Understanding the characteristics, outcomes and experiences of women with children's social care involvement during pregnancy and early motherhood

A summary report from the MUMS@RISC study

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A note on language

This report uses the terms 'pregnant women' and 'mothers', reflecting the identities of those that took part in the research. However, we recognise not everyone who is pregnant or gives birth will identify as a woman or a mother.

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Report briefing

This report provides a summary of the findings from the MUMS@RISC study. This research explored the healthcare experiences of women with children's social care (CSC) involvement during pregnancy and the postnatal period, including those who are separated from their newborn baby due to care proceedings. A range of different methods and data sources were used to better understand the socio-demographic and health characteristics of these women, and the care they experienced.

This report presents key messages, based on the findings from the different parts of the study, with reflections on implications for clinical practice.

What are the key messages from the study?

1. The past does not stay in the past, but casts a shadow on pregnancy and early motherhood
2. Current care pathways are not fit for purpose for women with complex adversity
3. Domestic abuse is common, but professional focus is directed towards the baby and too often ignores mothers at risk
4. Multi-agency systems are challenging and complex
5. Judgement, stigma and bias are detrimental and isolating
6. Post-separation support for mothers is crucial
7. Kindness and trauma-informed, person-centred care can save lives

Each of the key messages is accompanied by the voices of women who took part in the research, some key findings and an illustration, co-created with the MUMS@RISC advisory panel and illustrator Tonka Uzu.

A message from women with lived experience

This research project aimed to centre the voices of women with lived experience throughout the research process. Instrumental to this was the MUMS@RISC advisory panel, consisting of women with lived experience of children's social care involvement during pregnancy and infant removal. On behalf of the panel, Martha reflects on why this work is important for people like her, and other birth mothers who will go through potential infant removal in the future.

Child removal is a taboo subject, not often are open conversations had about it. Society reinforces negative perceptions and stereotypes about people going through the process which can result in feelings of shame or judgement for those of us involved. I spent my entire pregnancy in a state of fear and anxiety. I dreaded questions about when my baby was due or how my pregnancy was going. I couldn't convey my reality because it felt so embarrassing. I was constantly worried about what people would think and what they were saying about me behind my back. The pain and trauma that I was going through was too difficult to talk about, so I felt I had to go through it alone.

These biases and judgements often leach into the professional mindset which hinder authentic connection and support. For me this was felt most during those meetings where numerous health and social care professionals discussed my case. They often referred to me as 'chaotic,' 'incapable' or 'an addict', rather than describing me as a mother who was struggling and in need of support. This reinforced my belief that I was a problem and didn't deserve to be a parent. It is experiences such as this that the MUMS@RISC study has so strikingly highlighted. I am not alone in what I went through.

This study has given a voice to birth mothers. It has forced a microscope on our reality, evidencing the shortcomings of a fractured system. We hope it will raise greater awareness of what is happening to those, like us, who struggle to advocate for themselves and are faced with red tape, lack of compassion and a 'one size fits all' approach.

What prevented me from falling off a cliff were small acts of kindness, such as being allowed a private room in the maternity ward to say goodbye to my baby daughter before she was taken away. Or being held by a midwife who could see my pain, and the family worker who told me I was still a mother, even though my baby hadn't come home with me.

What is needed, is trust, compassion, inclusion and empowerment. All the birth mothers involved in this research described being lost in the process, feeling powerless, that their needs were consistently overlooked and that there was no belief that they could change.

We are evidence that change is possible when the right, nourishing, conditions are created: having peer support, being listened to, being made part of the process, being given time and space to assess things without feeling pressured, having trusted advocacy, having ongoing emotional support even after a removal…the list goes on.

Life will always be transition. Faith in the capacity for humans to grow, learn and flourish is essential to give every family the best possible start. ”

Martha, on behalf of the MUMS@RISC lived experience advisory panel

Why is this research needed?

The first 1,001 days are critical for a child's development and wellbeing. Ensuring every child grows up in a safe and nurturing home is therefore paramount. Children's social care (CSC) has a crucial role to play in supporting families to achieve this goal.

The last decade has seen a rise in CSC involvement for children across all age groups. It is now estimated that by their 18th birthday, one in four children will at some point have been identified by CSC as in need of some intervention.[1]

When safeguarding concerns are raised during pregnancy, CSC might become involved to plan for safeguarding interventions once the baby has been born. Involvement from CSC during pregnancy, through pre-birth assessments, is a strong predictor for children requiring state care at some point during childhood.[2] CSC involvement is also known to complicate ongoing relationships between parents and health and social care professionals,[3,4] as it comes with scrutiny and surveillance of parents. The 2022 independent review of children's social care has raised concerns that the current system is not fit for purpose for those that need it the most.[5] The report highlighted many parents have experienced trauma and adversity themselves, and often fall between gaps in services. An intergenerational cycle of CSC involvement is for many families a reality, difficult to avoid. Rather than focusing on families' challenges, the report urged to build on the strengths within families, to keep them together.

Availability of administrative data about babies and children known to CSC has given us more insight into the scale of the problem in recent years. We now know that the vast majority of children in care proceedings in England and Wales are infants under the age of one,[6] with more than half being newborn babies less than two weeks old.[7]

In contrast, evidence about the women with CSC involvement during pregnancy and the postnatal period remains limited, and few research studies have explored the quality of healthcare these women receive during this time. This is important, as CSC involvement during pregnancy and the postnatal period is associated with increased maternal mortality and morbidity.[8-10]

The MUMS@RISC study aimed to address these evidence gaps, to inform recommendations to improve care for this group of women who are so often overlooked, silenced and ignored.

What did the study do?

The MUMS@RISC study had four distinct parts.

1. A systematic review of previous research to understand what was already known about healthcare for women with CSC involvement.	The review included 41 qualitative studies, representing the views of a total of 1040 women and 307 healthcare professionals. The included studies were analysed using a Critical Interpretative Synthesis.
2. Analysis of healthcare record data from the early Life Cross Linkage in Research (eLIXIR) – Born in South London database.	The eLIXIR-Born in South London database consists of linked healthcare records of women and birthing people who gave birth in South London. The database contains pregnancy and mental healthcare data, including information on social care involvement. A cohort of 36,322 singleton pregnancies was studied, with CSC involvement identified in 2,206 pregnancies (6·02%).
3. Analysis of UK national maternal mortality surveillance data submitted to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) collaboration and a confidential enquiry into the care of women known to children's social care who died during pregnancy or in the year afterwards.	Between 2014 and 2022, 1,695 women in the UK died during pregnancy or the year after birth. For 244 women, it was not known whether they had CSC involvement. Of the remaining 1,451 women, 420 had CSC involvement for their unborn baby or infant. The anonymised care notes of a random sample of 47 women with CSC involvement prior to their death were included in an in-depth review. This approach, also known as a confidential enquiry, helps to identify common areas for improvement through the review of data from individual care notes.
4. Interviews with women who faced separation from their baby due to CSC involvement.	Eight women from different parts of England took part in the study, with the support from third sector organisations for women facing child removal. Women had access to their interview data, were able to comment on the analysis of their interview transcript, and chose their own pseudonym. Interview data was analysed, using a personal and thematic narrative analysis.

1. The past does not stay in the past, but casts a shadow on pregnancy and early motherhood

Past life experiences matter. They have a profound impact on women's life course, how women perceive others, and whether they trust those in positions of power and authority.

Across all the different parts of the research, we found that most women with CSC involvement had had previous adverse life experiences, often from childhood onwards. Four of the eight women who were interviewed had been in care themselves and all had previous children removed at older ages, prior to having their newborn baby removed. Similarly, two thirds of multiparous women (24/36, 67%) whose care notes were included in the confidential enquiry, did not have their older children in their care.

This cycle of CSC involvement has been described in other studies, and its impact cannot be underestimated. We found that previous negative experiences with health and/or social services deepened distrust of professionals and feelings of shame and stigma. For some, this would affect how they accessed and engaged with services during pregnancy and the postnatal period.

Our confidential enquiry also found that women's past experiences impacted how professionals viewed women, with past issues often documented as an 'ongoing risk'. For instance, when a woman disclosed previous addiction, this was noted as a 'red flag', even when she had been in recovery for a long time and was no longer using substances. It contributed to a perception of ongoing risk, stigmatising women and reducing them to their past and/or ongoing issues.

Such an approach can perpetuate mutual distrust, professional bias and internalised shame.

> *"I never really had a good start to having my children. My mum had social services involved from when I was born. Me, my brother and sister had to go into foster care at a young age for respite. My mum didn't really look after us, didn't have food in the cupboards. She didn't even take us to school. I grew up way too fast, looking after my brother and my sister, cooking and cleaning. I got put into foster care at the age of 11 by my mum. I kept going missing, from different foster carers, because I didn't want to be in foster care. I wanted to be with my mum. I've always wanted to be loved. Have someone around me and be looked after. That's why I couldn't be without anyone in my life as I grew up. I've always had a boyfriend. I jump from relationship to relationship. Even if they're wrong relationships and bad ones, I still wanted it because I never had it as a child."*
>
> **Louise**

Looking in more detail – eLIXIR Born in South London database

Using the eLIXIR – Born in South London database, we studied women who gave birth in South London. We investigated differences between women with and without CSC involvement during pregnancy and explored whether those with CSC involvement had any risk factors that warranted a referral to CSC according to local pre-birth referral guidance.

Women who had been in care themselves as a child were **17 times more likely** to be referred to CSC during pregnancy than those that had not been in care

Women who had had a previous child adopted or removed were **15 times more likely** to be referred to CSC than those who had not

Looking in more detail – national maternal mortality surveillance data

Using UK national maternal mortality surveillance data, we investigated differences between women with CSC involvement (n=420) and those without CSC involvement (n=1,031) and who subsequently died during or in the year after pregnancy between 2014-2022. We found that:

33% of women known to CSC disclosed abuse during childhood abuse during childhood, compared with just **2%** of women who did not have any CSC involvement.

It is important to note that disclosure of childhood abuse is known to be under-reported, so these figures may not reflect the true prevalence, in either group.

2. Current care pathways are not fit for purpose for women with complex adversity

Women with CSC involvement face multiple challenges. They are more likely to have pre-existing medical diagnoses, poorer mental health, and obstetric complications than women without CSC involvement. This was evidenced across the different study components. For instance, our analysis of UK maternal mortality surveillance data showed that 75% of women who had CSC involvement during the perinatal period and who subsequently died had pre-existing medical problems, compared to 59% of women who died without CSC involvement (MBRRACE-UK). From the eLIXIR-Born in South London analysis, we found similar trends; women with CSC involvement more frequently had medical risk factors (84% versus 69% of those without CSC involvement), obstetric risk factors (47% versus 34%), mental health problems (57% versus 27%) and higher rates of smoking (19% versus 3%).

When reviewing the healthcare records of women with CSC involvement who subsequently died, we found that almost half of them (45%) had more than five complex social risk factors, such as domestic abuse, poor mental health, substance use, current involvement with the criminal justice system, homelessness, learning difficulties, poverty or having no social support.

The interaction between medical and social complexity was often unexplored. Health and social care professionals often focused on one aspect of risk, when a more holistic approach was needed. In some instances, maternity professionals focused on women's medical risk factors, with no exploration of her social circumstances. In others, women's social risk factors seemed to blind, or distract, professionals from responding to underlying medical conditions, resulting in delayed treatment.

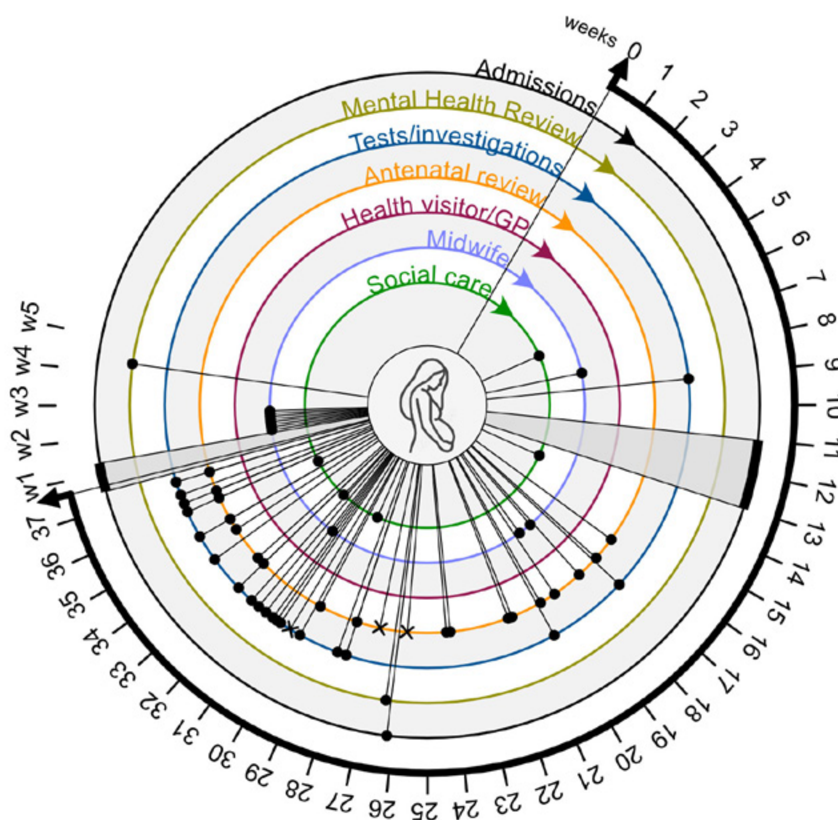
The combination of medical and social complexity often meant a range of professionals from various services and specialities became involved. This resulted in frequent antenatal appointments, across different settings, with different professionals, often in close succession. Our review found that many women had a demanding schedule of appointments, which at times exceeded thirty different contacts during pregnancy. This potentially compounded the adversity women experienced.

For some women, these schedules became impossible, leading to non-attendance or disengagement from some services. This was often escalated to social workers involved. A narrative of 'poor engagement' was pervasive but often unjustified. Women's records included references to non-attendance or poor engagement, even when absences were limited and not representative of women's efforts to access and engage with services. Furthermore, the multiple demands and challenges that women faced were not acknowledged.

> *Because I was homeless, social services were part of the pregnancy from the beginning. I did get a flat. And we were struggling. The boiler broke, so it was always cold. We were short of money, because my ex-partner smoked a hell of a lot, so we hardly had any food in, or electric. We were constantly using food banks or social care for funds for electric and stuff, and that got used against us. They said we couldn't bring him home to that flat, so I had to move in with my nana. My uncle had to move out, because he likes a drink, so they were concerned. They constantly said they were referring and they were waiting to hear back from services. I had the Smoking Cessation Service, but all it does is just basically ring you every couple of weeks. That's not enough for me.*
>
> **Cece**

Looking in more detail

We mapped out the burden of care for some of the women included in the confidential enquiry. Every dot represents an appointment, and every circle a different level of professional involvement. Appointments with non-attendance are marked with x. Sections in grey represent inpatient admissions.



For the woman whose care is mapped in the figure above, the high frequency of antenatal reviews with multiple ultrasounds and additional cardiotocographs (CTGs) seemed uncoordinated and reactive, with no regard for the financial and social barriers that the woman had to overcome to travel to hospital so frequently. On three occasions, miscommunication by the hospital was evident, leading to the woman missing appointments. 'Failed to attend' was recorded in her maternity notes.

3. Domestic abuse is common, but professional focus is directed towards the baby and too often ignores mothers at risk

Across the different components of the research study, we found that a high proportion of women with CSC were subject to domestic abuse, either through physical, sexual and emotional abuse and coercive control. However, during interviews women shared their ambivalence about disclosing abuse to professionals because they were worried about the consequences. For some, the fear of losing their children prevented them from sharing the extent of abuse they experienced. Those who confided in professionals often were not the listened to and felt their concerns dismissed.

In the confidential enquiry, we found examples of missed opportunities and of best practice around domestic abuse disclosure. We saw evidence of midwives' out-of-the-box thinking, creating opportunities to enquire about domestic abuse, followed by adequate actioning and compassionate care and advocacy, to ensure women were safe and other professionals were aware of risk. In contrast, we also saw evidence of minimal professional curiosity, resulting in missed opportunities to identify domestic abuse, and to recognise its impact on women's mental health and their day to day lives. Even when domestic abuse was known to maternity professionals, few women were signposted to relevant services.

Maternity professionals are expected to routinely enquire about domestic abuse during pregnancy and the postnatal period. However, there was minimal evidence of domestic abuse enquiry in care notes that were included in the review. Clinical documentation such as '*inability to maintain personal boundaries*' or '*chaotic interpersonal relationships*' reflected how professionals were attributing responsibility for the harm from domestic abuse entirely or partially to the woman whilst evidence of concern about the perpetrator's abusive behaviour was limited or absent. At the worst of times, health and social care professionals took a punitive approach towards women, holding them accountable for the abuse, even when it was clear women were on the receiving end of abuse.

Safeguarding in such circumstances was focused on the (unborn) baby, with the impact of the abuse on the mother being dismissed or ignored. This was confirmed by the women who took part in the interviews. They described how they were made to feel that they did not matter and were held responsible for their abusive partner's behaviour.

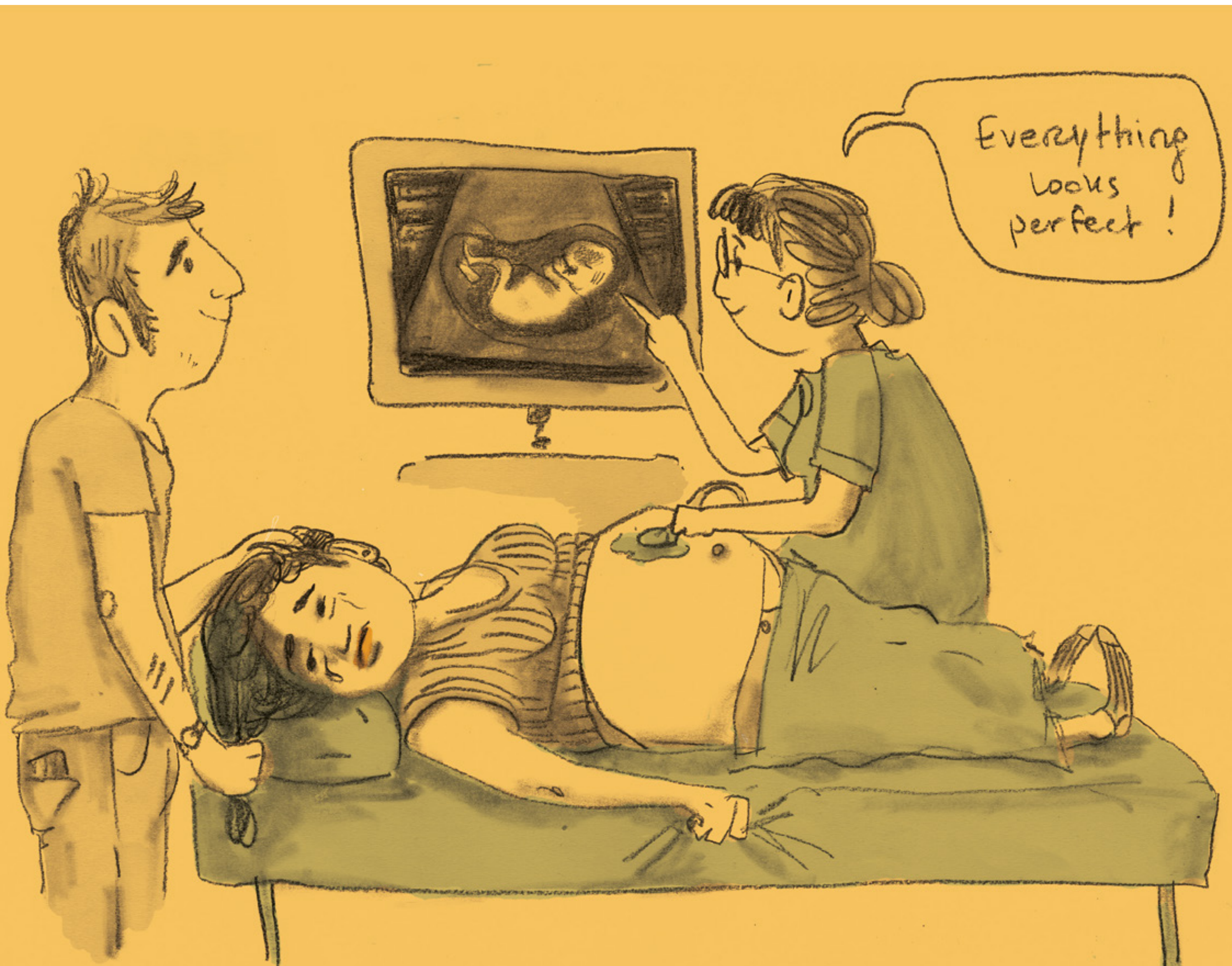
> *So I went to the doctors, I told them I was being domestically abused. I thought 'right, I'm going to take this opportunity to try and get some help', I told the doctor, and he gave me anxiety tablets and sent me out with no help at all, but he did note it on my medical file. And then my anxiety tablets got found and I got beat up again. So then I was kind of scared to speak out.*
>
> **Demi**

Looking in more detail

Among the women with CSC involvement who subsequently died, 65% reported domestic abuse prior to or during pregnancy, compared to 3% of women who died without CSC involvement.

Among the women whose case notes were included in the confidential enquiry, 60% experienced domestic abuse during pregnancy. In the majority of case notes (68%) abuse was know to maternity staff, through sharing of police or social care reports. Unfortunately, only 26% of the women who were subjected to domestic abuse were offered specialist domestic abuse support. In only a third of case notes (34%), we found evidence of at least one enquiry around domestic abuse during antenatal contacts.

A similar pattern indicating low rates of professionals' actioning following domestic abuse disclosure was seen from the eLIXIR-Born in South London analysis. Of the 36,322 pregnancy records analysed, a disclosure of domestic abuse during pregnancy, either to maternity or mental healthcare services, was recorded in 847 (2.3%) of cases. It can be assumed that this figure is an underreporting of the true scale of domestic abuse in the database.[11] An additional issue was that maternity professionals escalated domestic abuse disclosures in only half of these disclosures (386/847, 45.5%).



4. Multi-agency systems are challenging and complex

Pregnancy is a stressful time for women with CSC involvement. Children's social care involvement also creates challenges for professionals supporting women through pregnancy as gaining a comprehensive understanding of all the services, agencies and professions involved can be difficult. Multi-agency systems are challenging, and their complexity is compounded by ambiguity about professional roles, disjointed processes, and fractured communication, for instance through the use of different digital electronic notes systems.

From the confidential enquiry, we found that information-sharing was a particular issue at transition points, for example when women moved to a different area, were taken into custody, or were discharged from one team to another. Handovers between different agencies or teams were ineffective, with slow response times and crucial safeguarding information often missed or lost altogether.

We also found evidence of good practice. Three women of the 47 whose medical notes were included in the confidential enquiry were offered a so-called 'one-stop-shop' approach, with input from different professionals at one location. The coordinated approach enabled access to specialist input, with continuity of midwifery care by a designated specialist midwife across the perinatal period. By organising care and support this way, navigating the complex maze became easier and more manageable for the women at the centre of care and for the professionals looking after them and their babies. Unfortunately, these good practice models were only available to a few women, when many more could have benefitted from this approach.

The confidential enquiry also found challenges in inter-agency communication, particularly during the final weeks of pregnancy, when local authority planning for the baby should be shared with maternity services. On several occasions, plans were not shared in time, leaving parents as well as maternity professionals in limbo and unable to prepare for future events. Alternatively, detailed plans were made and shared a few weeks prior to the birth but were not adhered to during the birth admission. This professional inconsistency and consideration for mutual planning had a profound impact on women's experiences, and was echoed in the interviews with women who had a baby removed shortly after birth, as illustrated by the following experience:

> *Up until a week before her due date, they'd put a plan in place that she could come home. I would be very heavily watched to make sure that the same things that happened with my eldest weren't happening to my middle. The week before she was due, the social worker and her manager turned round and said they were taking her from hospital and taking me to court. […] They said that even with the help and support that I was going to be getting when my middle was born, they were still concerned that the same would happen to my middle. I had two choices: either sign the interim care order or they would go to court and she would be taken no matter what. It was explained to me that it helped my case to sign the order. There were no warnings.*
>
> **Lizzie**

DOMESTIC ABUSE SUPPORT
PRE-BIRTH ASSESSMENT
DRUG AND ALCOHOL SERVICES
OBSTETRIC CONSULTANT
MENTAL HEALTH SUPPORT
ANTENATAL CARE
LEGAL ADVICE

5. Judgement, stigma and shame are detrimental and isolating

While CSC focusses on ensuring a child's safety and wellbeing, it is also commonly viewed as an indication of parental failure. As such, professional judgement, stigma and shame are never far away. Internalised stigma and shame can prevent women from fully disclosing how they are feeling and what they are going through. It can also determine whether women feel confident or fearful to interact with healthcare professionals.

From the confidential enquiry, we found evidence of professional bias and stigma towards women with CSC involvement through use of dehumanising and stigmatising language in their health and social care records. This was most evident in the care of women with substance dependency and those who experienced domestic abuse. We found limited evidence of trauma-informed approaches, and little exploration of, women's complex social circumstances and previous adverse life events. However, it is important to note that guidance to support trauma-informed approach in perinatal healthcare settings[12] was published in 2021 and so came into effect after the time of this study cohort (2014-2022).

When speaking to women who had a baby removed after birth, shame was a central theme in their accounts. The women not only described how they felt *ashamed*, through internalised feelings of guilt and failure, but also that they felt publicly *shamed*, by professionals, family, friends and members of the public.

> *My house was full of baby stuff: I had bought a pram, changing unit, clothes, Moses basket, everything, bouncers, bottles, prep machine, steriliser, the lot. I had bought everything and it was just so hard. I kept the pregnancy a secret from a lot of people until I was 35 weeks because I was scared what people said. If anyone seen me buying baby clothes, I'd make something up, like, "Oh it's for my nephew", because I was scared of what people would say. "Why would you have another baby when you've had your other children taken away?" I don't get along with a few people. There's two girls that I've known for years and they constantly stick their nose down, "Ha-ha, she's had her kids taken off her." I've had it all and it makes me… I didn't want to leave the house because I was sick of getting people talking about me. It was horrible. I barricaded myself in the house for weeks because I didn't want to go out.*
>
> **Missy**

Looking in more detail

From the confidential enquiry, we found the following evidence of professional bias and stigma in clinical documentation.

Finding	Example
Use of negative generalisations or labels, stripping women of their individuality	*'drug user', 'addict', 'learning difficulties person', 'non attender', 'poor historian'*
Use of exclamation marks to sensationalise information	*'hiding out in the area!'*
Referencing historic behaviour when there is no clinical indication to do so, and presenting this as an ongoing risk	*'ex drug-abuser', 'ex sex worker'*
Absence of trauma-informed approach to understand previous trauma and adverse life events	*'Chaotic lifestyle', 'dysfunctional'*

Evidence of socio-economic and ethnic disparities among children known to CSC have been widely evidenced in the literature. We found similar evidence of socio-economic and among women in contact with CSC during pregnancy from the eLIXIR database analysis – Born in South London:

- 42% of women with CSC involvement were Black, compared to 20% of the women without CSC involvement.
- 10% of women with CSC involvement were from mixed or multi-ethnic groups, compared to 4% of women without CSC involvement.
- 75% of women with CSC involvement lived in the most deprived areas of South London, compared to 59% of women without CSC involvement.

From our study using national maternal mortality surveillance data, we also found significant socio-economic and ethnic disparities among those women with CSC involvement who subsequently died.

Women in the most deprived areas were **twice as likely** to have CSC involvement than women living in the least deprived areas (RR 2.19, 95% CI 1.42-3.50))

Women from Black ethnic groups were **less likely** to have CSC involvement than White women (RR 0.56, 95% CI 0.56-0.84)

Women from Asian ethnic groups were **less likely** to have CSC involvement than White women (RR 0.26, 95% CI 0.14-0.44)

This finding is different from the trend in the existing UK literature regarding the impact of ethnicity on maternal mortality rates,[13,14] and CSC involvement.[15,16] However, it is important to note that rates are for women who died during pregnancy and the year afterwards; they do not reflect the wider cohort of women with CSC involvement.

Why?
She must have done something!
I don't understand...

Abuser...

Junkie!

They took her baby!
Ooh!

Bad mum!

6. Post-separation support for mothers is crucial

Mother-infant separation due to CSC involvement is known to trigger an acute mental health deterioration. The anguish over the loss of their child, in combination with societal stigma and internalised shame can become a catalyst for unhealthy coping strategies, suicidal thoughts and behaviours.

In many of the interviews, women shared how suicidal thoughts became prominent and offered a way to deal with the profound pain and sorrow, especially after care proceedings had been finalised. The support they had received during pregnancy, from maternity and/or mental health services ceased shortly after giving birth, leading them to feel totally abandoned.

We found evidence of similar abrupt endings to care and support in our confidential enquiry, with women being discharged from maternity care days after birth. For some, discharge from maternity services occurred sooner than standard care, after a single visit or phone call. Those with known mental health issues rarely received enhanced postnatal care.

The increased vulnerability in the postnatal period, especially in the context of infant removal, is also reflected in our analysis of maternal mortality surveillance data when CSC were involved. Of the 420 women who died between 2014 and 2022 with CSC involvement, 75% died between six weeks and one year after the end of pregnancy. Women with CSC involvement were more likely to die from suicide, other psychiatric causes including substance overdose, and homicide, compared to women who died without CSC involvement.

From reviewing the care notes of women with CSC involvement who subsequently died, a particular issue was found. Among the women that had their baby was removed from their care, many were falling between gaps in services post-removal. For several of them, their profound psychological distress resulted in multiple admissions to emergency services with suicidal behaviour. Unfortunately, the context of these suicide attempts was often overlooked or unexplored, and women were discharged with little to no follow-up or support in place. Missed opportunities to reduce the risk of suicide were identified in several case notes to discover and acknowledge the women's recent separation from their infant and to empathise with the anguish they were going through.

> *I had the normal check-ups, to check my scar was healing fine and that was about it. I've got mental health issues, I've tried to talk to people and they just…We went to the doctors and he was just like "everyone has mental health issues", I was like "yeah, you're a barrel of help", so no one really listens. I wished I had just support, any support really, but I had nothing.*
>
> **Lucy**

What about me?

7. Kindness and trauma-informed, person-centred care can save lives

From the various parts of the research, it was clear women with CSC involvement want to be treated like every other mother, free of judgement and stigma. When they encounter professionals they can truly trust, women feel safer to disclose the true extent of their issues and feelings.

The confidential enquiry found evidence of exemplary high quality, personalised care, where professionals rallied and worked together, to ensure mother's and baby's wellbeing and safety. However, personalised care requires time, commitment, expertise, and a willingness to work with women around their preferences for care. Our findings highlighted that implementation of trauma-informed approaches needs to be accelerated in services working with women who have social complexity. Given the complex adversity in women's lives, services cannot solely rely on women's disclosures or information-sharing but should embed trauma-informed principles to ensure compassionate and supportive care.

When this happens, care can be transformative and life-saving. In interviews, women shared how kindness and compassion had made them feel seen and heard. For this group of women, who have been silenced so often throughout their lives, this can truly have an empowering and lasting impact.

The power of kindness is best illustrated by the words of those that experienced it:

> *"When you're being judged left, right and centre, and you feel so down on yourself, that one little piece of kindness can be that kindness that stops you from getting worse. If I'd been treated like a villain in hospital, like I was by everybody else, I would have left the hospital alone with no baby that night and I wouldn't be here now. I honestly do. They literally were the ones that saved me, because if they had not treated me like that I wouldn't have thought I were going to be enough to live."*
>
> **Demi**

> *"I couldn't fault the hospital at all at the time. The midwives on the midwife-led unit took such great care. They kept coming in, making sure I was okay, that I wasn't in pain, making sure that little one was being fed and changed. They treated me like they treated every single other mum that had just given birth."*
>
> **Lizzie**

How can we help you, Mum?
HOPE BOX

What are the implications for care and support?

It is our collective responsibility to improve care and support for these women and their families. Even when resources and services are under pressure, change is possible and essential. The findings and messages in this report were extensively sense-checked by women with lived experience, and by professionals with expertise in maternity and mental health care, social care and the voluntary sector.

These discussions helped to identify a number of implications for care and support, and shaped the following recommendations:

- Continuity of carer is essential to facilitate a relationship of trust. This is crucial for any service that is in contact with women and their families. Applied to maternity settings, enhanced midwifery care provided by a designated midwife or midwifery team, skilled and confident in safeguarding, can improve outcomes and engagement with these mothers and facilitate advocacy.
- Routine enquiry about domestic abuse during antenatal and postnatal contacts, mandated by the Domestic Abuse Act 2021, needs to be robustly implemented across healthcare settings, in order to identify and support those at risk.
- Consideration of 'risk' requires a holistic approach, grounded in the current, individual circumstances of each woman and her family. Medical and social risk, and their interactions, must be jointly considered. This requires multi-disciplinary teamwork and communication, within and between health and social care partners.
- Integrated care models, such as one-stop-shop models, need to be tested and adapted to tailor multi-disciplinary care around the complex physical, mental and social needs of pregnant and postnatal women.
- Services need to work with families to determine and align shared expectations, to avoid duplication, overload or conflicting messages, and to communicate with transparency and clarity.
- Professionals need to understand how previous trauma and ongoing adversities can impact engagement and interactions with health and social care. Trauma-informed approaches to care are critical for all, but in particular for this group of mothers.
- Communication about and with women needs to change. Stigmatising language and labelling is unhelpful, inappropriate and against healthcare professionals' Code of Conduct.
- When women are facing removal of their baby, a person-centred approach is essential to avoid further trauma. Assumptions around birth or feeding preferences should make space for compassionate conversations about their wishes, and these should be respected as much possible.
- Separation at birth must always be approached with compassion. Interventions, such as the HOPE boxes (https://www.givinghope.org.uk/), can support connection, dignity and compassion, and minimise trauma for everyone affected.
- Enhanced postnatal follow-up after infant separation is critical, both by maternity and mental health services.
- Training to facilitate these improvements, whether this is about domestic abuse enquiry, trauma-informed care, meaningful conversations about social risk factors, supporting women through separation from their baby, etc. has to be given the same gravitas as training in clinical skills, as it can equally be life-saving.

What needs to happen next?

Reflections from Kirsty Kitchen, Head of Policy at Birth Companions

The MUMS@RISC study is hugely valuable in centring the significance of the first 1001 days, and the role that CSC services can, and should, play in supporting parents to give their baby the best possible start in life. But this report also shows us that services and systems are often unable to meet the needs of pregnant women and mothers in the most complex and traumatic situations, with sometimes tragic results.

There is some very good practice underway in parts of the country, building and delivering excellent support. Unfortunately, these efforts are often in spite of, rather than supported by, the wider systems in which they operate. That is why we need a new national pathway to ensure women and their babies experience compassionate, consistent and coordinated care, wherever they live, and whatever their circumstances.

Our Birth Charter for women with involvement from children's social care recommended the creation of a National Care Pathway, reaching across all areas, including health, social care, housing and criminal justice. Together with women with lived experience, local and regional service providers, academics, and the voluntary sector, and in close partnership with central government, Birth Companions are about to start co-designing such a pathway. We hope this will support and catalyse existing good practice, and help establish a new focus on women who have CSC contact in the 1001 days.

While we do that work, there are also several particular priorities for action, including:

- Changing perinatal mental health provision, to ensure women are not discharged from specialist mental health services after their baby is removed.
- Prioritising and ring-fencing funding for the 'loss through removal' pathways in Maternal Mental Health Services.
- Work to embed specialist voluntary sector 'navigator' models of care to ensure personalised, woman-centred support for those with CSC involvement across the 1001 days.
- Investing and reallocating resource to focus on personalised, holistic models of care, including specialist safeguarding midwives, perinatal mental health, and coordinated multi-agency provision through co-located services.
- An update to NICE CG110 Pregnancy and Complex Social Factors, to include the needs of women with CSC involvement and to ensure all relevant services integrate medical and social risk factors.
- Prioritising routine enquiry around domestic abuse, with appropriate action and referral to specialist services, and Independent Domestic Violence Advisors (IDVAs) located in maternity and social care teams.
- Further research to improve understanding of the complex links between ethnicity, CSC involvement, and maternal outcomes.

By elevating and embedding a clear focus on supporting families with CSC involvement in the 1001 days, we can address many of the issues this report has highlighted around coordination of care, barriers to engagement, staff competency, bias, and adopting a more holistic approach to assessing and responding to risks as they apply to both mother and baby.

Acknowledgements

It was the summer of 2020. Lockdown had lifted and I was completing an antenatal check in the living room of D. Baby items filled every corner of her tiny but tidy flat. I was D.'s midwife and had been from the very start. She had a difficult childhood and was diagnosed with severe mental illness during her early twenties. During a previous psychotic episode, she had committed a criminal offence and had served a prison sentence. D. was now 38 weeks pregnant with her first child and was excited to give birth. Plans had been made with a wide range of professionals to support D. and her baby after the birth.

But plans changed.

Within a few days after the birth, D.'s baby was taken into foster care through an Interim Care Order. Heartbroken and devastated as her hopes for the future had vanished, D. tried to take her life a few days later. Over the next few weeks, I visited her regularly on the psychiatric ward where she had been admitted. Six weeks after she gave birth, I visited her for the last time, to discharge her from maternity care, in her tiny but tidy flat, still brimming with baby stuff.

D. was the catalyst of the research project that has led to this report. During my doctoral research fellowship, I have been privileged to learn from and work with so many inspiring people. This report would not have been possible without them:

- The women who took part in the interviews and shared their story with such generosity and resilience
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- Tonka Uzu, for translating difficult messages into beautiful and powerful illustrations

Above all, I want to express my gratitude to the MUMS@RISC advisory panel, for their continuous involvement, their advocacy and commitment to improve care for others.

To this day, D.'s grief and despair have stayed with me, and made me want to do more to improve care for women going through a similar experience. She made it painfully clear how we can and must do better for women facing separation from their baby due to safeguarding concerns, and by extension to all families in contact with children's social care.

I hope this report will find its way to all those that can contribute to this goal and set change in motion, great and small.

And to D., I dedicate this to you.

References

1. Jay MA, Troncoso P, Bilson A, et al. Estimated cumulative incidence of intervention by children's social care services to age 18: a whole-of-England administrative data cohort study using the child in need census. *Int J Popul Data Sci* 2025; 10(1): 2454.

2. McHale P, Filipe L, Hodgson S, Bennett D, Barr B. What factors are associated with children being taken into care by the state after initial contact with services? A survival analysis of Children's Social Care data in Liverpool. *BMJ Public Health* 2024; 2(2): e001130.

3. Everitt L, Homer C, Fenwick J. Working with vulnerable pregnant women who are at risk of having their babies removed by the child protection agency in New South Wales, Australia. *Child Abuse Review* 2017; 26(5): 351-63.

4. De Backer K, Chivers K, Mason C, Sandall J, Easter A. Removal at birth and its challenges for midwifery care. *European Journal of Midwifery* 2022; 6(April): 1-4.

5. MacAlister J. The independent review of children's social care. London: The independent review of children's social care, 2022.

6. Doebler S, Broadhurst K, Alrouh B, Cusworth L. Area-deprivation, social care spending and the rates of children in care proceedings in local authorities in England. *Children & Society* 2024; 38(2): 578-95.

7. Edney C, Ryan M. Newborn babies in urgent care proceedings in England and Wales: An update, 2025.

8. Wall-Wieler E, Roos LL, Nickel NC, Chateau D, Brownell M. Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. *Am J Epidemiol* 2018; 187(6): 1182-8.

9. Wall-Wieler E, Vinnerljung B, Liu C, Roos LL, Hjern A. Avoidable mortality among parents whose children were placed in care in Sweden: a population-based study. *J Epidemiol Community Health* 2018; 72(12): 1091-8.

10. Wall-Wieler E, Roos LL, Brownell M, Nickel NC, Chateau D, Nixon K. Postpartum Depression and Anxiety Among Mothers Whose Child was Placed in Care of Child Protection Services at Birth: A Retrospective Cohort Study Using Linkable Administrative Data. *Maternal and Child Health Journal* 2018; 22(10): 1393-9.

11. Hildersley R, Easter A, Bakolis I, Carson L, Howard LM. Changes in the identification and management of mental health and domestic abuse among pregnant women during the COVID-19 lockdown: regression discontinuity study. *BJPsych Open* 2022; 8(4): e96.

12. Law C, Wolfenden L, Sperlich M, Julie T. A good practice guide to support implementation of trauma-informed care in the perinatal period, 2021.

13. Knight M, Bunch K, Vousden N, et al. A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. *EClinicalMedicine* 2022; 43: 101237.

14. Felker A, Patel R, Kotnis R, Kenyon S, Knight M. Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2024.

15. Bywaters P, Child Welfare Inequalities Project Team. The Child Welfare Inequalities Project: Final Report, 2020.

16. Hood R, Goldacre A, King A, Jones E, Webb C, Bywaters P. The social gradient in English child welfare services: an analysis of the national children's social care datasets - Full Report: Nuffield Foundation, 2021.

De Backer, K. et al. *Understanding the characteristics, outcomes and experiences of women with children's social care involvement during pregnancy and early motherhood – A summary report from the MUMS@RISC study.* London. 2025

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