

## **Title: Babies removed at birth: What professionals can learn from “women like me”.**

### **Introduction**

There is international concern about the growing numbers of birth mothers who experience having their babies removed at birth (Broadhurst *et al*; 2015) and that substance misuse, ill mental health and living with violent partners, are contributory factors (Marsh *et al*; 2015). Mothers who are separated from their babies at birth suffer high levels of emotional distress and will express normal grief reactions (anger, guilt and depression) likened to a mother whose baby has died (Askren and Bloom, 1999). Evidence further suggests that if these grief emotions are not recognised or acknowledged, they will persist and could lead to chronic unresolved grief, leading to long term psychological problems. Persistent memories of losing their babies and the actual moment of parting can intensify the feelings of grief, loss and for some mother's guilt, which leads to feelings of lack of self-worth and low self-esteem (Logan, 1996). Furthermore, whilst mother's whose babies have died can usually resolve their feelings of grief, within six months of the loss, the feelings of mother's whose babies have been removed at birth can and often will intensify (Logan, 1996). A traumatic experience like having her baby removed at birth can also have a powerful impact on women's' self-esteem, and the shame experienced by women for not being “adequate” mothers is something many women carry with them for life (Askren and Bloom 1999). This statutory intervention is an emotive and intrusive event on mothers and their families lives, disrupts the natural processes of breastfeeding and attachment but can be essential to protect the baby (Masson and Dickens, 2015).

Whilst the decision by courts to remove babies from mothers at birth, is considered to be “draconian” (Masson and Dickens, 2015, p108), the court decision is often informed by a body of evidence suggesting that babies have a limited window of opportunity, to develop and reach fundamental milestones. If the environment and care givers are not conducive to babies being able to reach these key milestones, it can have a negative effect upon their future health and development, that can continue throughout their lives (Allen, 2011, Schore, 2013). Professionals working in this context are often social workers, midwives, family nurses and health visitors. They are often challenged to provide the courts with factual evidence, to aid the decision making when babies are removed from their mothers at birth. To do this they need to engage in education that will enable, inform and nurture their underpinning knowledge, analytical thinking and judgement formation to contribute in a professionally mindful, humanistic and accountable way.

This continuous professional development (CPD) **paper** contributes to our collective understanding of the context surrounding babies who are removed at birth and the impact of this intervention on the mothers who birth them. This understanding will provide valuable insight into a topic that has previously received minimal research attention within a changing social landscape, and evidence to guide and inform professional practice now and in the future. This **paper** aims to inform and educate professionals, in

preparation for and in their continuing professional practice, in the context of working with women whose babies are removed at birth.

### **Context setting:**

The latest neuroscience and imaging research suggests that childhood neglect and trauma significantly affects a baby's brain development in a negative way (Allen, 2011). There is also a growing body of evidence, that an infant's environment plays a major role in shaping the behavioural, social and cognitive development of the infant brain and that the relationship they have with their primary caregiver, will impact upon their ability to develop and sustain trusting attachments now and in their future (Schorre, 2003). Without positive and nurturing attachments to caregivers part of the baby's brain will fail to develop, which for some babies will be permanent (Allen, 2011). Where problems within families are so entrenched and complex, the decision to remove babies is often much quicker due to the evidence base to suggest, that the longer babies remain in potentially neglectful and abusive environments, the less likely they are to ever recover (Allen 2011). Up until 2007 there had been some downward trends for children who were subject to child protection plans and who were subsequently removed to local authority care. However, the emerging research in neuroscience has provided an evidence base that has contributed to a significant increase in initiation of court proceedings, across all age groups and particularly in children aged under one year of age (Broadhurst *et al*, 2015). It is further known that if a baby can be adopted before 12 months of age the better chance they have of total recovery (Ward *et al.*, 2012).

It is this evidence that has reduced the time care proceedings can exceed, when courts are making permanent decisions about the futures of babies and children. Whilst this ensures babies and young children are quickly placed in long term homes where they can begin to develop secure attachments it does not always enable enough time for mothers to be able to evidence significant lifestyle changes for the courts to be adequately satisfied that a baby need not be removed from its mother (Masson and Dickens, 2015).

### **Brief summary of evidence base:**

Evidence suggests that mothers who have substance misuse addictions, learning difficulties, mental health conditions or engaged in relationships where domestic abuse is present, are at a greater risk of having their babies removed, above and beyond other population groups of mothers' (Marsh *et al*; 2015). Mothers who suffer from substance addiction, poor mental health, learning difficulties, victims of childhood abuse themselves and domestic abuse find it hard to bond, respond and create safe and nurturing environments for their babies and children to live in and therefore it is believed that these babies are at greater risk of having unfulfilled and unhealthy relationships with others including their own future children and it is often this evidence that underpins and supports the decision to remove babies, from mother's at birth (Marsh *et al*; 2015). The association between substance misuse and child abuse is often recognised by practitioners in the UK. However, whilst substance misuse rarely occurs in isolation and is often

observed in combination with poor mental health and poverty it is the substance misuse that is cited as the contributing factor in removing babies into care (Famularo et al 1992). However, to date there have been no studies that clarify the cause and effect of each contributing factor making it difficult to suggest that substance misuse itself is the sole contributing factor.

According to the thematic analysis around the experiences of mothers that have their baby removed at birth, there is often no acknowledgment from society of their loss and the subsequent intense grief symptoms they may experience (Marsh *et al*, 2015). It is this lack of acknowledgement and understanding that can see them often resort to coping strategies such as repeat pregnancies, suppression of feelings and searching behaviours, all of which inhibit their recovery, from what is described as one of the most traumatic experiences a human being can endure (Masson and Dickens, 2015). A woman's desire for a repeat pregnancy, in order to replace her baby is common, as is the attempt to evade detection from authorities and keep their babies by not engaging with services. Of these mothers, those aged sixteen to nineteen years at the time of their first removal, are most at risk of recurrent pregnancies and subsequent repeat removals (Broadhurst *et al*; 2015). The Mother's apart project and PAUSE are organisations that work with mothers who have experienced, or are at risk of repeat removals of children from their care.

To conclude, while children's best interests are paramount, we also have an ethical and moral responsibility to support mothers after the removal of a child, in order to prevent greater harm to their mental health and subsequent repeat pregnancies to replace the perceived lost child.

### Summary of key learning points for practice

- Mothers report feeling unhappy about continually having to share their stories over and over again, with different professionals as they claim this caused them repeated shame, embarrassment and distress.
- Mothers are not always truthful to professionals about their social situation for fear of judgement. This may be informed by the mother feeling vulnerable or the lack of ongoing relationship with a professional.
- Mothers experience extreme feelings of grief and loss when their babies are removed from them at birth and one that they liken to that of a mother whose baby has died.
- Whilst evidence does reveal similarities in the symptoms of grief and loss, described by mothers, it is evident from the mothers' stories, that the way in which they processed these emotions are very different.
- Creating a comfort box for the mothers at the time of removal enables them to store tangible memories and is thought to be helpful in the immediate and ongoing timeframe.

Marsh (2017)

Finally, professionals involved in this element of care need to recognise that their engagement in reporting and removing babies at birth can cause them considerable professional and moral distress. This can also be the case where the decision to remove a baby was clearly deemed to be in the baby's best interests. It also highlights the need for appropriate support mechanisms and time and space to reflect on feelings, when dealing with this aspect of their role.

### Test your knowledge

1. How many babies were subject to court proceedings at birth or shortly after (within one month) between 2007 and 2014?
  - A. 10,800
  - B. 13,000
  - C. 4,800
  - D. 8,300
  - E. 4,500

Answer: B

2. What percentage of these babies mothers were aged less than 24 years of age at the time of removal?
  - A. 50%
  - B. 25%
  - C. 10%
  - D. 42%
  - E. 33%

Answer: A

3. Once a woman has had one child removed how high is the incidence of removal a baby at birth in subsequent pregnancies?
  - A. 30%
  - B. 40%
  - C. 55%
  - D. 60%
  - E. 25%

Answer: D

4. What coping strategies do women report using to cope with the experience of having their babies removed at birth?
  - A. Self harm
  - B. Excessive drinking/substance misuse
  - C. Repeat pregnancies
  - D. Searching behaviours
  - E. All of the above

Answer: E

5. What do women whose babies are removed at birth, need from the professionals who are working with them?
- A. Access to counselling
  - B. Legal information
  - C. Kindness
  - D. Create memories
  - E. All of the above

Answer: D

### **Reflection**

**Please watch the digital story in the following link and reflect on the experiences of mothers whose babies are removed at birth.**

<https://www1.bournemouth.ac.uk/about/our-faculties/faculty-health-social-sciences/public-involvement-education-research/our-resources/children-families>

Having watched the digital story, please identify one thing you will take away and use in your personal practice when working with a woman whose baby was or is likely to be removed at birth.

(1836 words)

## References

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