Parental involvement in child protection services and parenting experience as a drug or alcohol using parent: an interpretative phenomenological analysis

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Abstract
This paper explores the emotional experiences of drug- and/or alcohol-using parents who have child protective Social Services involvement. Research suggests that protective processes can reduce children's experience of poor outcomes while parents undergo treatment for substance misuse. Semi-structured interviews combined with photovoice, and journal writing were used to generate data. Eight UK-based parents participated. Each was accessing drug or alcohol treatment and had a child who was the subject of a child protection intervention. The resulting data from the 17 interviews were analysed using Interpretative Phenomenological Analysis (IPA). Key findings are presented within four themes. The first two outline parents' perceptions of themselves and how they felt they were viewed by others. Themes three and four focus on specific emotions: anger and frustration; fear and guilt. The research identifies the complex nature of parental emotions surrounding drug/alcohol misuse when social care services are involved. Parents conceptualised their experience as a psychological trauma. They discussed the emotional roller-coaster of the effects of having combined interventions. The research provides insights into how drug/alcohol use can influence parenting. It also highlights issues for professional practice, including developing successful treatment models for substance using parents.

Keywords – Identity; Parental drug/alcohol abuse; Parenting; Social care intervention; Trauma.

Summary
In this article, we demonstrate how the parents included in this research, who were all subject to child protection interventions, experienced a range of conflicting emotions in negotiating these interventions. We present a novel methodological approach, where including a variety of methods of data generation over an extended period enhanced understanding of the longer-term emotional effects of child protection interventions on the experience of parenting. These parents' views of themselves, and their perception of others' assessments of them, often related to self-blame and feelings of worthlessness. They conceptualised their experience of the involvement of child protection services as a psychological trauma. We argue that there is a need for more appropriate treatment models, including further exploration of family interventions, for drug or alcohol using parents.

Introduction
This paper explores the experience of parental substance misuse (Goddard, 2021; Collins, 2011; Velleman & Templeton, 2016) and the potential effects on parents' capacity to meet their children's needs (Cleaver et al., 2011; O'Shay-Wallace, 2020). We focus on emotional effects including participants' perceptions of their circumstances, anger, frustration, fear and guilt. We suggest there is a need for more appropriate treatment models for drug/alcohol using parents.

At times when risks are high child protection services can be implemented (Brandon et al., 2012). These might result in children's temporary or permanent removal from home (Conners et al., 2004). Velleman & Templeton (2016) suggest these protective processes can reduce the chance of children experiencing poor outcomes. Many parents (and professionals working with them) derive benefit from social care interventions (Taplin & Mattick, 2015) such as Child Protection and Child in Need Plans. Child Protection Plans follow a child protection enquiry if it is believed a child will experience significant harm. They outline the support and monitoring to be put in place to reduce this risk of harm. Child in Need plans are used when children are assessed as needing help to stay safe and healthy, or to develop correctly. Both plans are required and governed by the Children Act 2004 (UK Public General Acts, 2004).

For some users, rather than complete removal of a child/children the extended family might care for them. The potential use of the family as a system for long-term change is often ignored (Lander et al., 2013). Family members can be vital to both preventing and intervening with substance use and misuse. They can reduce risk and encourage and promote protection and resilience (Velleman, et al., 2005; Cassidy & Poon, 2019). Despite them being framed as 'the first line of defence' (Flacks, 2019), this can result in blurred roles and responsibilities for family members involved. The imbalance of power in family relationships can be a source of anxiety and prompt feelings of being judged (Kenny & Barrington, 2018). Matthews (2007) suggests that initial gratitude for the increased support may cause power struggles when users return to parenting. Families might need treatment for themselves; solely focusing on the substance user fails the extended family. To prevent family breakdown, services should work collaboratively to educate those with a family

member accessing treatment. They should be on hand to step in and support the family, parents and children where necessary (Cleaver et al., 2011; O'Shay-Wallace, 2020).

Parents accessing drug and alcohol treatment may experience a range of emotions (such as shame and guilt) before, during, and after treatment (Klee, 1998; Sithisarn, Granger & Bada 2012; Kearney, 2014). Awareness of 'disfranchised grief' is necessary for those working with parents accessing treatment (Elizabeth, 2019). This can occur when a loss has been experienced that is not acknowledged by society (Doka, 2001; 2008). This grief might be the result of ongoing circumstances or of historical incidents of child removal. Parents might feel they do not have the right to grieve or express their emotions due to their addiction: their loss has been caused by their substance abuse (Smithson & Gibson, 2017).

Improving understanding of treatment programmes' and social care interventions' impact on drug/alcohol using parents is necessary. The complexity of addiction means that tailoring care plans to individuals is often misunderstood by treatment providers (Flynn, 2017). Standardised treatment packages might not address this complexity, resulting in frustration for parents. To avoid this, parenting and substance misuse should be treated separately. Reducing drug and alcohol dependency does not always result in improved parenting (Cleaver et al., 2011). It can take time for parents to change their behaviour. Day et al., (2018) suggest issues relating to engagement in treatment programmes should be explored. Cleaver et al., (2011) and Cornwallis (2013) suggest that flexible time frames for interventions can lead to success. They suggest parents should not be pushed to change deep-rooted behaviours. Services should support them to actively address their addiction and encourage them to access treatment.

One such programme (Parents Under Pressure) is run by the National Society for the Prevention of Cruelty to Children (NSPCC; Hollis *et al.,* 2018). Through helping parents to have a better understanding of their own addiction and supporting them to manage crisis events the programme reduces significant problems (Dawe *et al*., 2003; Dawe & Harnett, 2007; Barlow et al., 2019; Eggins et al., 2022). A second programme – Moving Parents and Children Together (M-PACT) – focuses on family time and repairing family relationships (Templeton, 2014). Parents taking part in this programme benefit from realising others have similar experiences. Day & Mitcheson (2017) suggest that implementation of such programmes results in therapeutic intervention for the user, thus enhancing their coping strategies. It could, therefore, be argued that delivering treatment in this way might lead to better outcomes for those in treatment.

In this paper we explore the experiences of drug/alcohol using parents when accessing treatment for their addiction plus having an intervention in place for their children. We address a gap in the literature by explicitly giving voice to parents in relation to their lived experience. We show elsewhere that drug/alcohol-using parents with a child subject to a Child Protection or Child in Need order feel powerless in the Social Services system (Goddard et al., 2023). They are afraid to be open and honest with professionals for fear of having their children removed (Smithson & Gibson, 2017). We argue, here, that more research is necessary to understand the complex emotional impact from the perspective of parents. This will inform the development of better models of practice, thus improving the relationships between families and those authorities monitoring their progress.

Methods

Design

This qualitative research included the same group of participants in three stages of data collection. Each involved individual, face-to-face, semi-structured interviews (Adams, 2010). Stage 1 explored participants' experiences of being drug/alcohol using parents of children subject to a social care intervention. Stage 2 explored the meanings attributed by participants to photographs they had taken about their day-to-day experiences. This method (photo-elicitation or photovoice), is well suited to vulnerable or marginalised groups, allowing participants to illustrate their worlds with images and words (Copes et al., 2018; Sutton-Brown, 2014; Woodgate *et al.*, 2017). Stage 3 explored the meanings of journal entries in which participants recorded their everyday experiences. This approach gives participants greater influence over the interview agenda and can facilitate collecting and sharing emotional data (Channa, 2017; Spowart & Nairn, 2013). The overall study design followed published guidelines for achieving fidelity and trustworthiness in qualitative research (Levitt et al., 2017; Chammas, 2020).

Context and participants

All eight participants (seven female, one male) were receiving treatment in the Midlands, UK, for drug and alcohol issues and were at different stages of recovery. The Office for National Statistics (2022) reports 11.5% of adults aged 16-59 years using cannabis every day. Our participants had been long-term regular drug users and were included if they were: (a) parents of a child/children currently subject to a social care intervention (Child Protection Plan or Child in Need Plan); (b) currently accessing treatment for drug and/or alcohol use; and (c) over 18 years old. Participants with previous knowledge of the primary researcher or with a partner participating in the research were excluded. All identified as White British and were given pseudonyms to protect their anonymity. Further summary information about participants is given in Table 1.

Ethical approval

Ethical approval was gained through local regulatory and ethics processes. All participants consented at each stage. Participants' photographs were processed and presented for publication following ethical considerations identified for this type of research (Copes et al., 2018).

Materials

Interviews were recorded using an Olympus digital voice recorder, VN-5500PC. In Stage 2 participants were given a standard disposable camera and asked to photograph aspects of their daily lives. In Stage 3 participants were given a notebook and asked to write a reflective journal about their everyday lived experience.

Table 1: Participant information

Pseudonym	Age	No. of children	Treatment summary	Social care intervention	Stages of participation
Darcy	30s	2	Fluctuated between treatment and incarceration.	Fluctuated between Child Protection and Child in Need Plans; then Special Guardian Order.	1, 2 & 3
Stephen	20s	1	In and out of treatment; incarcerated; residential treatment.	Child Protection Plan; then Child in Need Plan; then Special Guardian Order.	1, 2 & 3
Stella	20s	1	In treatment for the 2nd time. Stabilised on Methadone. Ended treatment.	Child Protection Plan; then Child in Need Plan.	1 (no longer contactable after Stage 1)
Reagan	30s	4	In treatment for several years. Stabilised on Subutex but then returned to smoking cannabis.	Fluctuated between Child Protection and Child in Need Plans.	1 (became pregnant; withdrew from study)
Nikki	30s	2	2nd time in treatment. Stabilised on Subutex and became mostly drug free with minor lapses. Ended treatment.	Child Protection Plan; then Child in Need Plan; end of Social Care involvement during study.	1, 2 & 3
Ellie	20s	3	Began treatment at a young age. Continued to purchase illegal Subutex whilst in treatment.	Child in Need Plan; then Child Protection Plan; then removal of all children.	1 & 2 (incarcerated; withdrawn from study)
Chloe	30s	1	3rd time in treatment for heroin use. Immediately became drug free and stable in treatment when she fell pregnant.	Child Protection Plan.	1 (became pregnant; withdrew from study)
Sarah	40s	2	2nd time in treatment for her alcohol use. Stabilised in treatment with a detox plan.	Child in Need Plan.	1, 2 & 3

Procedure

All research data were generated between 2016 and 2018. Interviews were conducted in the clinic by the first author (KG) at times chosen by participants. The research design and methods enabled those considered vulnerable or hard to reach to participate as fully as possible. This included those who may be less articulate or reflectively insightful about their experience. The procedure followed published good practice for collecting qualitative data (Chammas, 2020), e.g., ensuring familiarity with the culture of the participating treatment centre and debriefing sessions between authors.

Stage 1 interviews focused on early drug experiences and access to treatment. They included exploring social services' involvement and participants' feelings about any interventions. During Stage 2 participants photographed any everyday object/item that illustrated their feelings or experiences. Following a recap of their first interview they then chose photographs to discuss. They talked about how they took the photographs as well as their feelings relating to those chosen for discussion. In Stage 3, participants were given journals and advised what to focus on in their entries (e.g., recording everyday experiences and significant events). They recorded experiences for a month, followed by a third interview. Journals were shared with the researcher who highlighted specific entries to follow up. Participants also drew attention to their own significant entries. Photo-elicitation and diary-interviews are designed to enable participants to influence the research agenda. The interview focus is not only set by the pre-established interview schedule but also gives a greater balance of power in the research.

Analytic strategy

Each interview (17 in total) was audio-recorded and transcribed verbatim. Participants' photographs and diary entries were used as prompts during the interviews but were not analysed. Photographs illustrate themes and give further insights into participants' experiences. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA). This approach explores how people make sense of their worlds (Smith, Flowers, & Larkin, 2009). It focuses on examining life experiences important to participants (Smith 2015). Researchers familiarise themselves with each account by reading and re-reading participants' words (Smith, Flowers, and Larkin, 2009). The researcher gives voice to the participants, interpreting participants' own interpretations of their experiences (the double hermeneutic; Smith, Flowers & Larkin, 2009). Within our research, data generated across all stages and all participants was brought together as a whole to form the final themes. The first author guided the analysis, listening to the recordings alongside reading the transcripts multiple times to ensure rigour and accuracy. Theme organisation was agreed by all authors. Authors paid close attention to four markers of high-quality IPA: constructing a compelling, unfolding narrative; developing a vigorous experiential and/or existential account; close analytic reading of participants' words; and attending to convergence and divergence (Nizza et al., 2021).

Analysis

Salient aspects of the data are drawn together to give an overview of how drug use impacted on this group of parents. The analytic focus is on the emotional turmoil they experienced during treatment access. This includes struggling to remain drug and alcohol free while accessing treatment and trying to meet the demands of their Child Protection or Child in Need plans. Four aspects of their emotional experience are explored: perceptions of self-identity; others' perceptions; anger and frustration; and fear and guilt. These are illustrated in Table 2.

Table 2: Participant representation across themes

Theme	Participants
Perceptions of self-identity	Darcy, Stephen, Stella, Reagan, Nikki, Ellie, Chloe, Sarah
Others' perceptions	Darcy, Stephen, Reagan, Ellie, Chloe
Anger and frustration	Stephen, Stella, Reagan, Nikki, Sarah
Fear and guilt	Stephen, Stella, Reagan, Nikki, Ellie, Chloe

Perceptions of self-identity

All participants' perceptions of themselves as parents was acknowledged through a sense of internal conflict or dialogue. Darcy, for example, stated:

> *"When I heard the child in need plan, you know how that makes me feel. I feel criticised as a mom criticised because you are a drug addict. Automatically I am a bad person. I am a bad mother. That's what comes with it*."

For Darcy, the need for outside intervention for her child was internalised – she felt like a 'bad mother' because of being a 'drug addict'. She linked the two together, automatically becoming not just a bad parent but also a 'bad person'. A good parent, in contrast, would be one for whom such outside intervention would not be necessary. In Darcy's case, this intervention directly resulted from her use of drugs while also being a parent. A negative view of self also shaped Sarah's view of herself:

> *"I look around, and I see the state of the kitchen I see the state of the living room I see my bottles from the previous night, and I see where I have hidden them, I come across them and you know I say to myself that a good mum wouldn't live like this."*

Sarah reflected on her living conditions: the chaos of the bottles and the secrecy around her behaviour filled her with shame. This, in turn, led to an internal dialogue where she questioned herself as a 'good mum'. She knows that this type of behaviour is not usual, and her self-questioning indicates a recognition of the impact of her behaviour on her children. Ellie also felt the impact of her own behaviour on her children:

> *“I just feel like I have lost. It just makes me so sad that I am a bad parent because I am just a drug addict, and nobody is ever going to think I am any better, and I don’t deserve my kids. So, I feel like I have lost.”*

As with Darcy, above, Ellie makes the link between being a drug addict and being a bad parent explicit here. Ellie is ‘just a drug addict’ who does not deserve her children. This negative view of herself caused Ellie to feel that she had reached the end of the road; she did not think positively about herself and felt ‘nobody’ else would feel positively about her either. Stella highlighted the importance of continued engagement with parents who struggle with a positive identity especially when children are temporarily removed:

> *"I didn't feel like a mom for those three months (cries and a deep breath) I just felt like a dirty junkie.”*

When Stella's child had been removed, she had time to reflect on her own behaviour and began to feel that she had lost her identity as a mom. She emphasises this transition in identity relating herself to being ‘A dirty junkie’. The emotion behind this identity is clear in her taking deep breaths and crying during this part of the interview; however, the importance in recounting her experience was evident when she opted to carry on with the rest of the interview.

The notion of how drug-using parents see themselves can be so negative that it may cause some parents to think and feel they can never win or overcome their addiction. This was illustrated by Darcy who presented a photograph of flowers (Figure 1), introducing it with the following description:

> *“I don’t do anything constructive or anything worthwhile. I just cause misery. So, those flowers, so, they are happy enough, and they are thinking you are spoiling this. Wherever I go, I spoil everything.”*

Figure 1: Wilted Flowers, Darcy

The description of the flowers given by Darcy demonstrates the all-pervasive impact that addiction has had on her self-identity: her attribution that even the flowers are critical of her illustrates the negative emotion – 'I just cause misery' – that, she feels, constantly accompanies her.

Others' perceptions

In addition to the inner tensions that were identified in relation to these parents' perceptions of themselves, they also discussed how they felt others viewed them. These two aspects were closely intertwined in their accounts. Their perception of society's identification of what being a good parent consists of created confusion and self-chastisement in relation to their drug/alcohol use. With this negative image came the feeling of being embarrassed as illustrated by Chloe:

> *"Ok yeah, I do feel embarrassed when I go down there and sit with a big stomach, I feel embarrassed that people are going to look at me and look down at me.*"

Chloe spoke about perceived stigma as she was heavily pregnant; she felt the shame of accessing drug treatment while being pregnant as this was perceived to be taboo. She worried that her identity as a pregnant woman accessing treatment was negatively judged by others seeking treatment. The image of how one may be perceived during drug treatment was discussed by Stephen who felt he was being judged by others:

> *"I wasn't treated like a normal human being. I suppose I was looked at like a drug addict and different professionals who might only see us every month or every couple of weeks were deciding what we were doing week by week."*

Stephen's identity is brought into question as he felt that others treated him solely as someone addicted to drugs and not as a 'normal human being'. For Stephen this led to the feeling of having no control over his own life. Reagan encountered a similar feeling:

> *"It was because the first thing I ever heard was that you will be identified in the world as a drug addict. You will be outcasted or something and you won't be able to get a job."*

Reagan's concern about identity was something she attributed to the whole world – she felt her identity as a drug addict was foremost in others' perceptions of her. Accompanying this was the idea that she would be an outcast in society – unable to access any of the usual identifiers of success, such as employment. Darcy described this ostracization in extreme terms:

> *"In my family, I am the lowest I am the vermin. I am the one who stuck needles in myself. I am the one who smoked crack, and I can't breathe. I am the one who has had DVT and endocarditis, life-threatening illness due to using. I am the one with*

debt and the council house. I have even lost my children; do you know what I mean. It's not funny."

Darcy relates her feelings of negativity to her family rather than society, describing the various ways in which she feels judged by them. Her negative view of herself as a drug user and a parent is derived from this perceived judgement by them. She summarised this in terms of the resulting chronic health and lifestyle conditions with her outline culminating in the loss of her children and the seriousness of this. She illustrated this in the second stage of the research with a photograph (Figure 2):

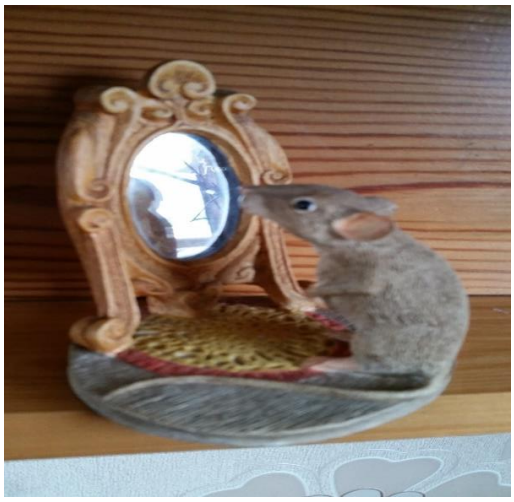

Figure 2: Mouse Looking in a Mirror, Darcy

Darcy's description of herself as vermin is clearly illustrated by the photograph: the vulnerability shown in Darcy's description and accompanying image summarises the feelings of many of the participants in this study: not only are they judged by society but also by close family members. This leaves them with the feeling that they have nowhere to turn to for support and leads them to feel insignificant in relation to others.

Anger and frustration

Five participants described the Child Protection or Child in Need Plans as resulting in pressure on them. The external pressure from families and society resulted in a build-up of internal pressure. Stephen, for example, felt that he could not express his emotions, likening the build-up of his feelings to a kettle full of boiling water (Figure 3):

"I took a picture of a kettle because I mentioned this in my first interview. The kettle represents the steam. It's boiling at the top. Like I said, I was going to explode. It was building up and building up. You never know what could happen, and you could snap. Anger is my biggest emotion you never know where it's going to lead."

Figure 3: A Boiling Kettle with Steam, Stephen

Stephen's experience was of emotions bubbling up to a point where he felt he might not be able to contain them. He described his feelings during the child protection process and illustrated them through the photograph of the kettle. The pressure that he felt was illustrated by the steam leaking out of the kettle: he was afraid he might suddenly snap because he had reached boiling point. Elsewhere Stephen expressed his anger in more detail:

> *"Anger is my biggest emotion really, angry that we have been treated unfairly for many years and nobody took the time even though they have been there long, they haven't really took the time to come and see our lives properly."*

Describing his anger as his 'biggest emotion', Stephen links it to the unfair treatment he felt he experienced as a parent. As with others in the study, Stephen's anger was linked to feeling a loss of control and the misunderstanding he attributed to those who had control. The perceived dismissal, where the professionals had a 'quick chat' or failed to take the time to see how they were living as a family, contributed to this anger. He felt important decisions were being made without consideration of the challenges of his day-to-day life outside of addiction. Nikki also described her anger with the professionals with whom she came into contact:

> *"I was angry about the fact that I felt like because I hadn't done things the way they wanted, and I haven't told them the truth. Suddenly bypassed the child, and it became between me and them, and that was what was making me feel angry."*

Nikki's anger was linked to the fact that child removal was being considered because of her lapse back into drug use. Nikki felt she was being punished by the professionals working with her. Similarly, Sarah felt angry with the implementation of the social care intervention:

> *"Well, I'm angry they're in my life, I don't think that I'm that bad you know, I'm ashamed that I'm not the mum that I want to be."*

As with Nikki, Sarah's emotions are complex. She is angry with herself that her behaviour has caused professionals to become involved in her life. At the same time, she is ashamed that she is not 'the mum' she wanted to be. The conflict between her behaviour and her desire to be a good parent leads to this complexity of emotion. For all participants, anger seemed to stem from the requirement that they stay drug free alongside the threat of possible consequences if they failed to comply.

Fear and guilt

Feelings of fear were discussed by six participants and were often interconnected with other emotions, such as guilt. Parents' accounts highlighted a cycle of behaviours that exacerbated these feelings. Coping with fear regarding interventions resulted, in some cases, in returning to using illicit drugs. Feelings of guilt followed – participants again jeopardised their return to drug-free parenting. The fear of the perceived consequences for any return to drug use was apparent across participants' accounts. Nikki had previously had a child removed. Rather than being open and honest she felt she could not risk a transparent professional relationship. She illustrated this with a photograph of a deflated balloon (Figure 4):

Figure 4: A Deflated Balloon, Nikki

Nikki felt stuck and fearful that she was still addicted, plus she was pregnant once again. Her experience left her feeling deflated and unable to make changes:

> *"I had a few lapses, and I didn't tell them. I didn't tell them. I wasn't trying to be you know like deceitful or pull the wool over their eyes I was just terrified that they were going to take my baby just because from having a lapse."*

Nikki's sense of being trapped meant she was scared to tell the truth but also worried about 'them' finding out. She could have been honest about her lapses but felt she knew the possible consequences, i.e., that this child might also be removed. Having experienced this once already, she was 'terrified' it might happen again. Stephen also echoed this fear of child removal:

> *"If I went back down that road using again. I think they would take legal action and they would look to remove Josh and move him to my parents. That's what I feel would happen if I were to mess up again with drugs."*

Though he does not know for certain, Stephen lives in fear of 'legal action' if he were to relapse. He reiterates the consequence that his child could be removed if he turned back to drugs. The emotional impact of this fear is expressed by Reagan:

> "*Upset gutted and traumatised. The end of the world and really worried. Really worried. I think I went to my lowest about then*."

Reagan's account illustrates the extreme emotions that resulted from living constantly with the fear of children potentially being removed. Describing this as her lowest point and 'the end of the world', Reagan emphasises the trauma of living with this threat. Ellie's photograph of an empty glass (Figure 5) expresses her feeling of emptiness:

Figure 5: An Empty Glass, Ellie

> *"I took a picture of the glass because I feel empty inside. Like my life has changed so much. It's because I have had a big part of me that has been taken away. I feel like I have lost. It just feels like a big hole inside of me. I have lost the biggest part of my life. Something that was the most precious thing in the world. It the thing I woke up for every morning (Cries). It's gone. It has just been ripped away from me."*

Ellie's children were removed because of continued drug use. Her feelings were like that of the bereavement cycle – she no longer had anything to wake up for. The trauma of having her children 'ripped away' was overwhelming. These feelings of fear were also linked to feelings of guilt for some parents. Guilt was experienced as an awareness of how their drug or alcohol use had impacted their children's' lives. For example, Nikki described her feelings after giving birth:

> *"I felt guilty, and I felt horrible, but it is not the same as seeing the baby there in front of you. When they said that they had found drugs in the system I can't even explain how I felt I just felt terrible. Nothing could have made me feel any worse. I hated myself."*

Nikki described the strength of her feelings of self-loathing and guilt when she saw her addicted baby in front of her. Her brokenness, when coming face to face with her baby, knowing she had taken drugs whilst she was pregnant was indescribable. Similarly, Stella also expressed the strength of her guilt:

> *"He used to cry, really cry, he wanted to come back home and I couldn't take him. I used to cry, and I still cry."*

Even though Stella now had her child back home, the aftermath of the separation caused her long-term trauma. She continued to feel guilty about the separation from her child. She still cried about it, demonstrating the lasting impact this separation had on her as a parent.

Discussion

The experiences of being a drug-using parent as detailed in our research are extremely complex. Parents are trying to leave their substance misuse behind them while maintaining their parental responsibilities and complying with any child protection interventions. Our analysis details these complexities, especially the emotional turmoil encountered by these parents.

The first theme outlines parents' feelings of challenge to their identities. It includes perceived criticism of them within their parenting role. Labelling themselves in disparaging terms, the parents felt these identities to be the only ones recognisable by themselves and others (Becker, 1963). Cleaver et al., (2011) suggest that substance misusing parents should not be pressured to change entrenched behaviour. This does not mean ignoring their illicit drug use; indeed, steps should be made to address it. Instead, the focus should be on helping parents to rebuild their lives. Both the PUP (Dawe & Harnett, 2007) and M-PACT (Templeton, 2014) programmes are shown to improve communication between parents and their families. Such programmes improve the lives of all concerned and are implemented to avoid the types of conflict outlined by our participants.

The second theme links closely to the first, shifting the focus to others' perceptions. These were reported to echo those of the participants themselves. Participants detailed feeling like outsiders: being outcast; viewed as vermin; looked down upon by others; sometimes not even being seen or recognised as people. Acceptance by society is essential to individuals internalising feelings of value (O'Shay-Wallace, 2020). 'Othering' (Goffman, 1967) results in further ostracism. The resulting psychological stress can lead to a fear of help-seeking (Frazer et al., 2019). The accounts in this research highlight the fine line between motivating parents to leave substance abuse behind and potentially driving them back towards it. Awareness that each case is individual, and no single intervention will suit all parents is important. Therapeutic interventions such as PUP, tailored to the needs of the

individuals, are likely to change self and others' perceptions (Hollis et al., 2018). Techniques such as creating artwork (M-PACT, Templeton, 2014) can help parents and children rebuild their lives together. Neither of these were discussed as options available for the parents in our research.

Themes three and four both focus on the combined internal anguish and external criticism felt by our participants. In theme three, anger and frustration were directed to the authorities encountered by participants. They reported feeling a lack of compassion and understanding regarding their various contexts. In some cases, where participants had difficulty meeting the demands of different interventions, anger turned inward. Taplin & Mattick, (2015) suggest that entering treatment can improve outcomes for women and children. This further reduces the involvement of child protective services. However, parents need time (Altobelli, & Payne, 2014); pressure to change entrenched behaviours instantly should be avoided (Cornwallis, 2013). Undue pressure can lead to further stress and frustration, thus intensifying their misuse behaviours.

The fourth theme focuses on fear and guilt. Parents repeated previous behaviours despite knowing the possible outcomes. Cognition and behaviour did not always correlate, leading to disenfranchised grief (Doka, 2001; 2008; Elizabeth, 2019). The threat of legal intervention following a relapse did little to halt returning to drugs/alcohol. Research shows positive changes are achieved through motivational interviewing (Miller and Rollnick, 2002). Collaboratively reviewing parents' ability to safeguard their children (Cleaver et al., 2011) is also successful. Family interventions are more effective than individual treatment programmes (Copello et al., 2006; Dawe & Harnett, 2007). Although our participants were not always supported by family, when available it was often positive in helping them address their substance misuse difficulties.

Tensions between parents and the agencies implementing treatment/child interventions were evident throughout the data. The accounts in this research highlight differential practice across those support mechanisms available. This intensifies the emotional trauma for parents. Future research should focus on the complex emotions that are tied up with being a parent while misusing drugs/alcohol. Professional training around helping balance parenting while engaging in treatment can lead to further success for parents and professionals alike.

Conclusion

In this paper we have explored the experiences of drug/alcohol using parents when accessing treatment for their addiction alongside having an intervention in place for their children. The longitudinal nature of the research (including three separate interviews over three years) and the combination of different data generation methods, gives a strength to the accounts presented that is not seen elsewhere. This approach has shed light on parents' perceptions of themselves and how they felt perceived by others. It has focused on specific emotional experiences (anger and frustration; fear and guilt) providing valuable insight into changes of these over time.

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