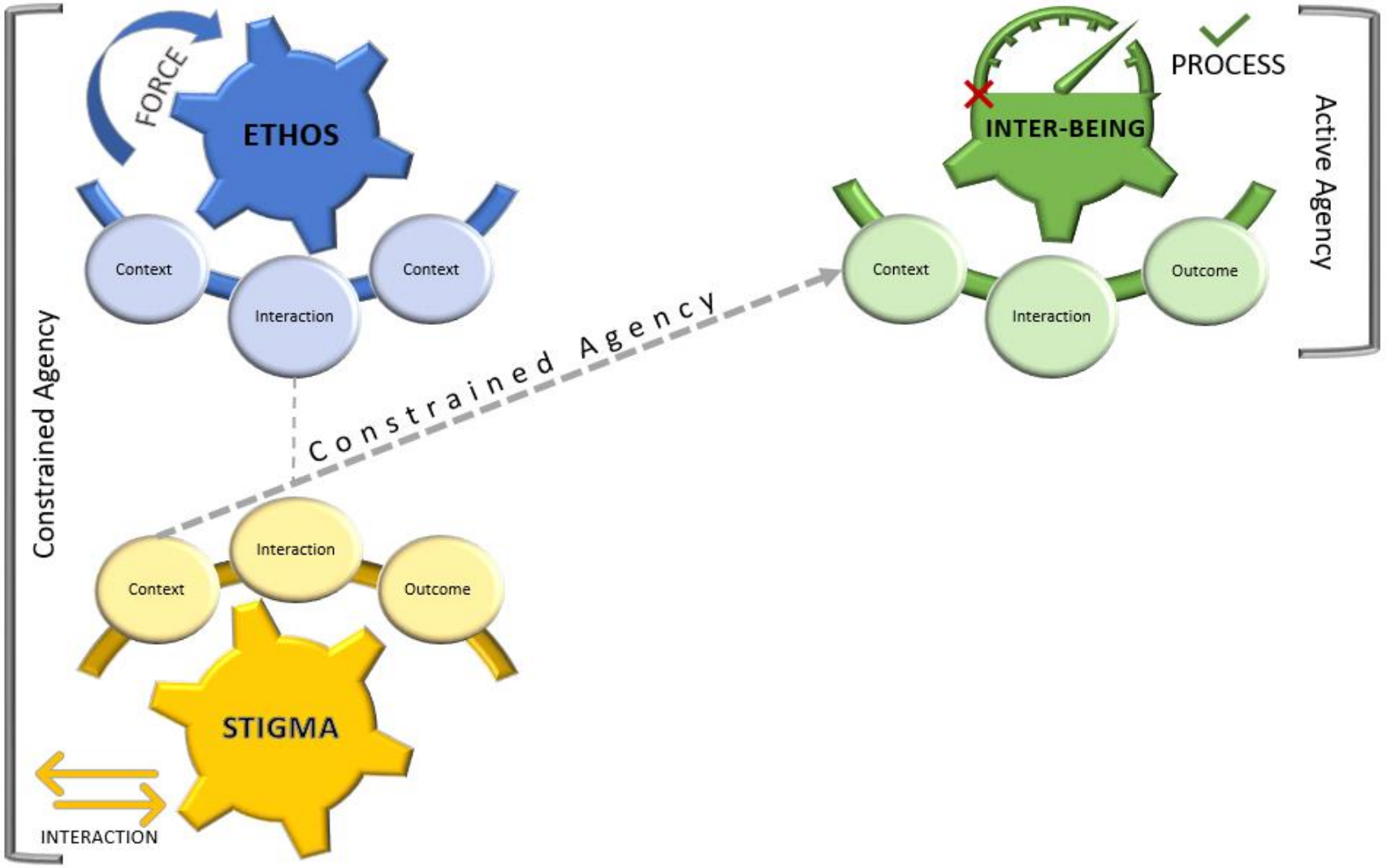


Figure 83. Case Study 3 Example of Mechanism Interaction Ethos-Stigma-Inter-being

Katie is a mother of three. When I first met Katie, she was pregnant with her third child.

Katie was not in a relationship when she became pregnant and lived alone. Katie was going through parenting assessment and recovery from drug use, which had resulted in increased access to her child. This access allowed Katie to see her child unsupervised and she was expecting to have custody of her child again.

Katie then found out she was pregnant, which came as a shock to her as she had taken emergency contraception. She didn't want to be pregnant however, her family's beliefs and values around pregnancy strongly influenced her decision to continue with the pregnancy. Despite having attended several distressing appointments, pursuing a termination of the pregnancy, Katie decided in her second trimester to continue with the pregnancy.

It was as a result of this increased stress of considering a termination or having another baby at the same time as dealing with the possibility of reunification with her second child, that Katie relapsed. As a result of the relapse Katie's parenting responsibilities were removed.

Katie recalls the moments she lost access to her daughter:

> *I was having my daughter unsupervised for like four hours and then one morning at seven o'clock it just got pulled away fae me, like I had nae warning that this was going to happen so I mean, it just wasnae good and I was quite unwell with the pregnancy.*
>
> (Katie.)

This contextual background is vital to understand Katie's experience with the service. Katie's many years of substance use and two previous pregnancies have resulted in many experiences with different recovery orientated support and child protection proceedings. At a point when Katie was beginning to show stability in her drug use, circumstances resulted in a relapse. Relapse is a common and considered normal part

of recovery (National Institute on Drug Abuse, 2019). However in the context of this service, Ethos and Stigma continue to function at EQ States I-III (Punitive, Autocratic and Benevolent) meaning relapse is considered evidence of a lack of stable parenting and therefore Katie is unsuitable for reunification with her child.

Figure 84. Case Study 3 Example of Mechanism Interaction Ethos-Stigma-Inter-being

When discussing support networks and working through the Eco-Maps and Genograms, Katie relayed painful concerns that her family would abandon her if she were to lose custody of her children. This mounting pressure was emotionally overwhelming for Katie as she became tearful, discussing the prospects of her life, without her mother and as a mother losing her own children.

> *I do have the most supportive family I could ask for, but I cannae blame my mum for saying like basically I am going to be out the family if (child) gets adopted, she cannot bear the thought of (grandchild) getting adopted, so that's hard to think that like I have had that (mum) all my life and then if my (child) gets adopted that's going to be hard enough, but then I won't even have a mum (tearful).*

(Katie.)

For Katie the experience of all supports and parenting responsibilities being removed further drove her drug using tendencies, acting as situational constraints as she lost hope of being reunited with her second child and mounting family pressure functioned as emotional constraint, further depleting her self-esteem. The mounting pressures Katie experienced at this stage including guilt, family pressure and low self-esteem laid the foundations for her individual context going on to affect how she perceived and received the service and the level of constraint affecting her use of agency.

The context present in Inter-being which activates the mechanism, functions as a dimmer switch. Incongruent or congruent perceptions and expectations activate levels of Inter-being, meaning Inter-being can be functioning to different degrees depending on the context. This requires time and evidence on both parts of practitioners and service user and can retract completely, ceasing the mechanism in some cases. This

was evident in the case of a service user (Jo) who became completely disengaged with the service after her parenting capacity assessment concluded recommendations against reunification with her child, (Figure 85).

Figure 85. Interview 4 Example of Mechanism Interaction Ethos-Stigma-Inter-being

Jo reflected on her relationship with the parenting officer, Jo did not trust her judgement and did not believe she wanted her baby to return to her. Jo felt the service had given up on her and was not supportive of her personal needs and aims. This further affected Jo's perceptions of the service, and overall Jo now believed that the service would more likely than not, place children in permanent custody. This further affected Jo's perceptions of the service in future potential pregnancies as Jo suggested she would conceal future pregnancies to prevent being referred to the service

> *If I fell pregnant again I wouldn't want…I would avoid going to the doctor to stop having to engage with [service].*
>
> (Jo.)

However, in many cases the more interactions practitioners and service users had through relational-based practice the more trust began to build. Over time and with evidence from each other, trust building in practitioners and service users increased both service user and practitioner's agency, counteracting the constrained agency produced by Ethos and Stigma.

The following examples (Figure 86), of Katie's interactions with two different practitioners demonstrate the move towards congruent perceptions and expectations between Katie and the practitioners

Figure 86. Case Study 3- Example of Mechanism Interaction Stigma-Ethos-Inter-being

At the time of our second interview Katie had begun to develop relationships with practitioners and we discussed the practitioners' role and relationship. Katie reflected on the importance of a kind and supportive figure in the parenting officer as she felt this role supported her both emotionally and practically. She spoke of a time when the parenting officer helped her and her mother during the discharge from hospital and expressed the practitioner went over and above her expectations, included her mother in her holistic approach. This detail was of great importance to Katie and reflects the importance Katie placed on her parents' expectations and values.

> *The midwife came and the parenting officer, they both came to like the discharge meeting you get before you leave, like you and the baby get before you leave. They came to that, they were really good, but in particular, the parenting officer, she was really good, she actually like took me home and took my mum home as well, and I had like bags and bags of stuff, and she helped with all of that…she was really, really nice and helpful, and even with my mum as well.*
>
> (Katie.)

Figure 86. Continued

Katie spoke of the professionalism she experienced with her drug worker and how she increased her value and respect for the drug worker when she knew she had previously worked in a rehab facility. Katie reflected on her own recovery journey and expressed many times that she felt rehab should be an option to support her longer-term recovery. Knowing the practitioner had worked in a rehab facility allowed Katie to put more trust in the practitioner and more faith in her abilities to help her recover from her drug use. Again Katie's values were expressed when reflecting her mother also had trust and faith in the practitioner's abilities to help Katie.

> *She sounds like she actually knows what she's talking about, so…*
>
> ***So you think that you have confidence in her, in her abilities as a drug worker?***
>
> *Aye, more so in the past few weeks. As I say, I know it sounds bad, but it was literally when she told me about her working in a rehab…even my mum said that, and my mum's never even met her.*

(Katie.)

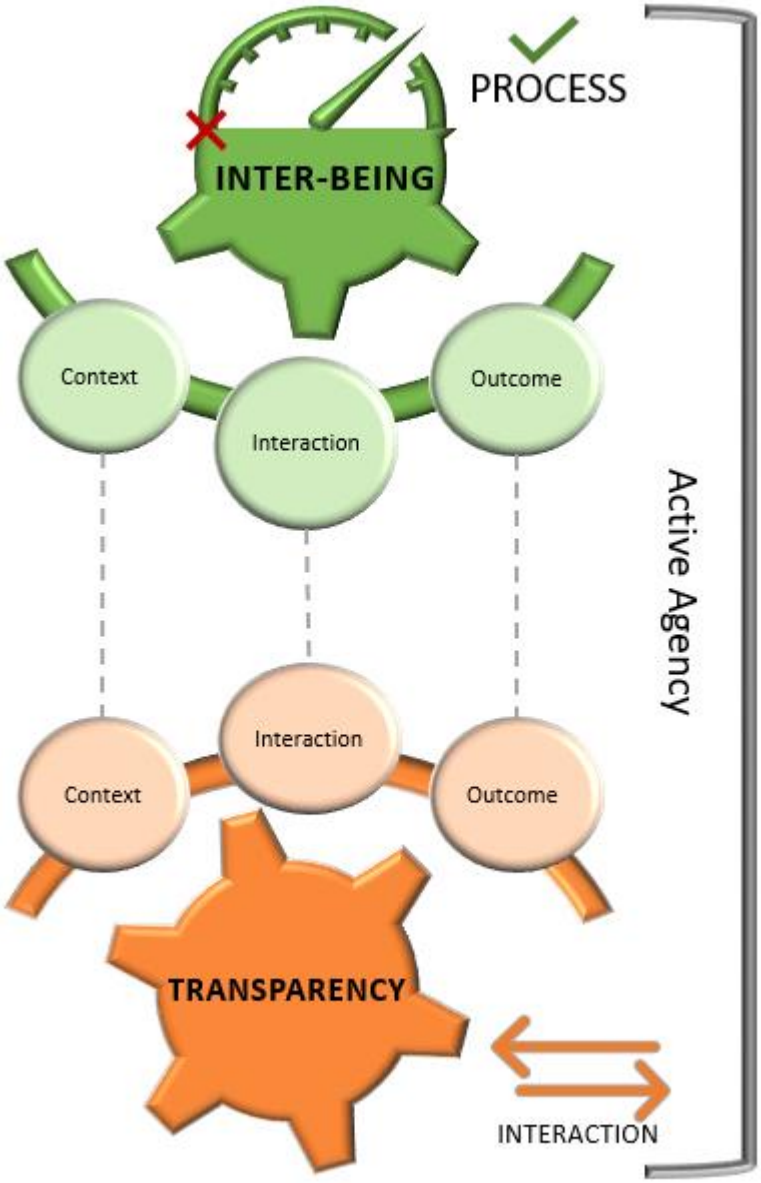
This change in context triggered Inter-being, increasing Katie's trust in the practitioners, belief in their abilities to support her and fostered motivation in Katie to continue to engage with practitioners. This process of feedforward and feedback steps (Westhorp, 2018) increased Katie's agency and therefore contributed to her growth process.

Transparency + Inter-being

Transparency and Inter-being mechanisms are both activated within EQ states IV-VII (Advisory, Participatory, Emergent, Organic and Holistic) (Gibb, 1991) and provide practitioners and service users to respond with active agency (Figure 87). Both mechanisms require authenticity and trust in self and others and work through processes or interactions between mechanistic elements to increase agency.

Transparency and Inter-being are both affected by Ethos and Stigma which can constrain their use of agency and stop or retract the growth process.

*Figure 87. **Transparency Interacting with Inter-being***



Transparency + Ethos

Transparency and Ethos begin with opposing contexts and result in opposing responses. Transparency is based on mutually aligned professionalism whilst Ethos is based on incongruent policies and practices. However when highly skilled and experienced practitioners who hold abilities in critical self-reflection work together with invested leaders in co-located space and over time, Transparency begins working against the overarching incongruent Ethos and begins to foster a compassionate working culture within the integrated team (Figure 88 and Figure 89).

Figure 88. ***Transparency Interacting with Ethos***

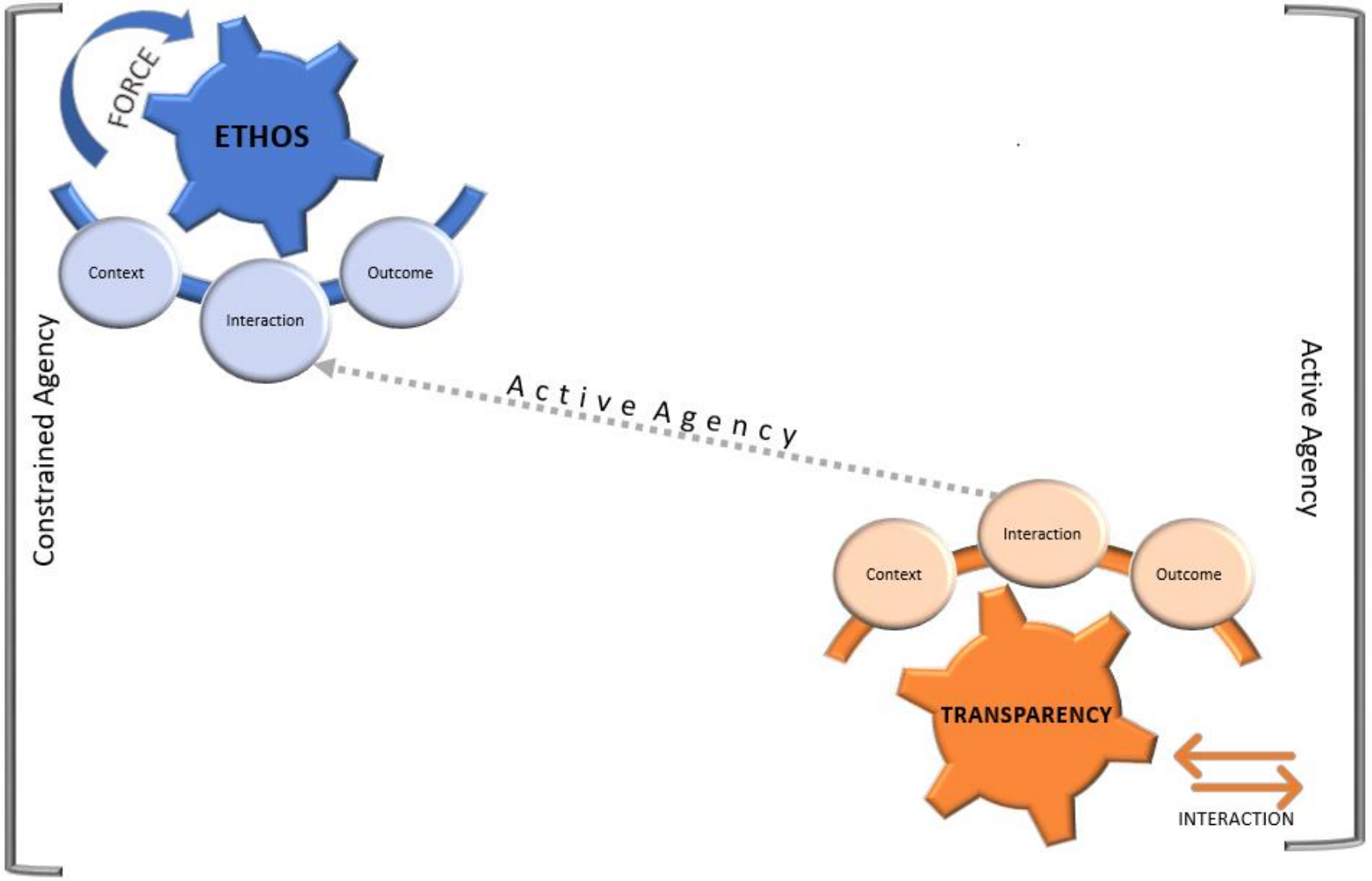


Figure 89. Extract from Theory Testing Phase Two- Transparency Interacting with Ethos

Practitioners described the practice environment as "challenging and gruelling" and their reliance on their colleagues to offload. All practitioners acknowledged it was essential to manage their own stress and wellbeing and utilised the co-located space to turn to their colleagues for support. These opportunities in the co-located space supported the development of working relationships and allowed practitioners to support each other in difficult or challenging times.

> *So I think coming into an office and having that base that you can come in and you can offload to your colleagues I think that is really important for our own well-being and our own mental health to actually have that base and there is most likely going to be someone to speak to or to offload on.*
>
> (Practitioner Interview 3.)

Practitioners who are open and honest with each other, step into their authentic self. The act of confiding in each other presents the practitioners true self and counteracts the strategic approaches seen in Ethos. These moments of interpersonal connection, foster equality and authenticity in the individual and the collective team. These interactions are further outlined below, as leadership within the team is approached in a personal and compassionate manner (Figure 90). Practitioners not only appreciate this personal investment from their manager but the manager themselves views this as a model required to manage situational constraints imposed by structural issues e.g. funding, training.

Figure 90. Extract from Theory Testing Phase Two- Transparency Interacting with Ethos

> Most practitioners felt encouraged and motivated by the team leader's actions, be that setting aside time to supervise individuals or investing in individual development. Through praise and recognition practitioners felt respected in their role by the team leader but also worthy of a place in the team.
>
> Specific resources were in place to foster a culture of compassionate team work including lone worker policies, management and peer supervision and plans for self-care assessments.
>
> *Supervision regularly for everybody on a frequent basis… self-care assessments at the moment as well for staff to look at their model of self-care within the workplace. Identifying and realising when people are stressed and what that looks like for them.*
>
> (Practitioner Interview 10.)

Relational functions of Transparency attempt to activate and to a degree succeed to activate relational approaches focusing on the growth of the individual and the collective. This differs from the structured approach directed by Ethos, which is based on the regulatory EQ states I-III (Punitive, Advisory and Benevolent) (Gibb, 1991). However differences in funding and opportunities across the agencies within the MDT meant not all support was equal. These incongruent approaches (present in the context of Ethos), constrained agency within the MDT pushing back at the Transparency mechanisms functions. This returns the mechanism cogs back to the start with Ethos' force producing pressure once again on the entire mechanistic functions of the service (Figure 91 and Figure 92).

Figure 91. ***Four Mechanisms Interacting***

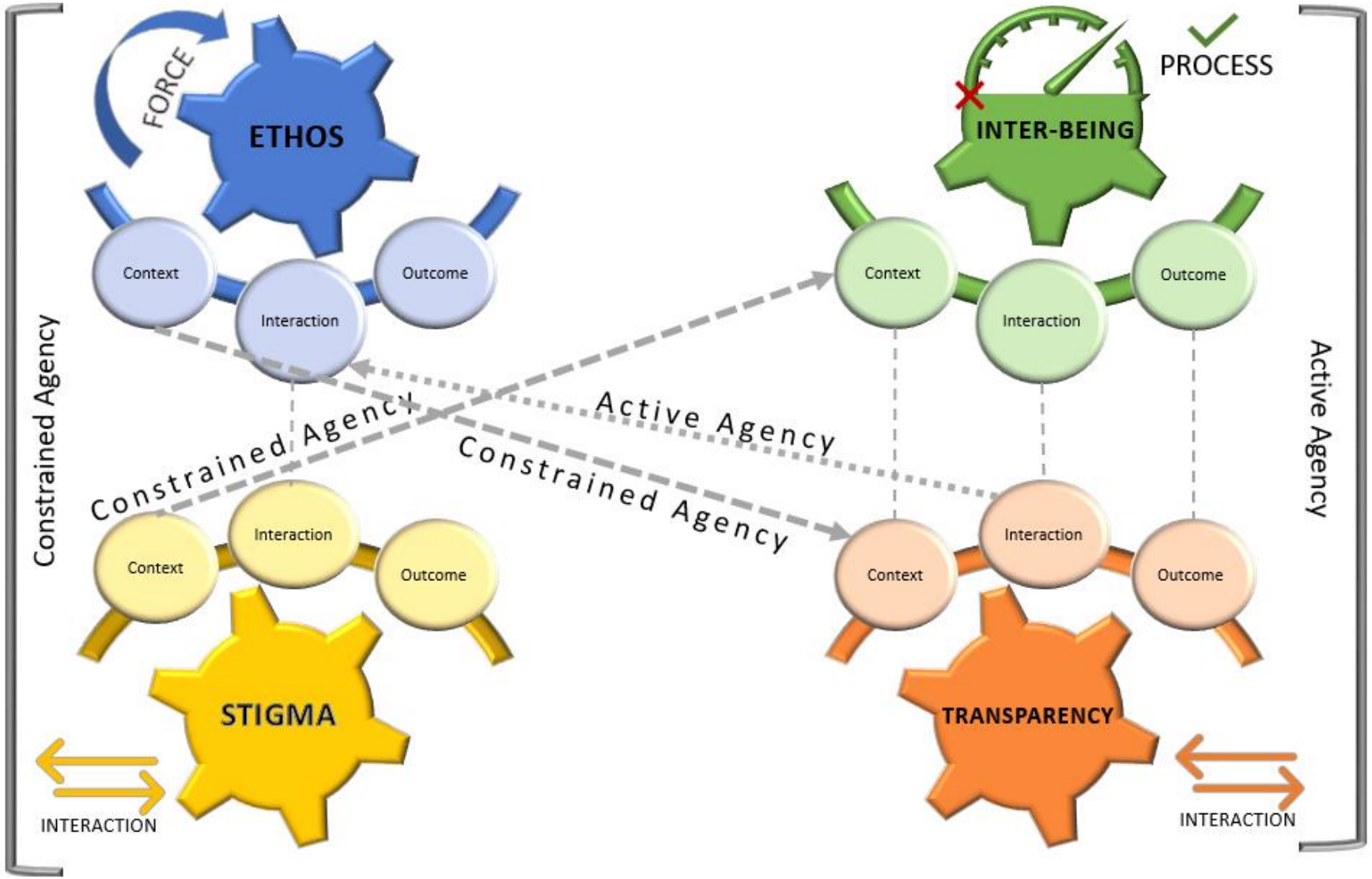
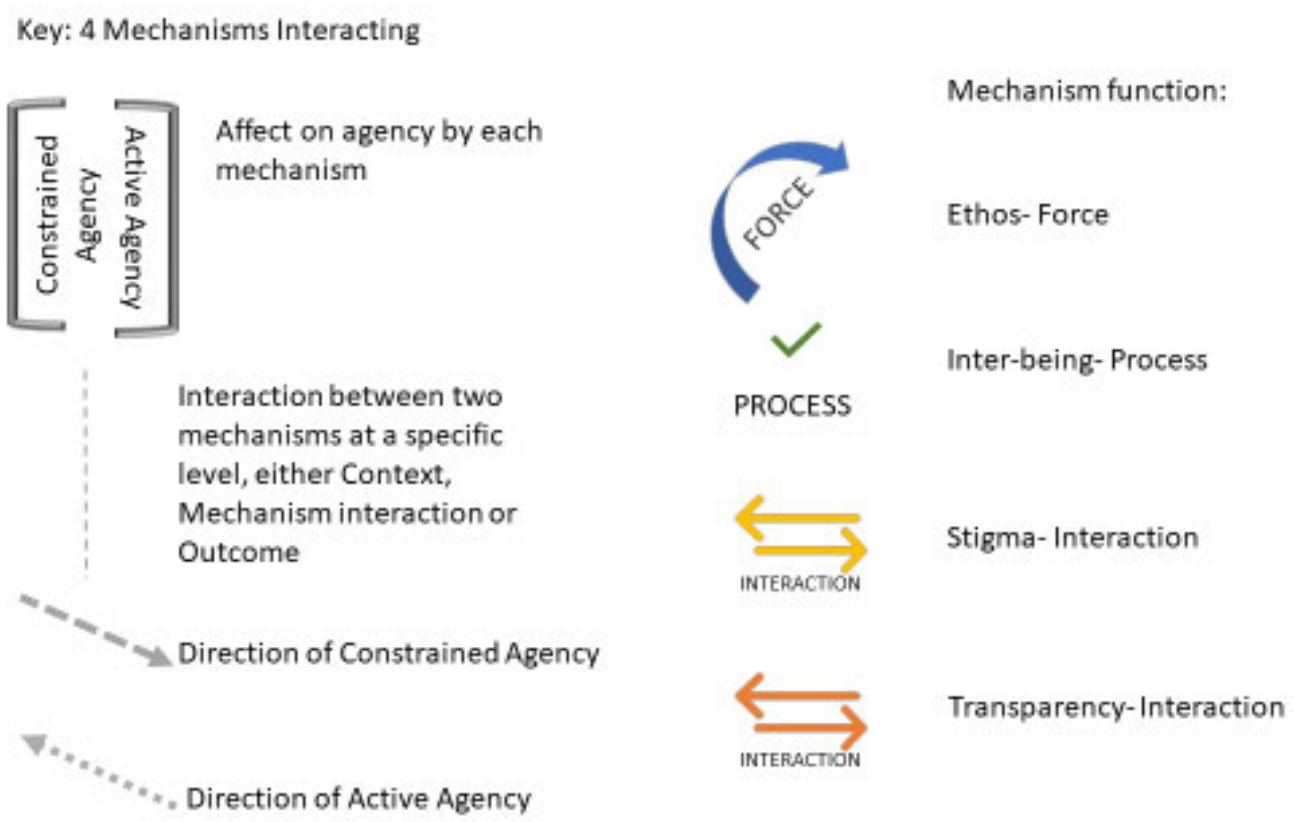


Figure 92. Diagram Key – 4 Mechanisms Interacting



Gibbs (1991) highlights the importance that social interventions must be congruent in Structure, Content and Process (p. 77) in order to flourish organically. Incongruence as highlighted above prevents, retracts or stops the growth process in the individual and the relationship, as this misalignment constrains agency.

Despite incongruent policies and practices, employing an integrated MDT model within a co-located space improves patient focused care, communication across agencies and further integrates services for this vulnerable population. To improve this further would be to align policies and practices across the service, moving to EQ states IV-VII (Gibb, 1991) (Advisory, Participatory, Emergent, Organic and Holistic), activating practitioners' agency and increasing collegial practices.

Chapter 8 Discussion

This chapter will critically appraise the findings from this realist evaluation and how these apply to wider research and practice. Initially I will summarise the key findings, demonstrating how these answered the initial research questions before expanding on key concepts and critically reflecting on the importance of wider relevance. I will situate my findings within wider critical thinking on the care of women who use drugs and, demonstrate how my findings inform and develop existing theoretical models and conceptual understandings of integrated care for pregnant women with alcohol and drug problems, more broadly, marginalised women with complex needs. Recommendations for further research and implications for practice will be outlined followed by a critique of the strengths and limitations of the study. Finally, this chapter will conclude the discussion of the transferability of my study findings and demonstrate my contribution to knowledge.

The role of integrated programmes for pregnant women with substance use issues

At the start of this thesis, I demonstrated how the existing evidence on integrated services for pregnant women with drug and alcohol problems provide a clinically justified approach to holistically address the health and social impacts of substance use in pregnancy. Systematic reviews and meta-analysis have reported a range of positive outcomes associated with integrated services such as improved parenting (Niccols et al., 2012, Moreland and McRae-Clark, 2018) reduced substance use (Milligan et al., 2010) and improved neonatal outcomes (Milligan et al., 2011). A further review of the background literature on multidisciplinary services for pregnant women with drug and alcohol problems (see Chapter 2 Literature Review), found some evidence that an integrated approach to service delivery, improved health and social outcomes for mothers, children and the wider family. However, missing from the evidence was a more in-depth and critical understanding of “how integrated services worked” to improve outcomes (or not) and how these specifically manifested in the local Scottish context.

Answering the research questions

A realist evaluation of a local multidisciplinary team was conducted to critically evaluate "what works, for whom, in what respects, to what extent, in what context and how?". Through realist methods this evaluation has focused on unearthing the unknowns of how the IPPSS worked. Answering these how questions required extensive iterative approaches to data collection and analysis. By applying multiple lenses, I analysed the data thoroughly to "test" theories of how and for whom the service works. This has resulted in a complex picture of connected elements which work for and against each other, contributing to the workings of the IPPSS. The findings of this evaluation identified that when services are provided in an integrated way with multiple disciplines, several aspects of the health and wellbeing of woman, child and wider family, can be addressed. However the extent to which these improvements are achieved are limited in certain circumstances. Four key mechanisms (Ethos, Transparency, Stigma and Inter-being) were identified to be working in concert and competition to contribute to the outcomes. Figure 93, Figure 94, Figure 95, Figure 96, and Figure 97 summarise the key research findings.

Figure 93. Key Research Finding 1. Co-location

Co-location

The evaluation aimed to test how co-location of the MDT practitioners could improve outcomes for the service. The findings show:

- Co-location improves integration of the team and supports meeting the clients' individual needs.
- By providing informal and formal opportunities for practitioners to communicate, practitioners can identify their role within the team, increase their own confidence and greater understand their client's experiences.
- However due to the challenging practice area and limited office resources, practitioners are required to be flexible in their working approach, encouraging in the moment communication (phone, email). Whilst this may reduce face to face communication, structured regular meetings in the co-located office continue to offer this option.

Figure 94. Key Research Finding 2. Leadership and culture of compassionate teamwork

Leadership and culture of compassionate teamwork

- A strong leader who is compassionate and transparent was found to improve team working, staff morale and retention as their presence in the co-located space provided "visibility" of leadership.
- By being present the team could rely on their leader to offer formal and informal support, praise and recognition, encouraging and motivating practitioners within the team.
- A culture of compassionate teamwork was fostered by the practitioners through their mutual peer support they offered each other in formal and informal ways.
- However due to limited time and resources within the service, practitioners often felt stretched and unable to afford the time to seek support or did not want to burden their colleagues.
- This was noted to impact their resilience and could lead to burn out and staff sickness, further impacting the wider team.

Figure 95. Key Research Finding 3. Integration

Integration

The multi-agency service combined practitioners from different disciplinary backgrounds which brought several aims, and goals to the service. Integration of the service was a key area which raised questions in early theory testing as to how the needs of the child, mother and wider family could all be met equally within the diverse service.

- The evaluation found that co-location, strong leadership and compassionate team working supported the integration of the service.
- However due to a lack of ownership for the service from an organisational level and disparities in practice agendas and motives from each discipline, the service faced some barriers to integration.
- Differences across the practitioners discipline affected their access to IT systems and access to training and support.
- Some practitioners faced disparities in their requirements to communicate with external services, increasing their workload.
- These barriers resulted in practitioners feeling their wellbeing was not prioritised and demotivated them.
- Disparities in practitioner approach depending on their disciplinary background also impacted the service users as this varied team ethos altered how service users perceived and received the service.
- An overarching risk-averse approach to practice dominated the service as the child's needs often took precedence over the mother's needs.

Figure 96. Key Research Finding 4. Relational based practices

Relational Based Practices

The results of the evaluation identified that:

- The IPPSS works by improving engagement, and personal growth of the service users it works with by building trusting relationships over time through relational based practices.
- These approaches achieve outcomes when both the service users and the practitioners have aligned perceptions and expectations of the relationship they are fostering.
- Relational based practices requires practitioners to communicate open and honestly, sharing information and evidencing trustworthiness.
- Providing flexible services which are holistic in their approach supports women to feel respected and reduces their stress and anxiety.
- Ensuring continuity of the providers involved in the woman's care supports the development of trusting relationships.
- However these relational based practices do not work in the same way for all practitioners and service users.
- For women with previous negative experiences of child protection services, there are many barriers to relationship building as their fear and sense of discrimination may cause resistance in the relationship.
- In other cases for women who have experienced the IPPSS before, relationships may in fact be easier to build.
- Practitioners disciplinary background can also affect the time it takes to build relationships between the practitioner and the service user.

Figure 97. Key Research Finding 5. Goal Setting

Goal setting

Finally, goal setting was a method used to encourage service user engagement and monitor the changes in behaviour of the parents during their time with the service.

- Goal setting was found to produce diverse outcomes depending on the wider context of the service user.
- Depending on their external social support (partner, family) and the location of the child (home, foster care, kinship care), goal setting could increase motivation and hope or increase stress and lower self-esteem.
- These differences offered by goal setting demonstrate how wider recovery capital can affect the outcomes of service users and how perceptions of motive and support alter service users' capacity to make behavioural changes.

Situating my findings within policy, research and practice

My evaluation has highlighted how complex services such as the IPPSS, have nuanced ways of working depending on specific contextual factors. A recent study by Coupland et al., (2021) aimed to develop a model of care for women with drug and alcohol problems during pregnancy. Their study included the perspectives of practitioners from a service similar to that of the service evaluated in my study. The findings of Coupland's study were similar to the tested theories outlined in Chapter 5, identifying the importance of provision of services which were multiagency in nature, flexible, person-centred and promoted a harm reduction approach. Yet my study has also applied a multi-layered lens, providing a perspective which includes the Macro, Meso and Micro aspects of social interactions. My study enabled the voices of service users to enhance the research and direct the study enquiry to reflect the experiences of those the service is designed to support. By applying these lenses, I provide a more in depth understanding by exploring the many layers and shifting perspectives to identify how and for whom services work.

Including both service user and service provider perspectives has enhanced the understanding of relationships within the IPPSS. The importance of relationships between practitioners and their colleagues and practitioners and their service users and service users and the wider social environment is an essential finding from my evaluation which adds to the current research and recommendations for Relational based practices (see Relational based practice improving retention in services). By treating people with respect and kindness, demonstrating empathy and compassion, trust can be built between people which supports longer term relationships between service users and their service providers. Evidencing trusting behaviours, builds trusting relationships over time and helps support the development of the individual and the relationships they hold. These human elements are essential components of services which are working with people during a challenging and stressful time. Reaching out a hand and offering support in a compassionate and non-discriminatory way allows the person to consider the potential support and use it to benefit them. These compassionate behaviours are also key for practitioners working in a multi-agency setting who require support from their peers. By evoking transparency within the team, practitioners rely on each other and engage in meaningful communication.

However, when services are risk-averse and society has negative perceptions of populations, practitioners are faced with an uphill climb (see Policy context and Discourse of pregnancy and risk). Breaking down the stigmatising barriers which deter service users can be a difficult task. Service users are fearful of the motivations behind the help and support they are offered and continue to protect themselves by remaining distant and defensive. As the risk agenda motivates practitioners' interactions and decisions, they use strategies and behaviours which are misaligned from the compassionate relational based practices. Tensions may rise across the multi-agency team as opposing agendas are prioritised. The hierarchical policies and guidelines which dominate practice, cloud the relational based practices practitioners want to adopt. Applying these findings to research and practice requires firstly appreciating the "environmental quality" (Gibb, 1991) of each context and how these contextual factors function within reality. Context is not only a backdrop to which the service functions, but also a functioning cog in the process, affecting all the mechanistic processes within the service. For example, understanding the origin of the

contexts which are present in Ethos and Stigma allows for a greater awareness as to why relational based practices may fail to meet their capabilities. Incongruent policies and guidelines which are weighted towards child protection, provide a contextual background for the functioning of Ethos and production of Stigma.

Whilst context is essential in understanding the local applicability of findings, realist evaluation enables the researcher to extrapolate meaning through the utility of Middle Range Theories (MRT) and refine theoretical perspectives to support their application more widely. A multi-site study carried out in Canada evaluated eight different holistic services which treat women considered to be high risk for having a baby with Fetal Alcohol Spectrum Disorder (FASD) (Rutman et al., 2021). The Co-Creating Evidence Evaluation project was funded by the Public Health Agency of Canada as part of the FASD prevention model. The findings from the evaluation highlight the importance of relational based practices, trauma informed services and integration of services especially in relation to disparities in child welfare and substance use treatment fields. These findings highlight the transferability of the core findings identified in my study through the utility of MRTs and the general principles which are paramount in developing and delivering services for pregnant and parenting women who use substances around the globe.

Policy context

A fundamental context identified within my evaluation is the role “policy” has on all aspects of the service and how local policy can influence the workings of services. One key report which has had considerable influence on policy and practice in the UK, is Hidden Harm (Advisory Council on the Misuse of Drugs, 2003), a report produced by an extensive working group of experts and politicians, which uncovered the risks of parental drug use on children and highlighted the limited interventions provided by services to reduce these risks. The report provided 48 recommendations for practice, which over two decades, have paved the landscape in many policies and guidelines across the UK. However there has been recent criticism, challenging the report on the stigmatising norms created by blaming and framing parental drug use as the problem bringing harm to children (Flick, 2018, Whittaker et al., 2020).

Hidden Harm (Advisory Council on the Misuse of Drugs, 2003) claim that parental drug use increases risks to children because of wider social factors e.g., homelessness and unemployment, yet Whittaker et al., (2020), reframe this perspective identifying that risk is present due to wider social determinants of health which may contribute to drug use behaviour and not the other way around. Reversing this causal claim towards an understanding of the social determinants of health, reduces the blame placed on the individual and recognises the wider social factors which bring risk to children as a whole. However, the report (Advisory Council on the Misuse of Drugs, 2003) had such political impact and created a ripple of policy changes contributing to a social norm presenting a stigmatising discourse of parental drug use.

The impact of this stigmatising discourse has been identified through the findings of this evaluation and are seen between the context and mechanism interaction of Ethos and Stigma. When norms and values are underpinned by a policy framework based on tackling risk to children by parental drug use, the strategies, agendas and motivations which follow are heavily driven by this discourse. In addition, the stigmatising discourse permeates society, causing expectations by both service providers and service users. These expectations are the threat and need for parental governance which causes service users to interpret practice as being punitive and autocratic as described by Gibb (1991). It is no surprise that this embedded discourse causes barriers for the relational based practices that are advocated for such services (Ingram and Smith, 2018). Relational based practices require opportunities for developing trust and allowing for open communication which, as identified throughout this study, can be challenging. Practitioners embedded in a risk perspective, perpetuate fear responses in service users, failing to build relationships, as noted in the findings presented in Chapter 5 Phase One Findings, Chapter 6 Phase Two Findings and Chapter 7 Phase Three Findings.

Additionally, both Flick (2018) and Whittaker et al., (2020) raise issues regarding the gendered approach to policy as framed by the Hidden Harm report (Advisory Council on the Misuse of Drugs, 2003). The analysis applied in both critiques questions what “silences” are present in the report (Bacchi, 2017). This identified the absence of fathers and their contribution to risk to children, their role within the family and their place in service provision. By providing limited discussion on fathers’ role, Hidden

Harm (Advisory Council on the Misuse of Drugs, 2003) embeds gender stereotyping, reproducing a culture of blame on mothers as the primary safeguard for children. Despite the report presenting data showing more fathers than mothers have drug use problems, nine recommendations are made specifically for mothers and none for fathers (Flick, 2018). These recommendations include the provision for services for pregnant women and ensuring assess to Long Acting Reversible Contraception (LARC) and abortion services (Advisory Council on the Misuse of Drugs, 2003). These recommendations which focus on reproductive rights, encourage consideration of how pregnant women are positioned within society. When "family planning" methods are encouraged in policy they become contradictory in their approach, produced by an oppressive agenda they restrict choice and control women's behaviour rather than empower and offer choice (Annie Surviving Safeguarding, 2019).

Discourse of pregnancy and risk

Discourses of pregnancy and the maternal body have been widely explored in response to the risk-averse approach taken by the biomedical model (Lupton, 2012, Salmon, 2011, Ettore, 2002). These authors and others express challenges between the regulation and monitoring of the needs of the mother versus those of the fetus. Highlighting the extensive lifestyle changes women are expected to make to their diet, fluid intake, physical movement and sleeping positions, Lupton (2012) demonstrates that pregnant women are constrained by the bio-political approach which governs their actions. Characterised as "Reproductive Citizenship" (Lupton, 2012, Salmon, 2011, Salmon, 2004), pregnant women (and those considering pregnancy or abstaining from) must "regulate, monitor and control" (Lupton, 2012, p. 3.) their mind and body to safeguard and reduce risk to their fetus as per social expectations. However, by placing these expectations and responsibilities on the individual woman, she will face guilt and blame should she diverge from social expectations.

These constructs further disempower women and can cause certain pregnancies to appear "riskier" such as the case for women with drug and alcohol problems. For example, a recommendation from the Hidden Harm report (Advisory Council on the Misuse of Drugs, 2003) suggested monitoring and reporting of fetal abnormalities across the UK from services for pregnant women with drug use. Policy approaches such as these within a society which expects "reproductive citizenship" (Salmon, 2011),

embeds blame and shame on mothers as individuals without addressing the wider social context. This was evident in the accounts by Katie in this study who recalled her midwife (out with the IPPSS) saying she was a "silly girl" for having become pregnant whilst using substances, disregarding her choice and disrespecting her as a mother. Katie reported feeling judged and stigmatised by the midwife because of her substance use which resulted in society not allowing her the dignity and respect of other mothers.

Developments in science and technology such as advancements in ultrasound and screening tests also contribute to the ever surveilling approach to pregnancy which invades the previously private nature of pregnancy; as Lupton (2012) explains: "This trend has become so exaggerated as to approach a fetishisation of the fetus, elevated as it is to such heights of value and eclipsing the maternal body in which it grows" (p. 10). This continued surveillance in pregnancy has been described as "natal-panopticonism" (Terry, 1989) as the practice of placing surveillance on fetal wellbeing is internalised by the mother and consciously always present. Thus producing "Stigma" as presented in the findings of this study, based on a contextual backdrop of child protection policies, the mechanism brings fear of child removal, self-stigma of "bad mothering" (Salmon, 2011) and constrains the actions of the woman as explained by Jo's experience in Chapter 6, Agency. This perpetuating cycle reduces the likelihood for individual "behaviour change" which is the goal within integrated services, yet again blaming the individual.

In contrast Morris (2009) suggests natal-panopticonism can produce "docile subjects" who become compliant due to the power of external and internal surveillance which in turn constrains the individual. These opposing actions of agency are outlined in all four identified mechanisms presented in Chapter 7 and continue to draw attention to the significance of power within relationships. This was identified in the findings Chapter 7 through the interaction of Ethos and Stigma on Inter-being. As practitioners hold power over service users through their motive and strategy, as demonstrated in this risk-averse context, service users may become "docile subjects" (Morris, 2009) experiencing constraint of agency.

In my study, participants demonstrated all spectrums of participation with the IPPSS, with the analysis suggesting contextual factors affected the response of individuals. Some women struggled to trust the IPPSS due to feelings of judgement and stigma as they felt watched by professionals and responded by defending their abilities as a mother. Similarly, women found it challenging to be honest with practitioners as their perception of disclosure was that confessions of substance use would be used by professionals as ammunition in the fight between them and their social worker. In some cases, women accepted the child protection process, seeing no alternative to the authority and passively participated as "docile subjects". Despite this discourse of pregnancy and risk within the narrative of substance use, women within my study demonstrated various degrees of "success". The external factors which contributed to the success of some service users, but not all, highlighted the importance of understanding that services do not work for everyone in the same way. The external resources such as family support, partner support, community support, domestic violence, poverty, employment, trauma (including losing custody of child), all contributed to different extents to impact the ability of women to make adequate changes to their substance use as required by social work.

Recovery capital

These external factors have been termed "recovery capital" as discussed by McGovern et al., (2021) in a recent meta-analysis which examined the effectiveness of psychosocial interventions for reducing parental substance use. This review found that integrated interventions which included parenting intervention and substance use interventions were more successful at reducing alcohol and drug use at six and twelve months of treatment, than non-integrated approaches. However, their analysis also concluded that mothers were less likely to change their alcohol or drug use compared to fathers. McGovern et al., (2021) raised the concept of "recovery capital" (Hennessy, 2017), which describes the physical, social and community resources available for someone to progress their recovery. When considering the women involved in my evaluation, their "recovery capital" could be considered a key resource which may affect their outcomes. Some women struggled to achieve the expectations of the service whilst juggling the impact of domestic violence and child removal. However, others managed to achieve their goals supported by their partner or secure

employment. McGovern et al., (2021) discuss the gendered impact on recovery capital as males are more likely to be employed and in stable relationships with non-drug using partners. Yet women are more likely to experience unemployment, low educational attainment and unstable relationships, thus highlighting the considerations of gendered experiences when designing and implementing integrated services for pregnant women with drug and alcohol problems.

"Negative recovery capital" (Hennessy, 2017) has also been considered a barrier to recovery as women experience imprisonment, mental health issues and stigma. McGovern et al., (2021) conclude their discussion regarding recovery capital by outlining that the studies examined suggested imbalance in recovery capital and intervention resources which are unable to counteract the individuals' substance use. This conclusion supports the observation from my realist evaluation which highlights the importance of constrained and active agencies' function within the mechanisms which are at play. For example, stigma as highlighted by McGovern et al., (2021) as a form of negative recovery capital, functions as a mechanism constraining women's abilities to enter into relationships with practitioners, preventing relational based practices from taking place. When considering the findings from my study which demonstrated the importance of relational based practices to build trust, motivation and self-worth, there is no doubt there is imbalance between recovery capital and resources in some cases, highlighting what "works" for some and not for others.

Relational based practice improving retention in services

A wealth of evidence underpins the important role of relationships in health and social care services (Greenhalgh 2014, Koloroutis, 2006), especially in social work (Ingrim and Smith 2018), maternity services (Sandal et al., 2016) and addiction services (Orr, Elliot and Barber, 2014). However, through the lenses of Trust Level Theory (Gibb, 1991) and Interactionism (Burbank and Martins, 2019, Kleinman and Cabaniss, 2019) my evaluation identified contexts and mechanisms which influence the success of relational based practices (outcomes).

A recent systematic review of parenting outcomes following parenting interventions within substance-use treatment programmes, recommended close consideration of the length in, or dose, of treatment on outcomes (Moreland and McRae-Clark, 2018).

The findings noted that parenting outcomes improved for those who maintained treatment for longer periods of time and therefore recommended consideration of methods to retain service users in treatment. Retention and outcome causality is not a new phenomenon in treatment for drug use as outlined by Simpson (2004), however understanding the complexities of service interventions and how they cumulatively impact outcomes remains fragmented. My evaluation has begun to open the "black box" of processes and interactions (Simpson, 2004) which take place within services, to understand how outcomes come to be. Identifying that building and maintaining trusting relationships between practitioners and service users, through relational based practices is a key aspect of the process. By sustaining relationships, as seen in several cases within my study, retention in services was maintained. This may also highlight the differences in outcomes between outreach models such as IPPSS which work closely with service users over intense periods versus standard care which is more fragmented. The wider complexities facing both the practitioners in their risk-averse practices and the women experiencing reproductive asceticism (Ettore 2002) must be considered as illustrated through the mechanisms identified in this evaluation.

In addition, the role of the child protection context and its effect of high fear relating to low trust (Gibb, 1991) is a vital aspect to consider when developing services which aim to develop relationships as a key motivator for retention. Placing relational care within a low trust, high fear context requires a deep understanding of the individual and their wider social context. Appreciation of the individuals' life experiences calls for holistic approaches to services as noted in maternity care (Scottish Government, 2017a) and substance use treatment (Mistral, 2016). A recent realist evaluation of "Pause" (Boddy et al., 2020), a service supporting women post child removal, found "relationship-based" interventions and holistic approaches improved outcomes for women including their wellbeing and addressed their histories of trauma. Trauma focused relationship-based approaches such as Pause, which put the woman at the centre of the service, also reduced the likelihood of subsequent child removal and improved women's relationships with their children and wider family. However, the programme has been met with criticism for its conditionality of Long Acting Reversible Contraception (LARC) (Annie Surviving Safeguarding 2019, Concerns Raised Again about Dundee Project's Conditional Support to Women – SDF – Scottish Drugs Forum,)

with critics raising concerns about the conditional support offered by Pause which removes human rights and women's choice by mandating the use of contraception. Thus highlighting yet again the power held by policy agenda and societies complicity in gender discrimination by diminishing reproductive rights and reinforcing reproductive citizenship (Salmon, 2011).

Trauma informed practice

Trauma informed care has also significantly improved in recent years with a broader understanding of what trauma is and how it can contribute to long-term health and social capital (Savage et al., 2007). However, a policy drive within Scotland has focused on Adverse Childhood Experiences (ACEs) as the early prevention of trauma on children. This approach has focused on the World Health Organisations (WHO) agenda for improving the first 1000 days of life, from conception to the child's second birthday, and has been framed by academics as the "first three years movement" (Thornton, 2011). Based on neuroscientific evidence, practices are encouraged to promote the brain development and attachment of children from in utero to pre-school in order to prevent trauma and improve the health of the next generation (Critchley, 2020). This focused agenda on preventing ACE's adds to the reproductive citizenship (Salmon, 2011) previously discussed, which causes scaremongering amongst mothers due to the consequences of "Toxic stress" which is theorised to impede neurodevelopment of the fetus (Shonkoff et al., 2011, Glover et al., 2018). Prevention of "Toxic stress" becomes another situational constraint mothers are responsible for, managing external stress and their individual physiological responses (Critchley, 2020). Critchley (2020) explored the child protection process of "Pre-Birth Planning Meetings" in Scotland, highlighting the individualised approach which blames mothers for the risk to children and fails to account for wider social determinants of health as previously outlined by others (Flick 2018, Whittaker et al., 2020). This highlights whilst recognising the effects of trauma, agenda and practice can perpetuate inequalities and reproduce stigma. For example, my evaluation found many references to "trauma" by practitioners who believed their practice was "trauma-informed", yet practitioners were also aware of the counterintuitive practices (e.g. withholding prescriptions) which contributed to service users' stress. This was a similar finding by Critchley (2020) who reported accounts of "Pre-Birth Planning Meetings" increased

stress for parents and effectively re-traumatised mothers. The findings from Critchley (2020) and my evaluation demonstrate examples of incongruent approaches to policy and practice for integrated services as the drivers to promote health and reduce risk to the fetus eclipse the wider needs of the mother. This highlights the short-term view of service users by practitioners who are working within a specified timeframe and do not have the luxury of long-term planning and provisions for individuals.

Areas of relational based practice and trauma informed care which try to overcome these barriers of short termism, relate back to the relationships between practitioners and the wider organisation. The findings of this study as presented in Chapter 7, demonstrate how interactions between practitioners and their colleagues (Transparency) and practitioners and service users (Inter-being) can activate agency in order to counteract the force of the overarching Ethos mechanism. Early models of relational based practices in nursing (Koloroutis, 2006) encouraged these interactions recommending "three crucial relationships: care provider's relationship with patients and families, care provider's relationships with self, and care provider's relationship with colleagues" (Koloroutis, 2006, p, 4). My study has shown that the relationship between the practitioner and themselves, as well as their colleagues strengthens relational based practices and individual growth in my study. When "Transparent" interactions begin between practitioners, communication, individual growth, and morale improve as well as patient focused care. Similarly, my evaluation demonstrated that as practitioners and service users interact, growth of the individual improves and service users remain engaged. Yet these mechanisms of Transparency and Inter-being require congruent approaches, mutual attitudes and behaviours and shared beliefs. These are also outlined in Koloroutis' (2006) model which includes 12 values of transforming healthcare organisations, focusing on aligned personal and professional values. Challenges are faced when organisations are built on misaligned agendas and incongruent practices yet can be overcome by mutual attitudes and behaviours.

Models of Trauma Informed Practice (Substance Abuse and Mental Health Services Administration, 2014) have been designed to recognise the impact of trauma and the wider organisation's role in managing trauma. The "Four R's" outline organisational approaches to trauma informed practices which "Realizes" the impact of trauma, "Recognizes" signs and symptoms, "Responds" through policy and practice and "Resist

re-traumatisation" (Substance Abuse and Mental Health Services Administration, 2014). These four approaches consider the whole organisation's implementation of trauma informed practice to ensure from policy level down to the actions of the practice, trauma is at the forefront of the agenda. Whilst trauma informed practices were discussed and recognised as vital in the IPPSS, there was limited evidence of how policy and practice was aligned to "Respond" to trauma or "Resist re-traumatisation". These two aspects need to be explored further to understand how policy and practice can address trauma within this service, especially safeguarding service users from further re-traumatisation. Applying an approach such as this requires a multi lens perspective of the interaction between Macro, Meso and Micro levels within and across services as applied in this evaluation. The interactions between the context, mechanism and outcomes, as outlined in Chapter 7 Phase Three Findings, provide one perspective, however value is found in understanding the interactions between the four core mechanisms and the potential for development.

Recommendations for policy

Exploring alternative perspectives on the discourse of parental drug use and pregnancy, situates the findings from my evaluation within an encouraging discussion which calls for a reframing of policy and practice for parents who use drugs (Flick 2018, Whittaker et al., 2020). This reframing requires to account for the wider social determinants of health which are at play within parental drug use and the child at risk. Moving from an individualised risk-averse approach, which continues to blame and shame families for their choices and behaviours that increase risk to the "vulnerable" child, is absolutely necessary. Providing a 'social model' (Featherstone et al., 2018) offers a broader perspective which lifts the individual lens and appreciates the wider social constraints facing parents in modern society. In order to shift the discourse of risk, politicians need to reflect on their approaches, and recognise their role in re-producing risk in society. Featherstone and colleagues have been campaigning for a revision of the risk-averse approach to child protection and advocate a move towards a 'social model' as previously seen in disability and mental health sectors (Featherstone et al., 2018). My study has highlighted the negative impacts on relationships and service engagement when individual risk is the main driving force in agenda and

practice, therefore a shift towards a social model would be advocated across policy and practice.

Recommendations for research

Improvements in integrated services which aim to bring together the complex needs of pregnant women with drug or alcohol problems requires a multi lens approach. Whilst policy and guidance will continue to be fuelled by political agendas, it is essential researchers remain able to provide impartial studies which capture the nuanced realities of services. Bringing together perspectives from practitioners and service users will continue to explore how services are delivered, received and perceived in practice.

Co-design

Further steps to develop services should continue to welcome service users' involvement through collaborative approaches. There is a recent move towards co-produced research approaches which include service users from the outset of research as part of the research team. Whilst inclusion of Patient Public Involvement is encouraged in most research, the co-production approach facilitates service users to be fully involved in the research process rather than merely advisory or as research subjects. Co-design has been embraced by the Scottish Government as the "Scottish Approach to Service Design" (Scottish Government, 2019), empowering people to engage in service design which will ensure services are delivered appropriately for those who receive them.

Service user forums such as Maternity Liaison Committees were introduced across all health boards in Scotland in 2000 in order to include the voices and perspectives of mothers; yet a review conducted 20 years later (Healthcare Improvement Scotland, 2020) showed significant disparities across health boards in the continued recruitment, structure, support and representation of these forums. This is especially concerning when the Scottish Government have recommended implementation of a revision of maternity care in 2017 (Scottish Government, 2017a) without the provision of service user involvement across Scotland. The review highlighted issues regarding recruiting diverse representatives and gathering professionals and service users together for joint meetings. This does not include the difficulties which may be faced trying to engage

service users with mental health issues, substance use, poverty, and other negative social capital.

Additionally, despite the Scottish Government's vision for collaborative research approaches I could not identify any current studies which involve a co-design approach in research or development of services for pregnant and parenting women with substance use in Scotland or elsewhere.

Continued analysis

Despite the extensive evaluation I have conducted there are further areas of theory development, testing and refinement which were not possible within the scope of this PhD. Due to the nature of the PhD process as a training opportunity, my research skills and knowledge have significantly developed over the course of this evaluation. Subsequently, reflecting at this end stage has enabled me to identify areas of the evaluation which could be developed further. This includes the analysis of the four key mechanisms identified through the evaluation and their dynamic relationship with one another. Further opportunities to analyse this relationship may offer further insights into the workings of the IPPSS.

An area of study which was not tested through my evaluation was the role and impact of peer support for this population. Theory development had suggested peer support would be a positive approach for encouraging relationship building, self-esteem and continued engagement (Lefebvre et al., 2010). However, in the local setting, organisational barriers and individual motivations reduced the opportunities for peer support. This may be an area of interest to further theorise and test how peer support could be improved within the local setting. This is especially interesting as recent evaluations including The Co-Creating Evidence Evaluation project (Rutman et al., 2021) highlighted peer support as one of the positive aspects of integrated services. Large evaluations such as these are often presented as evidence for practice in national and local guidance with a lack of consideration for their local applicability, therefore a closer testing of peer support theories in the local setting may be of value.

Additionally, my evaluation was conducted pre COVID-19 Pandemic, when practitioners were encouraged to work in a co-located office and service users were encouraged to meet with practitioners face to face on several occasions each week.

Since the completion of the study the IPPSS has faced several enforced adaptations including home working, tele-health appointments and “lock-down” restrictions. Anecdotal evidence suggests that these enforced changes have limited the relational based practices prioritised previously by practitioners and have contributed to an increase in children being accommodated (foster care, adoption) in the short term due to limited opportunities to work with families during pregnancy. A further evaluation of the IPPSS post COVID-19 pandemic could further contribute to the testing of relational based practices and their impact on child placement outcomes, among others.

Recommendations for practice

Throughout Chapter 7 Phase Three Findings practice recommendations were stated for each refined theory. The following Practice Points highlight how practice could be altered to improve integrated services for pregnant and parenting women who use drugs and alcohol.

Ethos Practice Point: To improve synergy across interagency working, the service requires congruent principles and practices, which align with the services mutual aims. This requires equal buy in from partners at organisational and practitioner level and relevant resources in terms of funding.

Aligning policies and practices across the service, and moving towards EQ states which are “Advisory, Participatory, Emergent, Organic and Holistic” (Gibb, 1991) in nature would allow for collegial practices. In order to align the aims of the service, integration of services would need to be established on multiple levels including financial, managerial, and individual buy-in. Attempts to integrate services which are misaligned will continue to raise barriers for the practitioners, service users and service as a whole. Encouraging a neutral agenda such as family-centred, or trauma informed practice, based on relational based practices would move towards congruent principles and practices with all service users (child or parent) at the centre.

Transparency Practice Point: Transparency among team members supports growth of the individuals, the team as a whole and improves services for service users. Opportunities to cultivate transparency must be offered by leadership and commitment from experienced skilled practitioners.

Prioritising the individuals within the team and the vital role they play within the service is an essential part of fostering and maintaining effective services. This requires each individual to be respected in their role and contribution to the team as well as opportunities to develop their relationships within the team. This requires leaders who promote transparency and understand the value of transparent interactions within a team and will in turn foster transparency among the wider team.

Stigma Practice Point: An overview of the fundamental principles and practices of the service should be considered from a service users' viewpoint to reduce opportunities that may produce stigmatising or discriminative experiences for service users.

Inclusion of service users in the evaluation and development of services is vital to ensure their perspective is accounted for. Their contribution should not only be considered but taken forward as a driver for change to develop services for those they are designed to help. Understanding and valuing the service users' perspective should be at the forefront of service development to counteract the top-down approach which is driven by policy. This requires stakeholders from government, academia, service development and practice to collaborate with service users with lived experiences to ensure their perspective is valued and considered.

Inter-being Practice Point: To support service users to engage in services, priority must be placed on Relational based practices and practitioners should be encouraged to be personable in their interactions, and not mask behind their professional façade.

Priorities should be given to develop relational based practices from multiple levels including, policy, service development and practice. Practitioners should be given opportunities to develop their interactions moving from professional practices to more personal practices. Understanding the importance of the relationship as a two way process between two people is essential in establishing relational based practices moving away from therapeutic relationships which suggest a one directional process. Recognition should be given to the benefits of relational based practices which improve outcomes for service users and practitioners.

Strengths and limitations of the study

Methodology

Methodological approaches to study design aimed to overcome potential bias in qualitative data, sample and analysis. Realist methodology allows for incorporation of multiple methods as applied in this study. Through theory generation, testing and refinement; layering of data collection and analysis allowed for triangulation of data, aiding deeper understanding of complexity. This application of methods has been considered a fundamental approach to reduce researcher bias, sample bias and participant bias by encouraging greater diversity (Maxwell 2012). In addition, realist methodology actively seeks outliers and diverse perspectives in order to explore and test alternative theories (Jagosh, 2020). In some cases, reliance on a small sample of data to validate a finding may be considered poor research however in this study key nuggets of data supported rival theorising (Pawson, 2007). It is through the collection of applied methods and depth to the overall analysis which demonstrate and enhanced the validity of the findings in this study.

However, I acknowledge there is a fine line between scientific and critical realism which some purists may strive to divide further. Through my application of RE methods and my growing knowledge and understanding during this PhD process, I have become comfortable with my own interpretation of RE and the necessity to borrow from both positivist and constructivist lenses. In order to draw conclusions, it has been necessary to apply both paradigms of methodology whilst remaining true to my interpretation of realism. This may be considered a criticism of the application of RE methods or the paradigm of Realism itself, however I recognise this as a strength of the utility of RE methods to appropriately address the research question.

Furthermore, applying RE methods through a PhD study has been a feat in itself, as notably RE studies comprise multiple researchers. Although I was supported by several academic supervisors throughout the study, I sought opportunities to expand my knowledge and skills in RE and undertook all research myself. This has allowed me to develop many aspects of my research skills, especially development of my critical thinking and appreciation of methodological paradigms.

Macro Meso and Micro lenses

Applying a multi-layered social lens in the form of Macro, Meso and Micro level analysis has enhanced this realist evaluation and enabled a greater understanding and appreciation of the interactions between Context, Mechanism and Outcome. These lenses aided the development of the analytical approach I applied to the study data by expanding my perspective of services as they are delivered and received as well as broadening my analysis to include wider social realities. Applying a sociological perspective also supported the testing and refinement of programme theories and the broader understanding of the transferability of theories.

Including women's voices

As highlighted above there is a dearth of research and service development which truly includes the voices of the women who receive the services being delivered. Previously the IPPSS "evaluated" their service by asking for service user feedback on a written evaluation form during their discharge visit. This was conducted by each practitioner involved in the woman's care and would often be conducted through conversation instead of written evaluation due to the woman's individual literacy level. This process did not allow for anonymous feedback and in many cases could have been significantly biased by the practitioners' participation in the process. By conducting an impartial evaluation, the research design enabled women to provide honest anonymous feedback on their experiences of the service. My study has prioritised the service users' experience, and in conjunction with practitioners' views, has provided a balanced perspective, co-creating evidence. For the local women who receive the IPPSS this study has provided an opportunity to include their perspectives in future development of local services.

Sample

There were several limitations of this study which must be addressed when considering the findings. One of these limitations is the sample of service users who were recruited to the study. Participating service users were from a pool of engaged women who were actively receiving the IPPSS. This may have biased the findings as women engaging are, in theory, more likely to have positive experiences and better outcomes. Finding out why women do not engage with the service was one of the key research questions, identifying what works (or does not) for whom and why. Several

different approaches to recruitment were attempted, as outlined in chapter four, to recruit a diverse sample of women. However only two out of nine women who participated in the study were poorly engaging with the service and had children in foster care. Despite this all women had previous experiences of similar services and child protection proceedings, meaning most women had at some point disengaged from services. Additionally, as part of the referral criteria to the service, all women were disengaging from mainstream services. Although the most difficult to reach service users from the service were not captured in the data, the sample of women included do represent a hard to reach, highly marginalised group, often excluded from research due to recruitment and ethical challenges. Successfully including these women in the study and managing to gain their trust to share their experiences of the IPPSS has been a strength of the study which will contribute to the research landscape with regards to this population.

Secondary analysis

Secondary analysis of routinely collected data was not possible as initially planned. When designing the study, the service manager was collecting routine outcome data which was presented in annual reports. The initial plan was to compare the data over the study period and provide averages for the outcomes over the years. However, the annual reports changed each year presenting inconsistent reporting methods. In addition, during the study timeframe the COVID-19 Pandemic influenced practice as all staff were instructed to work from home. Home visits and meetings with service users did not take place as previous practice had required. Many core aspects of the service which were tested as vital components did not function as they had pre pandemic. This impacted the outcomes of the service including a delayed annual report which included 18 months of data. Secondary analysis would have been an effective method to increase triangulation during analysis and support the findings of this evaluation. However, given the issues which presented, this method was not used.

Conclusion

My study took a novel approach to evaluate what works, for whom, in what respects, to what extent, in what context and how within a multidisciplinary service for pregnant and parenting women with drug and alcohol use. A key finding of my evaluation is the disparity between policy and practice. As highlighted at the start of this thesis, this

study did not aim to undermine the seriousness of child protection concerns, however this study has identified disparities in policy and practice which focus on individual risk-averse approaches to the detriment of the wider social perspective. Further research and understanding as to how to ensure services meet the serious child protection concerns while at the same time support or facilitate a trauma informed social model, as described, is essential. To improve and develop services for pregnant and parenting women with drug and alcohol use, a social model which recognises the social determinants of health and prioritises relational based practices and trauma informed care at policy level, as well as practice, is necessary to improve outcomes for families. Applying realist methodology identified a complex interaction of mechanisms that work in concert and competition to provide observable outcomes. Understanding each mechanism is key to deciphering the components of the service, however grasping their relationship to one another elevates this understanding and contributes to the research and practice recommendations for models of care for this population. Taking a broader sociological perspective to evaluate the service has allowed me to focus on the nuanced relationships between society, the service and the individual, gaining a deeper understanding on how services work at the individual level. My study has included valuable perspectives from both practitioners and service users; however, the design of the study enabled the service user perspective to guide the direction of theory development. Thus, providing a marginalised population the opportunity to have their voice heard, valued and respected in order to better understand services from the perspective of those the service is designed to support.

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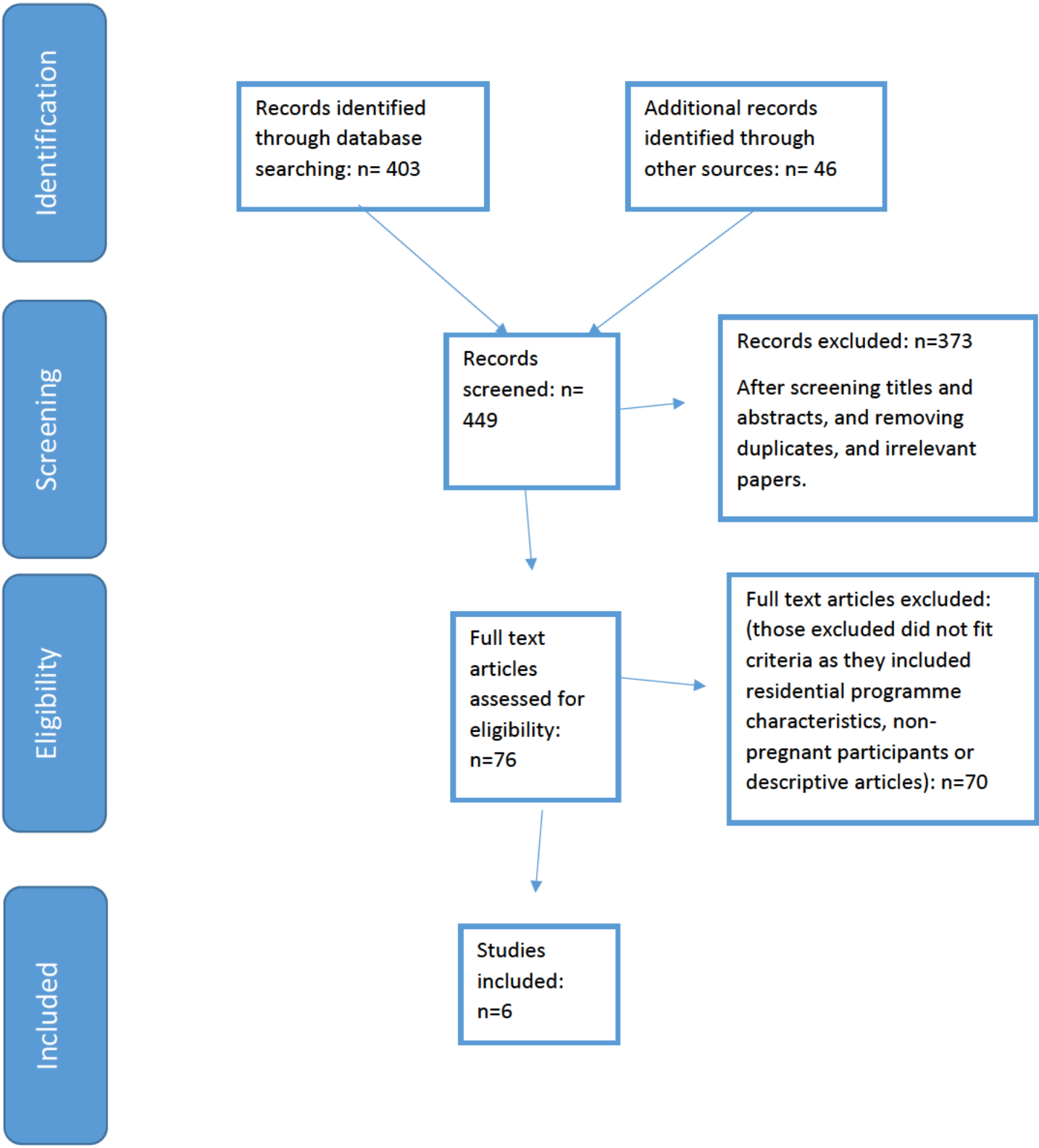
Appendix 1. PICO and PEO MESH terms

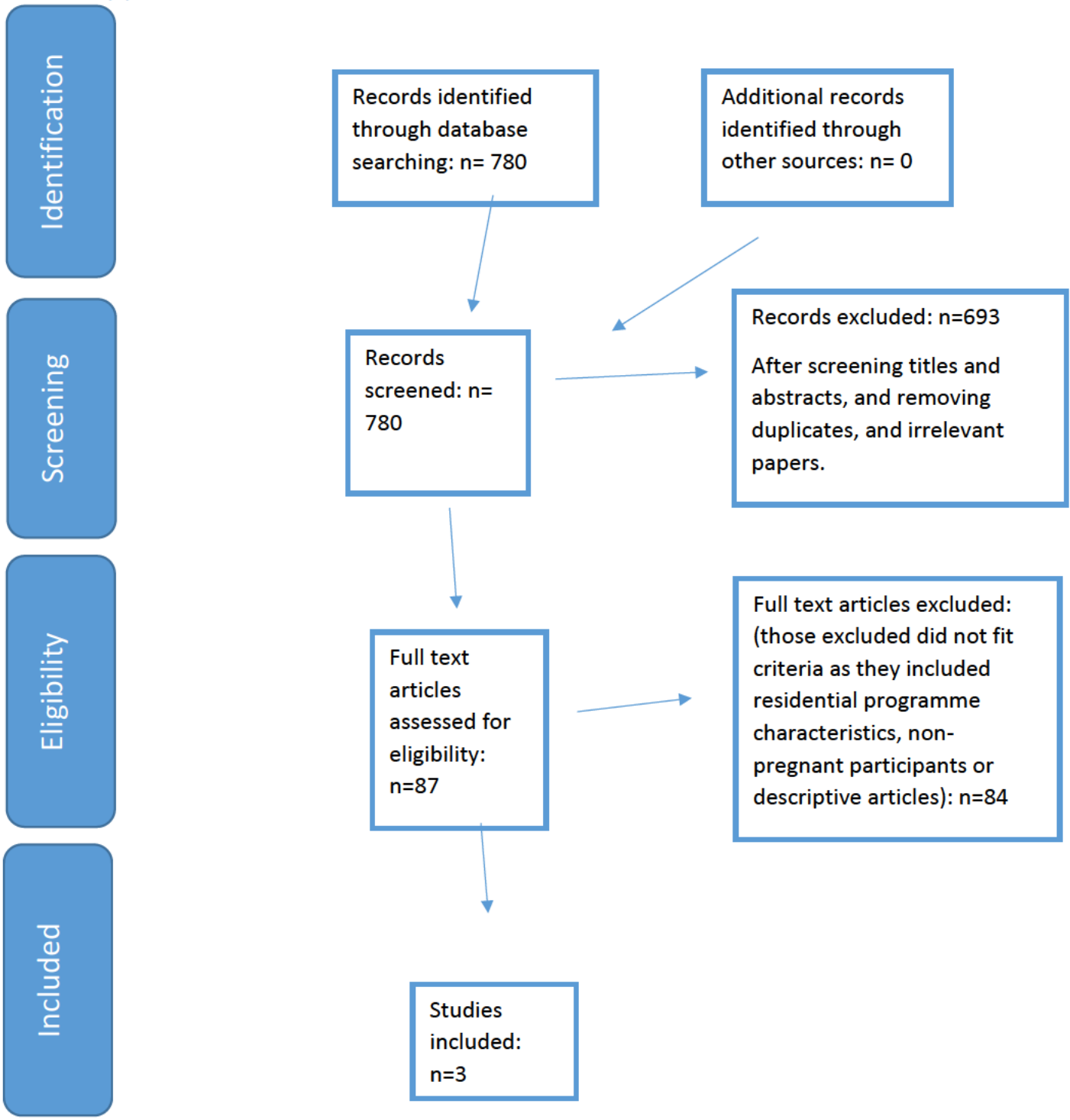
Phase One- List of search terms and mesh headings used: Pregnancy, pregnant*, mother*, father* maternal*, paternal*, couple*, parent*,Infants, newborn, neonate, baby, child, fetus, Parents+, fathers, mothers, expectant parents, substance use disorder, substance abuse*, substance misuse, or substance dependen*, drug abuse, drug misuse, drug dependen*, problem drug use, addict*, addiction service*, alcohol*, problem alcohol use, alcoholism, drinking behaviour, integrated services, integrated pathway, integrated program*, interagency, inter agency, multidisciplinary care, multidisciplinary team work, pregnancy outcomes, health outcome* neonatal abstinence syndrome, fetal alcohol spectrum disorder, fetal alcohol syndrome.

Phase Two- List of search terms and mesh headings used: Pregnancy, pregnant*, mother*, father* maternal*, paternal*, couple*, parent*,Infants, newborn, neonate, baby, child, fetus, Parents+, fathers, mothers, expectant parents, practitioners perspective or practitioner*, staff, nurse, mental health nurse, CPN, midwife, social worker, health visitor, substance use disorder, substance abuse*, substance misuse, or substance dependen*, drug abuse, drug misuse, drug dependen*, problem drug use, addict*, addiction service*, alcohol*, problem alcohol use, alcoholism, drinking behaviour, integrated services, integrated pathway, integrated program*, interagency, inter agency, multidisciplinary care, multidisciplinary team work, satisfaction, engagement, quality of care, expectations, experiences, opinion.

Appendix 2. PRISMA Table Phase One



Appendix 3. PRISMA Table Phase Two



Appendix 4. Ethics Approval Received from Edinburgh Napier University on 18.02.19

Rowat, Anne
Mon 18/02/2019 21:40
To: Aitken-Arbuckle, Alix
Cc: McInnes, Rhona; Stevenson, Paula
Dear Alix

Thank you for providing the documents. I have copied in Paula so she is aware you plan to submit to NHS Rec as soon as you have spoken with R&D

We wish you well and look forward to receiving the final letter of favourable opinion from the NHS REC soon.

Best wishes
Anne

Appendix 5. Ethics Approval Received by NHS South East on 02.04.19

Lothian NHS Board **South East Scotland Research Ethics Committee 02**

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000

www.nhslothian.scot.nhs.uk

Date 2 April 2019
Your Ref Our Ref

Enquiries to : Joyce Clearie
Extension: [redacted]
Direct Line: [redacted]
Email: Joyce. [redacted]

02 April 2019

Mrs Alix Aitken-Arbuckle
Edinburgh Napier University
Sighthill Campus
9 Sighthill Court
EH11 4BN

Dear Mrs Aitken-Arbuckle

Study title:	**Realist evaluation of 'XXXX' - an integrated multidisciplinary service for pregnant women with problem alcohol and drug use in Lothian.**
REC reference:	**19/SS/0045**
IRAS project ID:	**249782**

Thank you for your letter of 29 March 2019. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 22 March 2019

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other [Invite to Referrers]	2	29 March 2019
Participant consent form [Consent Form Women]	2	28 March 2019
Participant consent form [Consent Form Practitioners]	2	28 March 2019
Participant information sheet (PIS) [PIS service user]	2	28 March 2019
Participant information sheet (PIS) [PIS Practitioner]	2	28 March 2019
Research protocol or project proposal [Protocol]	2	29 March 2019
Response to Additional Conditions Met [response to additional conditions met letter to REC]		29 March 2019

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
GP/consultant information sheets or letters [GP Letter]	1	14 January 2019
Interview schedules or topic guides for participants [Topic guide]	1	14 January 2019
IRAS Application Form [IRAS_Form_25022019]		25 February 2019
IRAS Application Form XML file [IRAS_Form_25022019]		25 February 2019
Non-validated questionnaire [Service User Details]	1	14 January 2019
Non-validated questionnaire [Practitioner details]	1	14 January 2019
Other [Risk Assessment Proforma]	1	14 February 2019
Other [Genogram and Ecomap example]	1	14 January 2019
Other [Privacy Notice]	1	14 February 2019
Other [Debrief]	1	18 February 2019
Other [Data Management Plan]	1	14 January 2019
Other [Invite to Referrers]	2	29 March 2019

Participant consent form [Consent Form Women]	2	28 March 2019
Participant consent form [Consent Form Practitioners]	2	28 March 2019
Participant information sheet (PIS) [PIS service user]	2	28 March 2019
Participant information sheet (PIS) [PIS Practitioner]	2	28 March 2019
Research protocol or project proposal [Protocol]	2	29 March 2019
Response to Additional Conditions Met [response to additional conditions met letter to REC]		29 March 2019
Summary CV for Chief Investigator (CI) [CI CV]		15 February 2019
Summary CV for supervisor (student research) [Director of Studies CV]		14 February 2019
Summary CV for supervisor (student research) [Supervisor CV]		03 March 2019
Summary CV for supervisor (student research) [Supervisor CV]		03 March 2019

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

19/SS/0045	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

Joyce Clearie
SESREC 2 Manager

E-mail: [redacted]

Copy to: *Mrs Alix Aitken-Arbuckle*
ACCORD
Lead Nation
Scotland: nhsg.NRSPCC@nhs.net

Appendix 6. Amendment Approval Request Form submitted to Edinburgh Napier University on 19.03.20

School of Health and Social Care Ethics Committee
Amendment Approval Request Form

Edinburgh Napier UNIVERSITY

1	**Project ID Number: 18013**	**Name and Address of Principal Investigator:** Alix Aitken-Arbuckle School of Health and Social Care Edinburgh Napier University Room 1.B27 Sighthill Campus Edinburgh EH11 4BN
2	**Project Title:** Realist evaluation of 'XXXX' - an integrated multidisciplinary service for pregnant women with problem alcohol and drug use in Lothian. **Project Start Date: 25/3/19** **Project End Date: 01/03/21**	
3	**Type of Amendment/s (tick as appropriate)**	
	Research procedure/protocol (including research instruments)	☒
	Participant group	☐
	Sponsorship/collaborators	☐
	Extension to approval needed (extensions are given for one year)	☐
	Information Sheet/s	☐
	Consent form/s	☐
	Other recruitment documents	
	Principal researcher/medical supervisor* ☐ Other ☒	
	*Additions to the research team other than the principal researcher, student supervisor and medical supervisor do not need to be submitted as amendments but a complete list should be available upon request.	
4	**Justification** (give the reasons why the amendment/s are needed) The above study will be suspended from 19.3.20 as I am required to return to clinical practice in the NHS due to the COVID-19 Pandemic. This study is my PhD and I am the PI therefore the study can not continue at present. To this point all data collection is complete.	

5	**Details of Amendments** (provide full details of each amendment requested, state where the changes have been made and attach all amended and new documentation) I would like to suspend the study for 4 months at this point as suggested by the NHS and Head of PGR studies in SHSC.
6	**Ethical Considerations** (insert details of any ethical issues raised by the proposed amendment/s) As all data has been collected and I am analysing and writing up I do not see this posing any ethical concerns

Declaration (to be signed by the Principal Researcher)

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendments to be implemented.
- For student projects I confirm that my supervisor has approved my proposed modifications.

Signature:

Date: 19.03.20

FOR OFFICE USE ONLY:

Amendments to the proposed protocol have been …… by the Research Ethics Committee.

Signature of the REC Chair: …….

Date: ……

Appendix 7. Participant Information Sheets (PIS)

Evaluation of PrePare

Participant Information Sheet (Service User)

Edinburgh Napier University

We invite you to take part in a research study

We are looking for women who are involved in the PrePare service to tell us about their experiences.

What is involved?

You are invited to attend an interview or focus group at a local community health service.

You will be asked about your experiences with the PrePare service.

Interviews will last 60mins and focus groups will last 90mins.

What are the risks or benefits?

There are no risks to you or your baby's health from taking part in the research.

Your involvement with the PrePare team will not be affected if you choose to participate or not.

You will be offered £20 high street shopping vouchers to cover any out of pocket expenses.

Why are we doing this study?

There are not many studies which have been carried out in Scotland looking at **how services work** and **what impact they have** for women and babies.

Finding out **what works and why** may lead to changes and improvements to services like PrePare.

Who to contact?

If you would like to take part or discuss the study, please contact:

Alix Aitken-Arbuckle

[redacted]

Other staff involved: Dr Rhona McInnes, Dr Anne Whittaker and Karen Campbell.

PIS Women Version 1 IRAS ID. (249782) Study No. () 18.02.19

About the Researcher

My name is Alix, I am a postgraduate student from the School of Health and Social Care at Edinburgh Napier University.

I am conducting this study as part of my PhD.

Do I have to take part?

No, you do not need to take part in this study.

If you don't want to carry on with the study, you can stop at any time.

You will not have to give a reason and your involvement with the PrePare team will not be affected.

Further information

- Conversations with the researcher will be audio recorded but you can choose a different name, so you are not identified.
- In focus groups your identity cannot be kept confidential from others in the group however you will not be identified if the results are published.
- All the information you share will be stored securely on Edinburgh Napier University campus and only accessed by the researcher.
- With your permission the researcher will inform your GP that you are taking part in the study.

Will I be told the results of the study?

If you are happy to be contacted after the study has been completed, the researcher will invite you to an event where the study results will be presented.

Who to contact?

If you would like to speak to someone who knows about the study but is not involved, please contact:

[redacted]

Who is funding the study?

This study is funded by the Clinical Academic Research Careers Scheme.

Has the study been reviewed?

Yes, by Edinburgh Napier University and NHS Scotland Research Ethics Committees.

Evaluation of PrePare

Participant Information Sheet for Practitioners

Edinburgh Napier University

We invite you to take part in a research study

We are looking for practitioners involved in the PrePare service to tell us about their experiences.

What is involved?

You are invited to attend an interview at a local community health service.

You will be asked about your experiences working as part of the PrePare service.

Interviews will last 60mins.

What are the risks or benefits?

Involvement in the research will not implicate your position within the PrePare service.

The interview may provide an opportunity to reflect on clinical practice.

Participation will take place within your own time and can be arranged at a time which is convenient for you.

Why are we doing this study?

There are not many studies which have been carried out in Scotland looking at **how services work** and **what impact they have** for women and babies.

Finding out **what works and why** may lead to changes and improvements to services like PrePare.

Who to contact?

If you would like to take part or discuss the study, please contact:

Alix Aitken-Arbuckle

[redacted]

About the Researcher

My name is Alix, I am a postgraduate student from the School of Health and Social Care at Edinburgh Napier University.

I am conducting this study as part of my PhD.

Other staff involved include Dr Rhona McInnes, Dr Anne Whittaker and Karen Campbell.

Do I have to take part?

No, you do not have to take part in this study.

If you don't want to carry on with the study, you can stop at any time.

You will not have to give a reason.

Further information

- Conversations with the researcher will be audio recorded but you can choose a different name, so you are not identified.
- All the information you share be stored securely on Edinburgh Napier University campus and only accessed by the researcher.
- The researcher will go to every effort to anonymize the information collected from interviews however due to the select members of the team, elements of the information may be identifiable.
- The researcher will give you the opportunity to review the transcribed conversation prior to analysis being carried out.

Will I be told the results of the study?

If you are happy to be contacted after the study has been completed, the researcher will invite you to an event where the study results will be presented.

Who to contact?

If you would like to speak to someone who knows about the study but is not involved, please contact:

Who is funding the study?

This study is funded by the Clinical Academic Research Careers Scheme.

Has the study been reviewed?

Yes, by Edinburgh Napier University and NHS Scotland Research Ethics Committees.

Appendix 8. Consent Forms

Evaluation of XXXX

Consent form for Service Users

Edinburgh Napier UNIVERSITY

Participant Identification Number for this study (completed by researcher):

Title of Project: Evaluation of XXXX

Name of Researcher: Alix Aitken-Arbuckle

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and I am satisfied with the answers given. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
4. I understand that my interviews with the researcher are confidential **except** if I disclose details about a child or vulnerable adult at risk of harm or a serious unsolved criminal offence then the researcher may need to share this information. ☐
5. I understand for transcription purposes my interview/focus group recording may be shared with First Class Secretarial Service which Edinburgh Napier University have a data sharing agreement with (See Privacy Notice). ☐
6. I agree to take part in an interview or focus group with the researcher. My interview/focus group may be audio-recorded, and quotations may be used, but my identity will not be revealed. ☐
7. I agree to respect other members of the focus groups' confidentiality by not disclosing their identity or repeating what is said at the focus group. ☐

8. I agree to my General Practitioner being informed that I am taking part in this study. ☐
9. I agree to be contacted again within the next 12 months for another one or two follow up interviews. ☐
10. I agree for the researcher to contact the XXXX team if the researcher is unable to contact me via the telephone number I have provided. ☐
11. I agree for the researcher to contact me after the study to share the study findings and invite me to an end of study event. ☐
12. I agree to take part in the above study. ☐

Name of Participant……

Signature…….

Date……

Name of Person taking consent…….

Signature…….

Date……

When completed: 1 for participant; 1 for researcher site file.

Evaluation of XXXX

Consent form for Practitioners

Participant Identification Number for this study (completed by researcher):

Title of Project: Evaluation of XXXX

Name of Researcher: Alix Aitken-Arbuckle

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and I am satisfied with the answers given. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
4. I understand that my interviews with the researcher are confidential and may be audio-recorded, and that quotations from my interview may be used, but my identity will not be revealed. ☐
5. I understand for transcription purposes my interview/focus group recording may be shared with First Class Secretarial Service which Edinburgh Napier University have a data sharing agreement with (See Privacy Notice). ☐

6. I agree to take part in an interview with the researcher. ☐

7. I agree for the researcher to contact me after the study to share the study finding and invite me to an end of study event. ☐

8. I agree to take part in the above study. ☐

Name of Participant……

Signature……

Date……

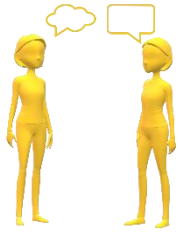
Name of Person taking consent……

Signature……

Date……

When completed: 1 for participant; 1 for researcher site file.

Appendix 9. Participant Debrief Letter



Evaluation of XXXX – Participant debrief information

Thank you for participating in the Evaluation of XXXX study. As previously stated this study aims to find out what services work for who and in what circumstances. Your experiences and opinions are greatly appreciated and will not affect your involvement with the XXXX service.

If you feel you no longer want your information to be used by the researcher please let the researcher know at this time or on the contact details below.

As previously stated the information you have given the researcher will be confidential and your personal details will not be used.

If you are affected by the discussions which have taken place during your interview and wish to discuss with someone else please let the researcher know.

Alternatively, you could contact Pregnancy Counselling and Care (Scotland) on 0131 555 2060 or info@lifelinescotland.org.uk.

Thank you again,

Alix Aitken-Arbuckle
Chief Investigator
Edinburgh Napier University
Email: [redacted]
Telephone: [redacted]

Appendix 10. Lone Worker Risk Assessment Completed 14.02.19

Risk Assessment Proforma: To Be Completed by The Researcher/ Supervisor or the Principle Investigator

Researcher Name:

Alix Aitken-Arbuckle

Title of Project:

Realist evaluation of XXXX- an integrated multidisciplinary service for pregnant women with problem alcohol and drug use in Lothian.

Date(s) to be carried out:

March 2019- March 2021

List here any potential risks you (as researcher) may face in carrying out this research: (Please consult the ENU Risk Assessment Information together with the SRA Code of Practice for Social Researchers available at :

http://the-sra.org.uk/wp-content/uploads/safety_code_of_practice.pdf

The researcher may be at increased risk of:

Physical or verbal abuse harassment from participants or members of the public whilst working alone.

Participants may be under the influence of drugs or alcohol when in contact with the researcher increasing this risk.

Outline here the measures/steps you are putting in place to minimise these risks:

The researcher's safety and wellbeing will be ensured through several measures including NHS Lothian lone worker policy, reflection and supervision support.

Interviews and focus groups will be arranged during working hours between Monday and Friday at a local community health centre. Arrangements will be shared with members of the research team and a "safe and well" communication will be shared with the team in line with NHS Lothian lone worker policy. The researcher will carry a personal alarm for emergencies and mobile phone to contact supervisors.

In the event of participants requesting interviews to take place in the home, if it is considered safe to do so, the researcher will attend with a colleague.

A reflective diary will be kept and monthly supervision meetings with the research team will continue throughout the study. If required the researcher will be able to contact a member of the supervision team for immediate support or advice via telephone.

Researchers carrying out research off-campus should complete the following:

I will ensure that on each occasion someone that I can trust knows:

Where I am going*.

How I am getting there (including travel route).

When I expect to be back.

What to do should I not return at the specified time

* Ensuring to maintain participant confidentiality

Outline here the procedure you will be using to do this:

The supervision team will be kept fully informed of the dates, time and location of interviews and mode of transport through a shared online diary through student email account. On most occasions a personal car will be used to travel to the research location. The researcher will carry a mobile phone and text/phone the director of studies when arriving and leaving the interview in accordance with “safe and well” practice.

If the researcher has not contacted the director of studies within 1 hour of the expected end of interview, then the director of studies will phone the researcher to check location and safety. In the event the director of studies is not available another member of the supervision team will be contacted. Two members of the team will be attending focus groups (in health centre) or interviews in the clients home for safety.

Researcher's signature: [redacted] **Date:** 14.02.19

Supervisor's/ PI signature: [redacted] **Date: 14-02-19**

Appendix 11. Privacy Notice

Privacy Notice

Name of Research Project: Realist evaluation of 'XXXX'- an integrated multidisciplinary service for pregnant women with problem alcohol and drug use in Lothian.

Description of Project:

This study is a realist evaluation of a multidisciplinary and multi-agency service (NHS and Social Services) for pregnant women with alcohol and drug use. This three phase study will consist of qualitative data with service users and practitioners, document analysis and secondary analysis of routinely collected annual reports from XXXX service.

Data Controller	Edinburgh Napier University Sighthill Campus 9 Sighthill Court EH11 4BN
Purposes for collection/processing	Data is being collected for the purposes of the above study only.
Legal basis	Art 6(1)(e), performance of a task in the public interest/exercise of official duty vested in the Controller by Statutory Instrument No. 557 (S76) of 1993 as amended, e.g. for education and research purposes. Edinburgh Napier University is the data controller and the legal basis for this study is that you have given explicit consent to take part. You have been advised of your right to withdraw consent at any time and how to do this.
Whose information is being collected	Practitioners working within the XXXX team and service users attending XXXX service.
What type/classes/fields of information are collected	Name, identifying numbers, contact details, sensitive personal data, demographic data, views and opinions.
Who is the information being collected from	From the data subject (directly),
How is the information being collected	In person by the researcher (Alix Aitken-Arbuckle), paper form, recorded interview, telephone.
Is personal data shared with externally	The audio-recordings will be transcribed by an external company called 1st Class Secretarial Services. The

	university has a data-sharing agreement in place with this organisation to ensure that all data is kept secure, you can view their Privacy Statement here https://www.1stclass.uk.com/privacy_statement_01052018.pdf.
How secure is the information	The information will be secure through the universities measures to protect data. The data will be stored electronically on the V:Drive on Edinburgh Napier University network and any paper documents will be stored in a locked file in a locked office only the researcher and director of studies has access to.
Who keeps the information updated	Researcher: Alix Aitken-Arbuckle
How long is the information kept for	Identifiable information will be destroyed within 12 months of study end date. All other data will be securely stored for up to 10 years from the end of the study.
Will the data be used for any automated decision making	No
Is information transferred to a third country? Outside the EEA and not included in the adequate countries list.	No

Information on subject rights and data protection queries:
http://staff.napier.ac.uk/services/secretary/governance/DataProtection/Pages/statement.aspx

Data subjects have the following rights:

a) To be informed e.g. receive a privacy notice
b) To access e.g. obtain a copy of their personal data being processed (subject access request)
c) To have their data rectified if it is incorrect
d) To erasure (right to be forgotten) where it is no longer necessary for the purposes, but not where this is likely to render impossible or seriously impair the objectives of a research project
e) To restrict personal data being processed
f) To portability (request a copy of the data provided in a machine readable format)
g) To object to processing in certain circumstances
h) To be notified of their rights
i) Not to be subject to decisions, which affect them as an individual, based on automated processing (only) and profiling activities
j) To be informed if there is a breach of their personal data which will result in a (high) risk to their rights and freedoms.

Appendix 12. Professional Indemnity and Liability Certificates

TO WHOM IT MAY CONCERN

16th July 2018

Dear Sir/Madam

EDINBURGH NAPIER UNIVERSITY AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following cover is currently in place:

PROFESSIONAL INDEMNITY

Certificate of Entry No.	UM176/17
Period of Indemnity	1st August 2018 to 31st July 2019
Limit of Indemnity	£5,000,000 any one claim and in the aggregate except for Pollution where cover is limited to £1,000,000 in the aggregate
Cover provided by	U.M. Association Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

[redacted]

Paul Cusition
For U.M. Association Limited

TO WHOM IT MAY CONCERN

3rd July 2018

Dear Sir/Madam

EDINBURGH NAPIER UNIVERSITY AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:

PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM176/17
Period of Indemnity	1st August 2018 to 31st July 2019
Includes	Indemnity to Principals and includes cover whilst University employees and its students are engaged in Health and Social Care activities world-wide – excluding Medical Malpractice claims except as under
Includes	Medical Malpractice (mistreatment) claims against the University and its employees and its students providing the latter are working under the supervision of a medically qualified person
Limit of Indemnity	£20,000,000 any one event and in the aggregate in respect of Products Liability and Unlimited in the aggregate in respect of Public Liability Medical Malpractice – £10,000,000 any one event and in the aggregate
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Ltd

Yours faithfully

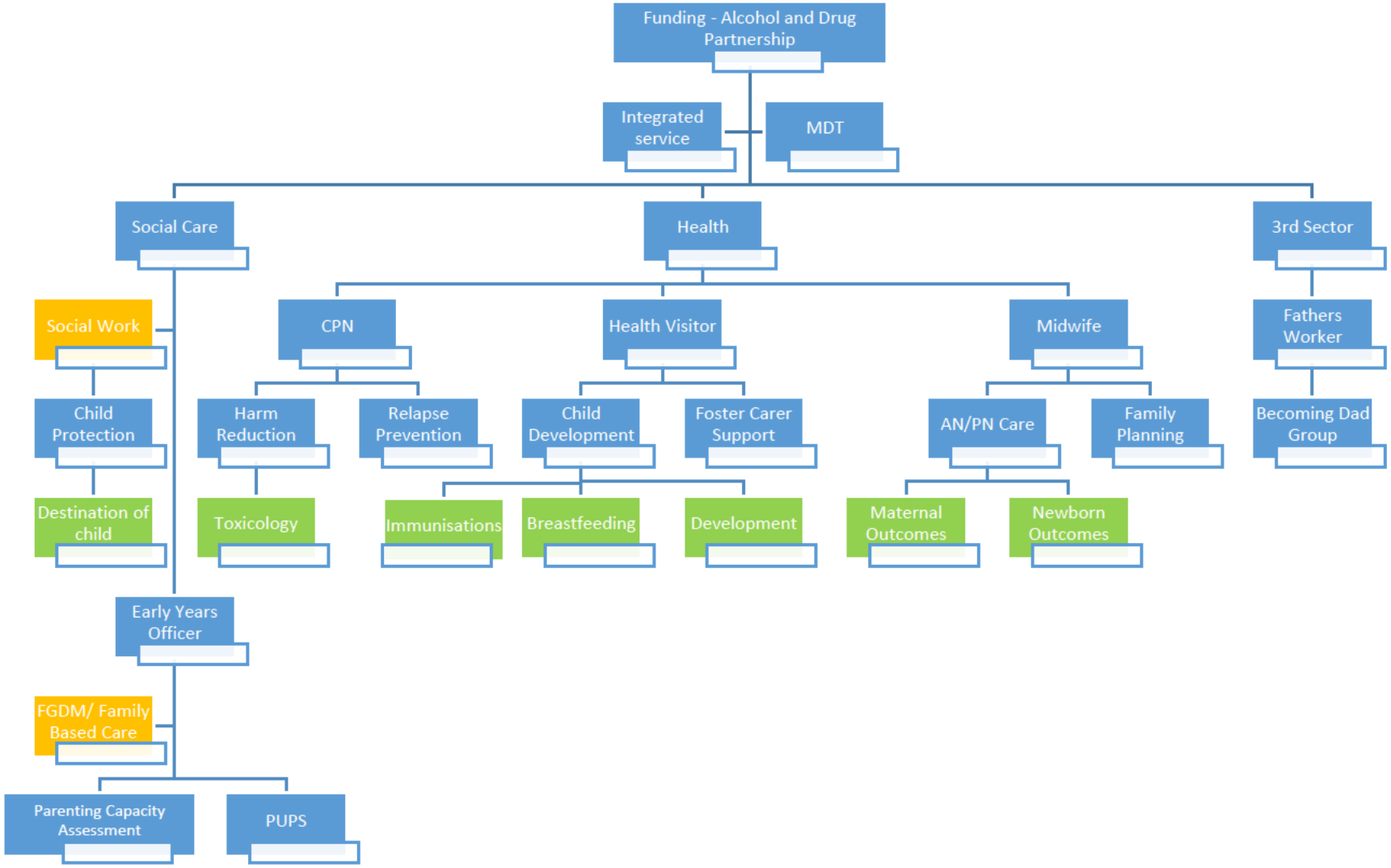
[redacted]

Paul Cusition

For U.M. Association Limited

5 St Helen's Place, London EC3A 6AB | T: 020 7847 8670 | www.umal.co.uk

Appendix 13. Programme Architecture



Key: Blue- Resource Orange- Referral Green- Outcome

Appendix 14. Policy Documents Included in Review

Author	**Title**	**Core principle**
Early Years and Child Protection		Child centred
O'Brien et al., (2003)	**Report of the Caleb Ness Inquiry**.	
Scottish Government (2010)	**National Guidance for child protection in Scotland**.	
Scottish Government (2018c)	**A Guide to Getting It Right for Every Child in Scotland**.	
Scottish Government (2016)	**GIRFEC:** Promoting Supporting and safeguarding the wellbeing of children and young people	
Early Years and Drug and Alcohol Polices		Family Centred
Whittaker (2003)	**Substance Misuse in Pregnancy:** a resource pack for professionals in Lothian.	

Author	**Title**	**Core principle**
ELBEG-PP (2013)	**Getting it right for children and families:** affected by parental problem alcohol and drug use. Guidelines for agencies in Edinburgh and the Lothian's	
Scottish Government (2013b)	**Getting Our Priorities Right**: Updated good practice guidance for all agencies and practitioners working with children, young people and families affected by problematic alcohol and/or drug use.	
Whittaker (2014)	**Practitioner Toolkit:** Getting it right for children and families affected by parental problem alcohol and drug use.	
Drug and Alcohol Policies		Person Centred
Edinburgh Alcohol and Drug Partnership (2015)	**Strategy and Delivery Plan 2015-18**	
Department of Health (2017)	**Drug Misuse and Dependence:** UK guidelines on clinical management.	

Author	Title	Core principle
Scottish Government (2018b)	**Rights, Respect and Recovery: alcohol and drug treatment strategy:** Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths.	
Maternity Policies		Woman Centred
NICE (2010)	**Pregnancy and complex social factors**: a model for service provision for pregnant women with complex social factors	
Scottish Government (2011)	**Reducing Antenatal Health Inequalities:** Outcome Focused Evidence into Action Guidance	
Scottish Government (2011)	**A Refreshed Framework for Maternity Care in Scotland.**	
Scottish Government (2017a)	**The Best Start:** A five year plan for maternity and neonatal services in Scotland.	

Appendix 15. Stakeholder Interview Topic Guide

Semi structured interview questions:
Implementation level stakeholder interviews.

Realist evaluation is based on the construction of theories. These are made from a series of context, mechanism and outcome.

> ***Context: what conditions are needed for a measure to trigger mechanisms to produce particular outcomes patterns?***
>
> ***Mechanism: what is it about a measure which may lead it to have a particular outcome in a given context?***
>
> ***Outcomes pattern: what are the practical effects produced by causal mechanisms being triggered in a given context?***
>
> **Pawson and Tilley 1997**

1. Can you describe who the "XXXX" team is aimed at?
2. What do you think "works" and does "not work"?
3. Overall what would be considered as a success for "XXXX"?
4. In your opinion what are the short and long term **aims** of "XXXX"?
5. What *outcomes* do you think are a priority?
6. What realistic resources are available for "XXXX"?

Appendix 16. Interview Schedules (Service Users)

	Question	**Logic**
1.	What were the most important things to you during your pregnancy/ postnatal period (time since you found out you were pregnant)	Q1-2 Introductory to get participant talking
2.	What has been most important to you during your time with the XXXX team? Has this been different? Prompt: what did you see as the best outcome for you and your baby?	Q1-2 Introductory to get participant talking
3.	How did XXXX help you with this?	Q3. Resource Mechanisms (M) leading to Outcome (O) empowerment, shared decision making, choice, control.
4.	What do you think was most important to the XXXX team- what makes you think this?	Q4. Context (C) of woman's perception of service, service focus and ethos
5.	Having experienced the XXXX team what do you feel is the most important to the staff? Has this changed to what you thought was important to them before you engaged with the team?	Q5. Context (C) of woman's experience of service, service focus and ethos.
6.	Where did you see XXXX staff? Is this easy for you to access? Acceptable to you? Did you feel welcomed? Prompt: services aim to be non-stigmatising, non-judgemental to include and welcome everyone- how did you feel?	Q6. Mechanisms (M) for accessibility (non-stigmatising, non-judgemental) and location of service leading to Outcome (O) of attendance/engagement
7.	Where you involved in the plans and decisions? Prompt: Was there expectations put on you? Was it clear what was expected of you? How was this shared with you?	Q7. Mechanisms (M) of communication on Outcome (O) shared decision making, empowerment, control,
8.	Someone else has told me the relationships they had with the staff was important- What can you tell me about the relationships you have with staff? Prompt-Are these good? Do you trust them? Why?	Q8. Context (C) and Mechanisms (M) of trust leading to Outcome (O) therapeutic relationships
9.	Tell me how XXXX helped include your family?	Q9. Mechanisms (M) leading to Outcome (O) shared decision making, inclusion of family
10.	XXXX involve Fathers- did you partner take part? Did someone else take part? How was this decided? Prompt: was this your choice and was it revisited?	Q10. Mechanisms (M) leading to Outcome (O) shared decision making, choice, inclusions of family

	Question	Logic
11.	In some areas teams like XXXX offer Peer support- some women find it helpful to speak to women going through similar experiences. – is this something you were offered? Do you think it would be helpful? Why? What might prevent or stop you from going along to peer support?	Q11. Context (C) of resource Mechanism (M) Peer support and Outcome (O) acceptance/ uptake within (C)
12.	Is there anything else you would like to tell me about your experience with XXXX or anything you think could have been done better?	Q12. Closing question scoping for additional input.

Appendix 17. Interview Schedules (Practitioners)

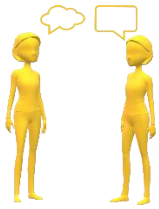
	Question	**Logic**
1)	In your own words can you tell me what your role is in the XXXX service? And what brought you to this role?	Introductory to get participant talking
2)	How do you see the service as **INTEGRATED,** to what extent and what this offers?	Testing integration of service
3)	How does a MDT approach help your practice? Prompt: Assess to skilled staff	Testing MDT approach to support practitioners and their work.
4)	How does a MDT approach help coordination of the service for families? I'm thinking about more timely assessments and problem solving	Testing MDT approach to improving service outcome, **unearthing mechanisms from MDT**
5)	How does co-location improve communication within the team? Im thinking about what the formal and informal communication opportunities can do for the team and individual.	Testing co-location as a resource for improved **communication**
6)	What can peer supervision within the team offer you? How do you see supervision influencing the individual and the team? (morale, retention, burn out)/	Testing **mechanisms and outcomes of peer supervision.**
7)	How is responsibility and accountability understood within the team? Is this helped by the specialist practitioners/ case co-ordinator? And in what way?	Testing **mechanism of responsibility and accountability.**
8)	What motivates and supports you/ keeps you dedicated to work in this challenging area? Prompt: other skilled staff? Peer supervision?	Testing theory of mechanisms improving team morale, retention, burn out.
9)	What do you think are the main aims of the service? How are these the same similar or different across the different disciplines?	Exploring ethos of team,
10)	How does this help or hinder the service?	Testing **tensions or complements of ethos** in team
11)	When you bring disciplines from different areas into one service, there are going to be different priorities, what is your priority?	Exploring ethos
12)	How do these priorities blend together in this service?	Testing ethos

	Question	**Logic**
13)	How do these priorities cause tensions within the service?	Testing ethos
14)	If the service is portrayed to or perceived by the woman to be **focused on child protection how do you think this changes your practice? the team? makes women feel?** Prompt: some thoughts are this could make women feel they have to prove themselves, not respected, no privacy, no autonomy. (Disengagement)	Testing context and mechanism of child centred approaches
15)	If the service is portrayed to or perceived by **the woman to be focused** on her as well as baby (recovery) how do you think this **changes your practice? The team? makes woman feel?** Prompt: respected autonomy, included, (Engagement)	Testing context and mechanism of woman centred approaches
16)	Often women referred to the service have had a past experience with social work service and have fear and distrust of the service- How do you aim to build relationships with women?	**RESOURCES**: non-judgemental, flexible, open, honest, info sharing-**MECHANISMS**: **RESPECT, CONSIDERED, TRUST, INFORMED**
17)	What is it about…that leads to therapeutic relationships	**MECHANISM: RESPECT, CONSIDERED, TRUST, INFORMED**
18)	In terms of the flexibility of the service- how do you offer a flexible approach and what does this achieve? Prompt: Choice- needs led. Example of talking through PUP booklet instead of using it in booklet form, Offering appointments near woman's work…	Testing resources and mechanisms and outcomes of flexible service: **RESOURCES:** tailoring, goal setting **MECHANISM: VALUED, CHOICE, AUTONOMY, HOPE** **OUTCOME:** satisfaction, pos experience, engagement, motivation, behaviour change.
19)	What expectations or goals do you set with/ for women? Prompt: Discuss ethos	Exploring expectations of the service
20)	How are these received by women? **Motivation vs constraining** Prompt: Hope vs false hope.	Testing mechanisms of goal setting, **HOPE vs FALSE HOPE**.
21)	What happens if these are/ are not met… And how do women respond?	Outcomes of expectations, goal setting from practitioner or woman's perspective?

	Question	**Logic**
22)	What do you think makes women **engage/ NOT engage** with services?	Exploring additional context mechanism outcomes of engagement
23)	Resources: can you tell me when and how you use these resource? How is this received by women? **INTEGRATION**	Intensions of service? Perceptions for service, Integration of service
24)	Is there anything else you think makes the service work or not work that we haven't covered? Anything else you think is important?	Closing question scoping for additional input.

Appendix 18. Participant Questionnaire (Practitioner)

Edinburgh Napier UNIVERSITY



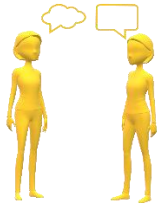
Evaluation of 'XXXX'- Participant details sheet (practitioner)

Date of interview:

Name	
Participant ID code	
Telephone contact number	
Email	
Date of birth	

Discipline	
Length of time in XXXX team	
Length of time in role	

Appendix 19. Participant Questionnaire (Service User)



Evaluation of 'XXXX'- Participant details sheet (women)

Date of interview:

Name	
Participant ID code	
Address	
Telephone contact number	
Date of birth	

GP Details	
Name	
Telephone no.	
Address	
Prescribed drugs for substance misuse (include daily dose)	

Marital status	**Previous 'XXXX' involvement**
Married / Divorced / Co-habiting	Yes / No (If yes please state dates)

List all children living at home

Gender		On child protection register?
❑ Male Female	❑	❑ Yes ❑ No
❑ Male Female	❑	❑ Yes ❑ No
❑ Male Female	❑	❑ Yes ❑ No
❑ Male Female	❑	❑ Yes ❑ No

List all children <u>not</u> living at home

Gender	On child protection register?	Details of out of home care (name of carer, type of care)
❑ Male ❑ Female	❑ Yes ❑ No	
❑ Male ❑ Female	❑ Yes ❑ No	
❑ Male ❑ Female	❑ Yes ❑ No	
❑ Male ❑ Female	❑ Yes ❑ No	

Accommodation status

Home owner / Own tenancy / Joint tenancy / Officially 'homeless' or living in temporary accommodation / other?

Employment status

- ❑ Employed full-time or part-time (official/unofficial)?
- ❑ Unemployed/Job seekers allowance?
- ❑ Sickness/Incapacity?
- ❑ Employment Training Scheme?
- ❑ In full-time/part-time education?
- ❑ Other? Please state

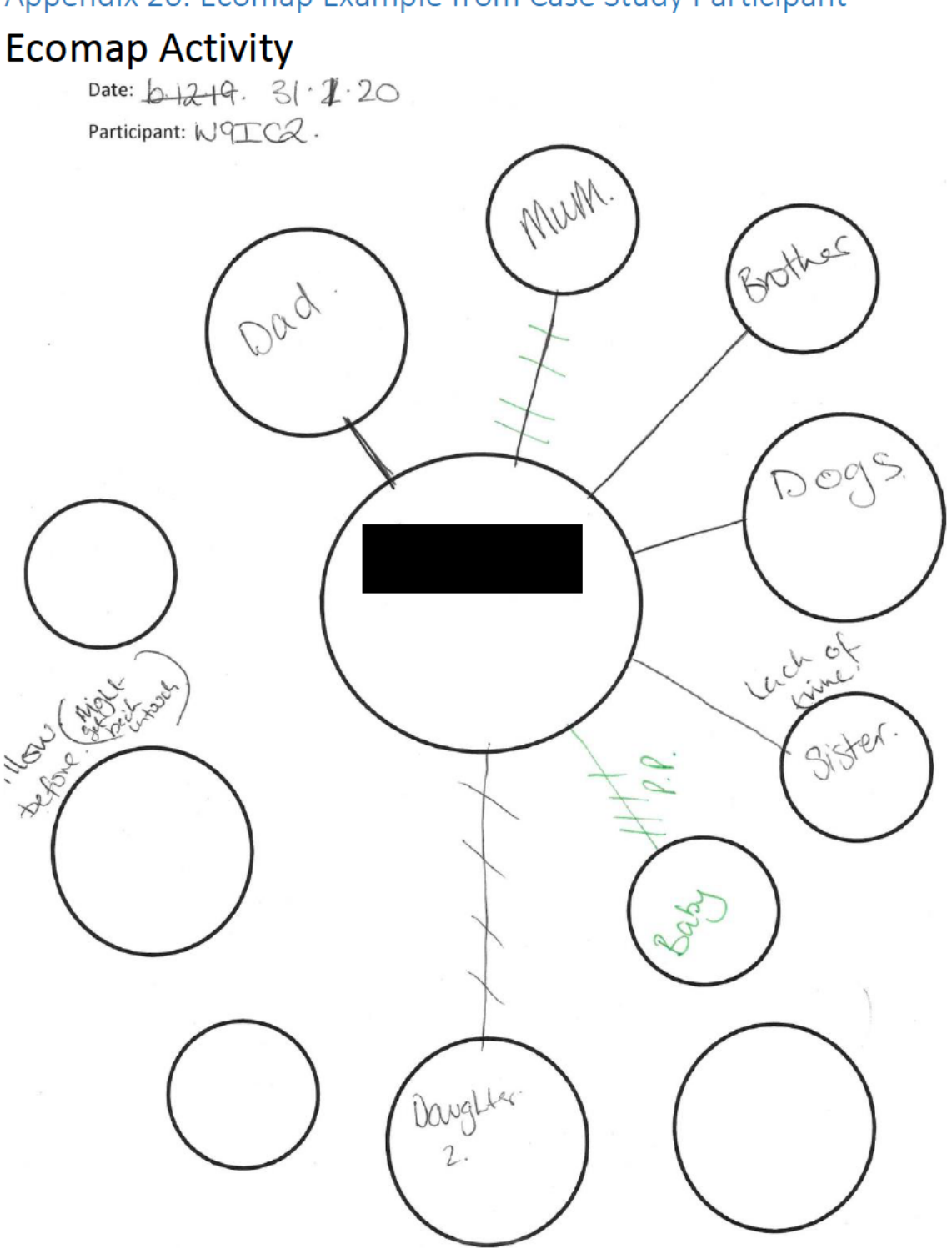
Educational status			
Qualifications?		Left school aged?	

Health status	
Any significant physical health problems (e.g. receiving treatment/under investigation)?	
Any significant mental health problems (e.g. receiving treatment/under investigation)?	
Number of years of problem drug use?	

Legal issues

- ❑ Prison history (sentences not remand)?
- ❑ Any impending court cases/sentencing?
- ❑ Any unpaid fines?
- ❑ On license?
- ❑ On bail?
- ❑ On a probation order?
- ❑ On a community service order?
- ❑ On a DTTO?
- ❑ Any other legal issue

Appendix 20. Ecomap Example from Case Study Participant



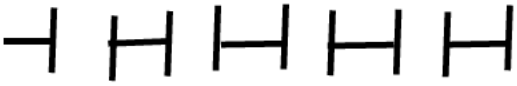
EcoMap Version 1. Evaluation of XXXX 20.8.19

Ecomap Activity Key

Strong Relationship

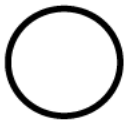
Weak Relationship

Stressful Relationship

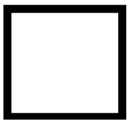


Broken Relationship

Direction of Energy/ Resource



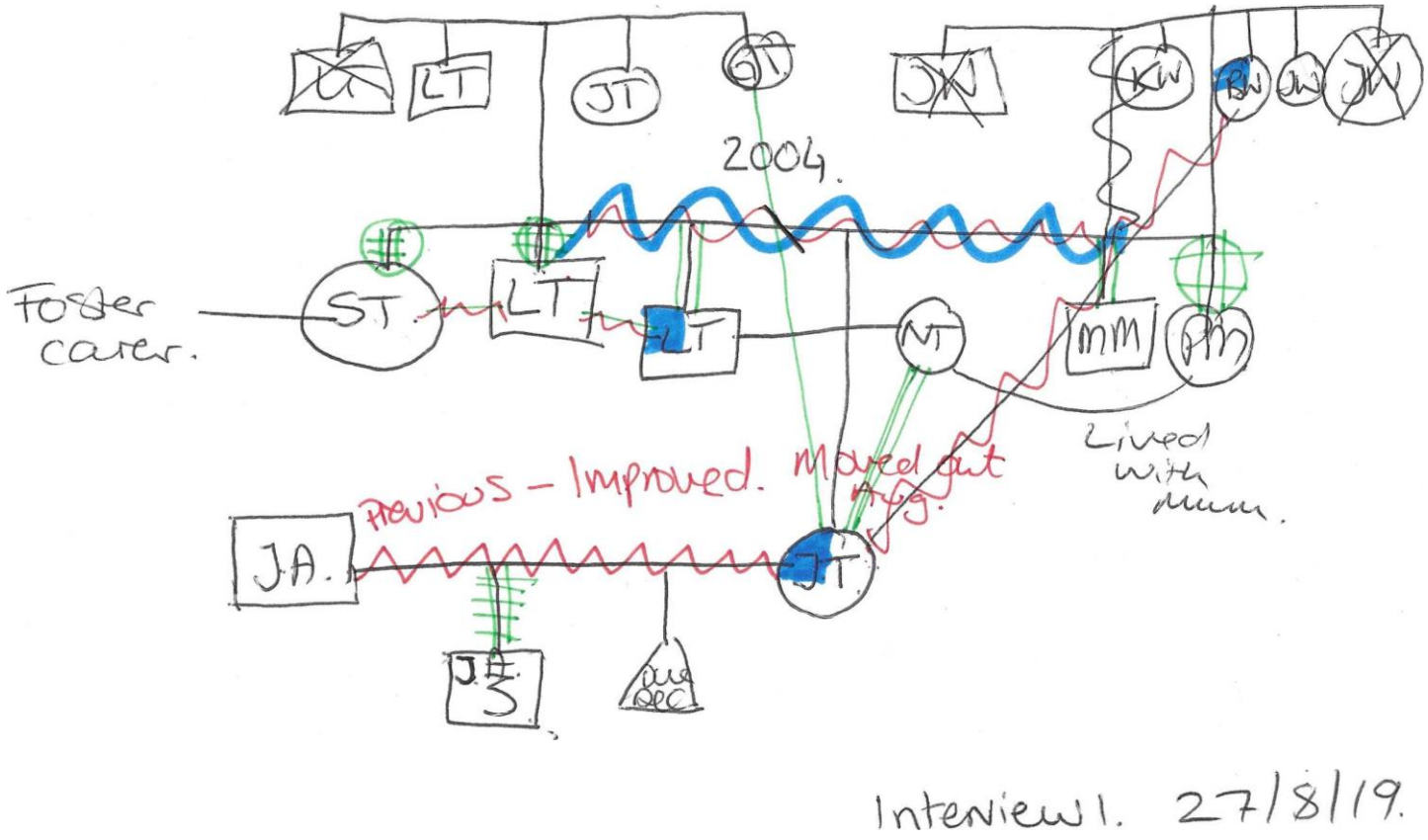
Woman



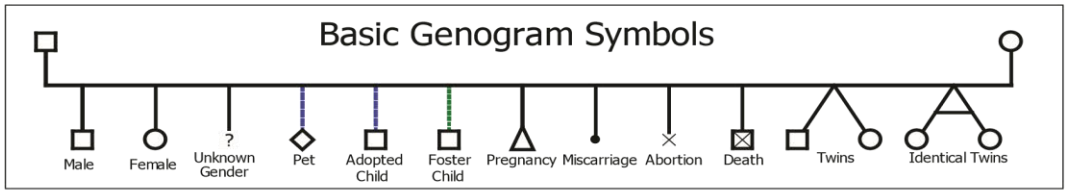
Man

Social Support	Family, friends, support groups,: neighbours, religious organizations, pets
Community Resources	Health care, mental health services, drug and alcohol services, legal assistance, court, employment, financial assistance, housing assistance,
Stressors	Family dynamics, health issues, transportation, pregnancy

Appendix 21. Genogram Example from Case Study Participant



Interview 1. 27/8/19.



GenoPro
www.genopro.com