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Biographical histories of gendered parental substance use: Messages from mothers to professionals as to what interventions help or hinder journeys of recovery

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Abstract

This paper reports on data that is part of a wider evaluation of a small-scale project that offers support to parents, children and families affected by alcohol and substance use. Using semi-structured interviews and a focus group, the data in this paper explore mother's sense making of their substance use and their experiences of various professional interventions which have helped or hindered their personal journeys of recovery. Mothers' narratives suggested a self-critical inner dialogue conceptualized as shame. Fear of stigma and a sense of shame derived from historical abuse and had a profound effect on how mothers perceived themselves and how they negotiated a web of professionals involved in their lives. Community projects with a focus on understanding mothers and their needs, and not the risk they posed to their children, were considered most supportive. Interventions working within a non-judgemental and empathetic framework that fostered the importance of relationships and connection had a greater impact on mothers' *long-term* recovery goals.

KEYWORDS
mothers, parental substance use, professional interventions, relationships, shame, trauma

1 | INTRODUCTION

Parental substance (mis)use is considered a significant social problem of international concern, particularly the harm to children (Harwin et al., 2013). It is frequently cited as negatively impacting upon parenting capacity and children's welfare (Cleaver et al., 2011; Farmer et al., 2011; Forrester & Harwin, 2011). Galvani (2012) argues that the central issue is how parental substance use affects parents' capacity to care for their children and not parents' substance use per se (Galvani, 2012). While there is much social work discussion on the adverse impact of parental substance use on children's welfare, development and safety, there is far less documented on parents' biographical histories and sense-making of their substance use, and how these influence and shape parent's experiences of working with social workers and other professionals. More specifically, it is mothers in the context of social work which the word 'parents' often represents. Without understanding mothers own sense making of their substance use from a gendered lens and what this means in terms of their parenting, it is problematic to assume that all parents who use substances are unable to adequately care for their children. For children whose parents use substances, the short- or long-term outcomes vary immensely (Cleaver et al., 2011; Templeton et al., 2006). Thus, we cannot *simply* generalize about the impact of parental substance use on *all* children, nor what interventions help or hinder journeys of recovery without being informed by parents' narratives of the complexities that lie therein. Thus, while parental substance use and the

impact on children is well documented, it is mothers sense making of their substance use and their experiences of various interventions which is the focus of this paper.

1.1 | Framing parental substance use

Data by Public Health England (2017–2018) suggest that 25,593 parents, with a total of 46,109 children under the age of 18, were accessing treatment for their substance use, but 81% of parents who use substances stated that their children were not receiving support from early help services or had children's social care involvement. Eight percent of parents living with children who were accessing treatment for their substance use had a child protection plan in place; only 3% had children looked after by the local authority, only 3% whose children were considered child in need (CIN), and a further 3% whose children were subject to early help interventions (Public Health England, 2018, p. 33). These figures suggest that parental substance use does not necessarily lead to concerns regarding children's welfare or parents' capacity to care for their children. However, it is worthy to note that these figures represent only those parents who are accessing treatment. Fear of stigma and access to services significantly affects Black Asian and Minority Ethnicities (BAME) who are likely to be an underrepresented population in targeted substance use services (Hurcombe et al., 2010). The social stigma surrounding substance use often means that parents largely seek professional help as a last resort irrespective of whether the need for help is identified by parents much earlier (Broadhurst, 2007). Stigma is the main psychosocial issue differentiating substance use between men and women (Covington, 2002), which suggests that the social construction of gender explains why women may experience stigma more acutely than men. Holland et al. (2014) highlight stigmatized identities in relation to parenting and substance use. As such, the stigma and the threat of severe consequences often lead women and their families to minimize the impact of substance use (Covington, 2002). For these reasons, it is likely that there are more parents (mothers) using substances than is currently known (Adamson & Templeton, 2012; Adfam, 2013). Therefore, the numbers of children living with parents who use substances may be considerably underestimated, which is neither helpful in safeguarding children, nor in parents including BAME parents voluntarily accessing support for their substance use.

In a social work context with children and families, Forrester and Harwin (2006) noted in their work that 34% of cases involved concerns regarding parental substance use. While parental substance use is a significant issue for childcare social workers, it remains an under researched aspect of practice (for important examples of British research see Forrester & Harwin, 2006; Forrester, Holland, et al., 2012; Holland et al., 2014). There are limited studies that seek to understand parents own lived realities and reasons for their substance use, why and when parents seek support for their substance use, whether accessing support is voluntary or not, and what helps or hinders parents accessing services to support their recovery, particularly when children have been removed from parent's care. Forrester and Harwin's (2006) study suggest that cases open to social services because of parental substance use rarely had any other specialist agencies involved, although an evaluation by Forrester, Holland, et al. (2012) noted in their evaluation of the Option 2 Intensive Family Preservation Service that the families were open to a number of agencies, including children's services which meant a reduction in parental substance use.

1.2 | A journey of recovery

Reaching a point of recovery is neither straightforward nor fast. (Re) lapse is to be expected (Harbin et al., 2000), wider family and potential support is affected (Templeton et al., 2016) and positive change for sustaining recovery is difficult (Barnard & McKeganey, 2004; Duffy & Baldwin, 2013; Farmer et al., 2011; Harwin et al., 2013; Harwin & Ryan, 2008). Reasons for parents being unable to reach a point of recovery is often connected to individual motivation, or key practical matters such as having the opportunity to attend treatment centres of other professional services because of caring or childcare responsibilities (Mendoza et al., 2010). The ability of parents to sustain recovery will of course be affected by many interacting factors including the type and number of difficulties they are trying to overcome (e.g., poverty, homelessness, mental distress, and domestic abuse) together with the quality of family and social support available to them. Laudett et al. (2006) note that higher levels of social and therapeutic support specific to recovery may lead to more successful recovery efforts for both men and women. However, research suggests that denial, shame, and guilt, frequently prevent women from accessing therapeutic support (Mendoza et al., 2010). The potential of losing their children can be particularly shame inducing for mothers (Walker, 2011). Even without the addition of substance use, mothers are generally the subject of scrutiny and judgement based on their capacity to adequately care for their children. From a child welfare perspective, Gibson (2015) suggests that professionals require a greater understanding of shame and the significance it holds in whether parents are able (or not) to make the desired changes that social workers impose on them.

Mitchell and Burgess (2009) found that family-focused services have positive benefits that improve outcomes for families, particularly those which foster therapeutic alliances between professionals and service users. Therapeutic relationships in this context mean professional encounters that do not exacerbate parents' feelings of fear, judgement and shame. While I have alluded to the possible negative impact of parental substance use on children, in this paper, the focus is parents' sense making of their challenges with substances, their experiences of professional interventions, and what has helped or hindered their recovery. Raistrick et al. (2006) suggest that positive *therapeutic* relationships between professionals and service users increases the likelihood of positive outcomes, which may be a significant factor in parents' success of recovery. Forrester, Holland, et al. (2012) found that long-term support with professionals that were caring and committed were significant for parents in reducing their substance use.

These findings suggest that there are factors that help but also some which hinder parents addressing their substance use which the findings from mothers narratives in this paper builds on.

2 | METHODOLOGY

The data for this paper form part of a wider qualitative mixed method, evaluation of a project in the North West of England that offers support to families affected by parental alcohol and substance use.

2.1 | Background (the evaluation)

At the time of the evaluation (April 2018–April 2019) the project had 44 open cases with one full-time team leader, a full-time family worker, a male volunteer and two social work students on placement working with parents, children and grandparents/carers accessing the project. Mapped against the ethos of the project in taking a 'whole family' approach, the aim of the wider evaluation was to gain direct service user perspectives from *all* family members regarding the interventions they were receiving from the project and whether the service provided by the project had a positive impact on their lives. Data for the evaluation were drawn from children and young people, substance using parents and grandparents/carers who were accessing the project prior to and during the evaluation period. Measures taken for evaluating the project included documentary analysis of organizational documents (e.g., referrals and Star Outcome data); direct observations of parents, children and grandparent/carers group sessions in terms of content, activities and facilities; separate focus groups with parents, children, grandparents/carers; one-to-one interviews with parents ($n = 8$) and project workers ($n = 2$); family day evaluation data from parents and grandparents/carers ($n = 6$), and a children's arts based evaluation suited to younger children ($n = 14$) to depict wishes and feelings around their experiences of the project. The design and methods used for the evaluation were mapped against the aims and objectives of the project, which were to reduce parental substance use; (2) improve children's self-confidence and emotional well-being, (3) reduce grandparents/carers stress through group support and (4) enable all family members to gain social/peer support networks. While data for the evaluation were collected from children and grandparents/carers, it is only focus group and individual interview data from consenting mothers attending the project that are the focus of this paper.

2.2 | Data collection and analysis (mothers)

As an exploratory study, eight mothers agreed to take part in one-to-one interviews following a focus group and were all over the age of 18. The sample size that forms the data for this paper is in part representative of the small number of mothers engaging or accessing the project for support during the time of data collection, but not the number of cases open to the project. A limitation of this study is not having the views of those parents that were not accessing the project at the time of the evaluation. At the time of participation, all mothers were accessing targeted interventions and/or support services, for their substance use either voluntarily (e.g., because they identified they had an issue) or because they had been directed to (e.g., by the court or social services). All mothers described a pattern of professional involvement that started with one agency, but which often meant the development of a complex web of involvement with other agencies. All mothers had more than one agency involved in their lives because of substance use and its perceived impact on their children. All mothers met the criteria for accessing the project, and all of those who agreed to participate in this study reported that they had ceased to use substances. For nearly all of the mothers, all or some of their children no longer resided with them and had been removed by children's services on a kinship care arrangement on grounds of their substance use. This meant that many of the children were looked after by family members. Carers (mainly grandparents) and children of many of the mothers who participated in the focus group and interviews were also receiving support from the project under evaluation, although as noted earlier, is beyond the scope of this paper.

Mothers attending the project were first asked what had brought them to the project in the first instance. This invited mothers to 'tell their story' in a collective setting to foster feeling safe and supported amongst peers with shared lived experience. Narratives are the principal way that humans give meaning to experiences (Murray, 2008), therefore it was important to consider both what was talked about by mothers in the sample, and how they told their stories. Mothers who had taken part in the focus group were invited to take part in individual interviews ($n = 8$), which enabled them to explore the meaning they gave to their experiences of substance use, their encounters with professionals both within and outside of the project under evaluation, how they experienced the targeted project that was under evaluation and what these experiences meant in terms of what had been a help or hindrance in their very personal journeys of recovery.

Verbatim transcripts were produced and analysed using thematic analysis techniques (see Braun & Clarke, 2006). Themes were generated from participants data and then mapped against the agreed aims between the funding body and service provider to establish if these outcomes were being met. The sense and meaning mothers applied to their experiences were analysed using thematic analysis which meant codes and later overarching themes were generated. This method of analysis was chosen for its applied and practical utility that the project a could work with and disseminate upon completion of the evaluation. Ethical approval for this study was obtained and granted from the Central Ethical Committees at the university where the researcher is affiliated. All participants were fully informed, gave their permission for sessions to be observed, to take part in the evaluation, and for anonymized data extracts to be used for the purpose of this paper. In acknowledging issues of power, participants were reassured that choosing not to take part or choosing to withdrawing consent for the use of their data would not have a detrimental impact on the type and quality of the service or the relationship with project workers prior to the evaluation.

3 | FINDINGS

The eight mothers that participated in the focus group and individual interviews were at various points of recovery. The concept of 'recovery' is used here as 'A process of change through which individuals improve their health and wellness, live a self-directed life and shine to reach their full potential' (Brown & Victor et al., 2017, p. 1327). In attempting to avoid the use of derogatory language, I have chosen to use the term 'substance use' throughout this paper rather than 'substance misuse' as the latter suggests a 'loaded term' (Allan, 2014, p. 8) with moral undertones.

All of the mothers' accounts suggested that the origins of their substance use were a means of coping with distressing life events or past trauma. This type of 'self-medicating' is seen as a way of reducing pain, or as what Hammersley and Dalgarno (2013) describe as 'Escape coping' (Allan, 2014, p. 44). The mothers reported difficulties in 'coping with life' and had previously 'self- medicated' to cope with a range of issues including mental health issues; trauma from childhood, including child sexual abuse; and abusive or negative relationships both in childhood and adulthood, such as domestic abuse.

3.1 | Shame, trauma and secrecy: Feeling inferior and disconnected

Previous research suggests a link between shame and substance use (Potter-Efron, 1987; Weichelt, 2007) and linked to supporting or hindering recovery (Luoma et al., 2012). The mothers in this study also evidenced these links, in addition to depression, anxiety, sexual abuse in childhood and domestic violence and abuse. Mothers made implicit and explicit references to feelings of shame and guilt when disclosing these sources of trauma and the nature of their substance use. Tracy and Robins (2007, cited in Gibson, 2015) helpfully demarcate shame as a stable negative attribution of the self as unworthy or bad (I am bad), while guilt is also negatively experienced as being behaviour specific (I did a bad thing). Walker (2011) suggests that individuals can feel alone, exposed, frightened and excluded from human connectedness. This is echoed by mothers who spoke of developing strategies to cope with their feelings around their substance use, such as the deliberate act of isolation as a means of protecting themselves from further pain, fear, and exposure. As one mother explained:

> I isolated myself because I did not want anyone knowing my business. I was scared to tell people what was going on and how I felt. I suppose I shut myself off from everyone … and my feelings and what was going on. I did not want people to know. I do not know … just fear.

Talking in the broader context of her growing dependency to cocaine, this mother consciously placed herself out of view to avoid anyone being privy to her cocaine use. Another mother also reflected on her isolation as a form of protection:

> When I was at the height of my addiction, and because I suffer from depression and anxiety as well I would isolate myself in my bedroom. I would not want to talk to anyone and I would not want to interact with anyone. I was ok if I kept those curtains closed and the door shut – no one could get in.

Making a link between her mental health and addiction, this mother used metaphors synonymous with 'home' and 'privacy' to explore how she protected herself from the outside world. Her home was positioned as a place of safety where there was less risk of her vulnerabilities being exposed. All mothers spoke of not seeking help due to fear of exposure, reprisal, or fear of the consequences. In not wanting to face the consequences of her alcohol use and feelings of guilt and shame, one mother shared the following:

> … the actions that I [did] while I was drinking, I hated myself for. So I did not want to face the consequences of when I drank, so I would have another drink. It's the shame and guilt cycle. You wake up in the morning with guilt and shame and so then you have another drink.

Here, the mother describes a self-loathing, and the perpetual nature of shame and guilt linked to her alcohol use. Her account provides a sense of a 'shame of shame' cycle that dominated her life during her alcohol dependency. There is a duality of shame and guilt in that her alcohol use is a cause of difficult feelings, and also a strategy for coping with the shame caused by her alcohol use. In a further example of how the cycle of shame and guilt works, another mother stated:

> I could make myself believe anything was true, and so that's how you live with it … the guilt and the shame because you make yourself believe, but then you wake up sober and go 'Oh no' and that's where the next drink comes in to deal with that shame and guilt. It is the shame and guilt you cannot live with, and then with the next drink it slowly becomes easier … through drinking you justify the things you do … everything erm [pause] you justify it. So until you are off that cycle it is just a painful wheel and there is no escape from it.

An association is made here between shame and guilt and this mothers alcohol use—it is a cycle that helps to numb feelings. She suggests that being 'sober' presents a problem for her in dealing with the painful realities of her alcohol use. It is a trap that she felt unable to escape from. However, over time, she provided a rationale for her drinking; she was able to 'justify' her alcohol use by attributing it to other people's actions. This direct othering of self and the displacement of shame and guilt on to others enabled this mother to rationalize her alcohol use.

3.2 | Experiencing loss: Reaching crisis point and accepting help

Catalyst events that prompted professional involvement in parents' lives occurred because of their substance use, leading in many instances to the removal of their children by children's services. For example, one mother described her own crisis point as occurring when she realized that her child was going to be removed from her care:

> It came to a head a couple of years ago. I become alcohol dependent and had not realised, and had a seizure while I was holding the baby … and my little girl she is only two. So she was removed from my care from social services. I was still fighting the world … So when I had the seizure with the baby I stopped drinking for seven whole weeks, but it was pure white knuckling without any help you know. At that point I still did not accept I was an alcoholic. My point was 'well I am not drinking so just give me my baby back'. When I found out she [the baby] wasn't coming back into my care when I thought she should be that's when I hit the catalyst and I did … well I thought 'well if they are not going to give my baby back then I am going out to have a drink anyway' and well that one drink I was supposed to have turned into a week-long of drinking, that led me to being sectioned.

Alcohol dependency was not something this mother realized until she experienced two traumatic events starting with the removal of her daughter by children's services. It was only through reaching a point of crisis (i.e., being sectioned by mental health services) that she began to accept her alcohol dependency—it is at this point of acceptance that her fight response dissipated and she was able to open herself up to receiving professional support. As the extract below demonstrates, loss and grief were also a catalyst for another mother in seeking help:

> I was made homeless. That was a big thing for me. I was there for 28 days before I got a place of my own …. That was my rock bottom. Lost my kids. Lost my relationship with my mum. Lost my home … So it got worse and because the girls were with mum they would not pay rent anymore so I was made homeless because of that. It should have been the worst thing but it was the best thing 'cos if that had not of happened I would have stayed in the same vicious cycle.

This mother's account highlights that reaching the lowest point in her life, specifically the loss of her children, finally made her seek help. While all of the mothers feared accepting professional support following defining crisis points, the exposure of their substance use became an opportunity to focus on their substance use rather than maintaining it as a 'secret'—a positive step forward towards recovery.

3.3 | Mothers' experiences of professionals being involved in their lives

Mother's accounts suggested that their experiences of services and different professionals in addressing their substance use varied considerably. Mothers experienced this profoundly, particularly in relation to the exacerbation of feelings of shame. Professionals affiliated to specialized services for substance use were experienced more positively by mothers, as the focus was on them and not the harm that their substance use posed to their children. These types of services allowed mothers to explore their substance use within a non-judgemental and empathetic framework. However, children's services, with a focus on risk to children, meant a very different experience for mothers in which shame was heightened by 'a sanctions and rewards' model—focusing on a 'deficit' model of their parenting through the 'choices' they made (i.e., substance use) and the impact of this on their children. For mothers with children's services involvement, social workers were experienced as judgemental and lacking empathy. Based on their experiences, and a fear of social workers removing their children from their care, mothers were reluctant to request support from social services and worked with them only if they had to. Mothers suggested a clear shift in how they experienced involvement with social workers which accompanied their acceptance of their substance use and being ready to accept help. Their relationships also changed at the point in which they understood that social workers held the power to make life-changing decisions about their children. One mother spoke of how it felt to have agencies involved in her life:

> Initially it was very intrusive where I was constantly having to air my washing about everything. Now because I am so open its not so intrusive, because I am an open book today. But I do know I can go to people if I need help today.

This extract denotes a shift from not feeling unsupported in the past to feeling supported in the present. This mother describes how talking about personal things to different professionals was both intrusive and painful. There is a recognition that professional help is available if she wishes to access it, although in accessing support, this mother is able to identify the 'right' people to meet her needs. This mother's response suggests that there are a number of professionals involved in her life who are supporting her recovery. In terms of the latter, the same mother suggested that her perception of professional relationships was fundamental in whether she accessed support and what kind of support it was:

> I do have a more personal relationship with [a project worker] than the social worker, so would feel more

> comfortable asking a question with [the project worker]. I would not feel [sighs] I do not know [pause] it would feel like I was just asking advice rather than being judged which they [social workers] can make you feel (Mother).

Here the mother suggested that interpersonal professional relationships matter in what types of help are sought from professionals. How professionals make this mother feel (i.e., comfortable or judged) determine who she will seek help from. However, there is a sense that social services remain a potential threat based on the judgements that they have made of her perhaps based on her past experiences. Another mother explains how asking for help depends on what kind of place you are in:

> It is far easier to ask for help when you are in a good place and things are going well. I would not ask for help when I was in a bad place because I was struggling anyway, so the more I exposed myself, the more likely [the baby] was going to be taken [by social services], or I wasn't going to get her back. Today when I am asking questions it is about retaining a good relationship I've got with social services rather than expose myself do you know what I mean. I am now on the right side of the fence with them now. I do not have anything to expose now. I think when you are in addiction you are always hiding a lot of things even from yourself.

This mother made a clear statement that asking for help is experientially more difficult to do when things are not going well. The mother provides a sense that services are potentially threatening, as it is a way of the private being 'exposed' once more, which may lead to negative judgements being made of her that have repercussions. This mother suggests that asking for help is likely to create a situation that will prove potentially harmful.

3.4 | Engagement for a more positive experience with professionals

Collectively, the mothers' narratives provide useful messages for practice in terms of how professionals might empower mothers who use substances to access services. All of the mothers described how level of engagement makes a difference in how professional interventions are experienced, as one mother noted:

> It is a lot easier when you work with them than if you fight them (laughs). Well first you are on a losing battle straight away if you fight them [social services]. That was my thing because I thought that the world was against me because I was fighting myself. So it was like everyone above me on a ledge and I was under it. I thought bad things about everyone because obviously I was in that bad place. If you are willing to work with people they are willing to work with you … and it's just mutual respect I've found. Today, people show me respect because I am giving respect as well, so that is half your battle. Engagement is key and that's how I manage professionals being in my life (Mother)

Drawing on the language of 'war' as a metaphorical battle ground, this mother conveys a feeling of powerlessness: she has no option other than to work with children's services as she knows she has even less power if she chooses not to. Here the mother places herself beneath everyone else with others looking down on her which clouds her perceptions of self and others. However, she draws on the value of respect and its importance in fostering a more equal working relationship between her and her social workers. Using the metaphor of a 'game' in describing the involvement of professionals and the support she receives, this mother noted:

> I do think I am helped and supported from a combination of everyone, but I think that's because I engage with everyone as well. You are central to it. If you do not engage with anyone then its game over, so you have to be open in order to get the help.

This mother believed that engagement is key for facilitating supportive relationships. Another mother equated her engagement as a way of negotiating power between her and social services:

> Social services being involved has not necessarily been a bad experience … everyone gets scared but if you engage with them then they will help you. The biggest fear is that they are going to take your kids away, but I had that done to me anyway. So the only way to keep [baby's name] was to engage with them. If I had not engaged with them then he [baby] would have gone too. I could not have dealt with that. You have to engage with them to be a mum.

This mother acknowledged the power that social workers held in deciding the fate of her youngest child that is still in her care. She highlighted a lay perception of what social workers do, namely, the removal of children, a view that was validated by her previous experience of having children removed. To prevent any chance of this happening again with her youngest child, she acknowledged that engagement with social workers is the only option she has. The mother powerfully equates engagement with social workers as a 'permit' to be a mother and does not see them in a negative light because she has already faced the loss of two children. As the mothers' narratives suggest, engagement with professionals is far easier when they have demonstrated change in regards to their substance use. Thus, a change in positioning (from a substance user to not) changes how professional interventions are experienced by

mothers. There still remains an issue for those mothers who are not able to demonstrate change in the same way as the mothers' narratives above suggest.

3.5 | It is not just me: A sense of mutuality as healing through group work

Hearing other mothers narrate their stories of substance use in a group setting moved mothers from a position of perceiving that they are the only one to have failed in some way, towards a sense of mutuality and empathy for themselves and others.

> I suppose it is about talking about our life experiences. We can look back and see where we went wrong without being judged, and seeing other people and what they are going through, so that really helps.

This mother described accessing group support and the strength she received from being able to look back retrospectively at life events that have led her current position. The importance of mutuality is important in that is means not 'being judged'. The process of being able to openly share experiences is important for parents. Being part of a group enabled important human connections to be established that were facilitated through the vocalization of shared experiences, as one mother noted:

> It is just information about what you are going through, what everyone has been through and just sharing advice because we share similar things in what we have been through.

Sharing personal information about life experiences precipitates peer mentoring in the form of advice giving and support. Interview accounts are consistent with group interview data in which mothers see a shift in position; from a place of disconnection to reconnection through the sharing of common experiences. Connections through experience are powerful in that mothers feel safe and supported without fear of judgement. In summarizing the power of the group in supporting long-term recovery one mother stated:

> you make important connections with like-minded people which makes you want to stay well

This statement is an important final message for professionals in working with parental substance use. Relationships are central to how mothers experience and negotiate professionals being involved in their lives. Such a position enables relationships and connections to be established that promoted this mother's sense of well-being and facilitated her recovery. Thus, facilitating gender responsive interventions for mothers who use substances that foster values of mutuality, empathy, human connection and relationships are very powerful ingredients for promoting change in supporting mothers' journeys of recovery from alcohol and other substances and for children remaining in their care.

4 | DISCUSSION AND CONCLUSION

This paper reports on eight mothers biographical accounts of their substance use and their experiences of various professional interventions as a result. While parental substance 'misuse' and its impact on children is widely documented, far less is documented on mother's own sense making of their substance use which has been the focus of this paper. Giving voice and value to these mothers' narratives has been an important antidote to the all too familiar feelings of judgement, shame, isolation and disconnection they have felt because of traumas of child sexual abuse, domestic abuse, mental distress and substance use. By presenting these findings, this paper has sought to provide important messages for practice as to how professionals may work with mothers' trauma narratives while offering support to mothers and their children in helpful, healing and affirming ways. Foregrounding relationship-based practice offering trauma informed responses to parental substance use is what the mothers' narratives and their experiences of various professional interventions would suggest is very helpful in supporting journeys of recovery.

The mothers in this study tended to possess a self-critical inner dialogue that was conceptualized as shame. Mothers' sense of shame had a profound effect on how they perceived themselves and how and to what extent they interacted and experienced professional interventions during the initial and longer-term stages of their recovery. For example, social work interventions with a focus on the risk substance use posed to their children were characterized by pain, powerlessness, loss, grief and fear and served to exacerbate mothers' feelings of shame. Mother's accounts suggest these feelings are painful rather than helpful and thus calls for the need for professionals to explore and work towards minimizing mothers' sense of shame (Gibson, 2015).

Denial about the extent of parental substance use is likely to be shame-based and may be a means for mothers to minimize the emotional pain of shame (Walker, 2011). The stigma and the threat of severe consequences (e.g., the removal of children by children's services which all the mothers had experienced) often lead women and their families to minimize the impact of substance use which is not the same for men (Covington, 2002). This means that mothers become known to agencies because of reaching crisis point and not because of voluntarily seeking support. For these reasons, it is likely that there are more parents using substances than is currently known (Adamson & Templeton, 2012; Adfam, 2013) which is not helpful for mothers needing support or for safeguarding children affected by parental substance use. Thus, working with shame requires professional relationships to be built with mothers which fosters a sense of trust, safety and respect so that mothers can seek help before crisis, to negate the potential judgemental, dehumanizing and punitive measures of professional practices such as the removal of children by children's services.

It is unsurprising from the mother's narratives that they had varied experiences of working with professionals from different agencies. Targeted projects addressing substance use were experienced by mothers most positively because the focus was on them and their needs, and not the 'perceived' risk they posed to their children. In these services, mothers considered professionals to be non-judgemental and empathetic which was most helpful in their journeys of recovery. Feeling understood, a sense of care and not feeling judged encouraged and determined mothers' level of engagement with agencies, who to seek support from, and the quality of relationships they built. Thus, for interventions to be deemed positive and something worthy of voluntary engagement, workers need to be caring and available, understand parents' problems, and importantly acknowledge their strengths (Forrester, Holland, et al., 2012).

An important intervention acknowledged by mothers was peer support groups which were offered by the project under evaluation. These groups were important reaffirming contexts for mothers as they created the conditions for mothers to re-establish a sense of connection with others – this had been lost for many years because of their substance use and living lives shrouded by secrecy, fear, and isolation. The power of these groups in supporting mothers' recovery relied on acceptance, empathy, and non-judgemental attitudes from both professional facilitators and other group members. Seemingly, the crucial role professionals played within these peer groups were 'connectors of relationships' in which mothers sought further opportunities for connection as a result.

Providing mothers with the opportunity to share lived experiences with others who share similar experiences is an extremely powerful source of intervention—mutuality of experience and not feeling like the only one has powerful therapeutic benefits for mother's emotional well-being and their recovery. It is evident that while it is deemed that professional interventions are necessary, it is the power of lived experience that can be significant to mothers' recovery goals. To et al. (2021) also notes the strengths of group interventions and which the mother's narratives in this study support. To et al. (2021) suggest that group interventions provide mutual support which is empowering, promotes a sense of agency. They further suggest the sharing of stories aids individuals sense making of historical events and experiences which can encourage personal growth and healing through the generation of new narratives. It is possible that such groups facilitate healthy relationships that create increased empowerment, self-knowledge, self-worth, and a desire for more connection (Covington, 2002) which is a powerful antidote to shame and disconnection the mothers in this study report.

Situated in the lived experience of mothers who have used substances and having a variety of professionals involved in theirs and their children's lives, messages for practice suggest a multi-agency response is essential for supporting mothers in their journeys of recovery. Mothers have shown how they negotiate professionals in various agencies in different ways and will utilize support from different professional's dependent on their experiences with them, how they make them feel and the relationship they have with them—it is these ingredients which offer the most futile grounds for recovery from substance use to take place. It is clear that there are shared commonalities of practice advocated by the mothers in this study that they suggest have supported their journeys of recovery—empathy, non-judgemental attitudes, acceptance, mutuality, minimisation of shame, and connecting with others have been important for change to happen for them.

In the best interests of the child, the removal of children by children's services might be a necessary intervention for safeguarding children, but one which is most painful for parents, as these mothers accounts have highlighted. However, what they also highlight is that is the *experience* of the interventions and relationships they have with professionals which are quintessential. As proposed by the method of Motivational Interviewing (M.I) it is *the way* professionals have a conversation about change and how they elicit a person's own motivation to change is what matters (Forrester, Holland, et al., 2012; Forrester, Westlake, & Glynn, 2012). Acknowledging a parents ambivalence to their substance use, professionals relinquishing the idea that they can make change happen if they are able to provide enough 'good' reasons to convince a parent to change their behaviours around substance use, and skills in how professionals guide conversations towards behaviour change is important if change is to happen (Miller & Rollnick, 2013; Forrester et al., 2014). Mothers key messages reported in this paper would suggest MI to be a way of working for positively promoting parents' recovery from substance use.

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CONFLICT OF INTEREST

The author declares that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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