

# How to HOPE:

## Emerging learning for Maternal Mental Health Services providing care for women facing separation from their baby at birth due to safeguarding concerns

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## Summary

For women who are separated from their baby close to birth due to safeguarding concerns, the psychological impact can be severe and long-lasting, marked by grief, stigma and profound distress at one of the most vulnerable points in their lives. Yet research identifies a significant gap between the scale of this need and the support currently available, with many women falling outside existing service thresholds and criteria. Though still an emerging area of practice, some MMHS have begun to develop bespoke pathways in response, recognising that women in these circumstances require a dedicated and psychologically informed approach.

Maternal Mental Health Services (MMHS) were established to provide trauma informed, specialist psychological support to women experiencing loss or trauma in the perinatal period. This included an offer to women who have experienced or are at risk of the separation of their baby at birth due to safeguarding concerns.

This learning review draws together findings from the ESMI-III study (The Effectiveness and Implementation of Maternal Mental Health Services), a webinar with MMHS sites, and a series of consultations with selected MMHS sites that have developed a specific offer. The findings show that, while there remains significant variation in the support offered, there is a strong sense of practitioner commitment to providing a service as part of a broader multi-agency approach.

As many services are still developing their offer, this report outlines promising practice and a range of approaches that MMHS can draw on as they build or strengthen their safeguarding pathway. It also emphasises the need for national coordination to support consistent development across sites, including investment in workforce training and support, clear national guidance, and further research to build robust evidence and ensure that women experiencing or at risk of separation from their baby at birth receive timely and appropriate psychological support

### **A note on language**

In this report, we use the term *safeguarding pathway* to describe the MMHS support offered to women who are open to Children's Social Care during pregnancy and at risk of, or have experienced, separation from their babies due to safeguarding concerns. We acknowledge that terminology varies across MMHS sites, and that in some elements of the ESMI-III work this was also referred to as the loss of *custody pathway*. For consistency, we use *safeguarding pathway* throughout, while recognising the diversity of language used in practice. We also acknowledge that, although this report predominantly uses the term women and mothers, the pathway and the insights presented are relevant to all birthing people. Our intention is to reflect common usage within services without excluding or marginalising anyone who does not identify as a woman.

## Introduction

To support the development of next steps, and in recognition of the clear need for service provision within this pathway, this document synthesises learning from existing services that support women who are experiencing, or at risk of, separation from their baby at birth due to safeguarding concerns. While recognising competing priorities and varied starting points across services, it draws on practice examples to identify potential components or ‘building blocks’ that could inform a Maternal Mental Health Service (MMHS) offer within this pathway. It provides an opportunity for MMHS to reflect and consider their own starting point as they move to develop their own service offers.

## Section 1: Background and rationale

There is growing international concern regarding the increasing number of babies separated from their mothers close to birth due to safeguarding concerns (Broadhurst, Alrouh et al. 2018; Mason, Broadhurst et al. 2022a; Mason, Ward et al. 2023; Doebler, Broadhurst et al. 2024). The separation of mothers and babies is a severe intervention in family life, fraught with ethical, legal, and procedural challenges. These decisions, often made through urgent court hearings, leave mothers with little time to understand proceedings, access legal advice, or appropriate support.

Since 2018, the *Born into Care* series, a collaboration between Lancaster University, Swansea University, the Rees Centre at The University of Oxford, funded by the Nuffield Family Justice Observatory has shone an important light into this area of practice. Early findings revealed a sharp rise in newborns<sup>1</sup> subject to care proceedings in England and Wales, with numbers more than doubling in the last decade (Broadhurst, Alrouh et al. 2018; Pattinson, Broadhurst et al. 2021).

Rates of newborns in care proceedings have risen significantly, and in 2019/20, 47.7 per 10,000 live births in England and 68.3 per 10,000 in Wales were subject to care proceedings. Regional variation is stark, London has the lowest rates of newborn removals, while the highest rates are found in the North-West, North-East, Yorkshire and the Humber. Latest updates show that this upward trajectory continues and newborns now account for half of all infant care proceedings in England and Wales (Alrouh, Abouelenin et al. 2022).

Qualitative findings from this research have also highlighted systemic and practice barriers and parents’ testimonies point to the urgent need for earlier trauma-informed help and support, and systemic change to reduce harm when separation occurs (Mason, Broadhurst et al. 2022).

### Mental Health Care and psychological interventions

Women with Children’s Social Care involvement during the perinatal period are less satisfied with the mental health support they receive than other mothers and have more needs left unmet after discharge (Lever Taylor, Brobbey et al. 2023). Mothers party to care proceedings are also more likely to disengage from

<sup>1</sup> The Born into Care reports referenced have examined babies subject to care proceedings within first 2 weeks of birth

mental health services and tend to have longer, repeated, involuntary admissions to psychiatric inpatient units, indicating high levels of need but difficult service interactions (Wall-Wieler, Roos et al. 2017; Pearson, Grant et al. 2022). Those who have their infants removed from their care describe a period of psychosocial crisis characterised by escalating trauma and adversity, but struggle to access therapeutic support (Lever Taylor, Mosse et al. 2019, Broadhurst and Mason, 2020).

A systematic review of support for families with mental health needs and children's social care involvement identified that social work interventions can intensify parents' mental distress leading to a "downward spiral" of difficulties (Bacon, Sweeney et al. 2023). Parents valued psychological support, but the review identified a mismatch between other types of support families typically needed (often financial or practical) and what support services tended to provide (primarily medication and monitoring). Many parents also reported feeling very fearful of the potential for child removal, which contributed to difficulties articulating their struggles openly, and reluctance to engage with services, especially where parents had a prior history of negative encounters with professionals. Parental non-engagement is frequently identified as a factor in decisions to escalate Children's Social Care involvement or initiate care proceedings, creating a vicious cycle and highlighting the need for a different, more trauma informed approach (Broadhurst and Mason 2017; Mason, Broadhurst et al. 2022a).

There is currently a lack of evidence or guidance to support practice in this area, and little is known about what mental health interventions or support are effective for families with child protection involvement. Examples of support offered to this population include those developed for post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (C-PTSD) However, there has been little focus on evaluating support for families in the perinatal period specifically, with most interventions and evaluations targeting a wider timeframe.

A scoping review of parental health and interventions in public family care proceedings found that the interventions identified were typically relationship based, trauma informed, multidisciplinary, family focused and longer term, with most delivered outside healthcare services and funded by local authorities, charities or short term innovation funding (Grant et al. 2023). The review mainly identified advocacy, peer support, wrap around provision and alternative court models, suggesting that support for this population has more often developed across social care, legal and voluntary sector contexts than as a well established area of healthcare provision. Relationship-based practice was found to be particularly important for addressing parents' mistrust of services, by focusing on developing a respectful, authentic, consistent relationship with one or more practitioners, which could act as a vehicle for improving the acceptability and effectiveness of interventions (Rutman, Hubberstey et al. 2020; Boddy and Wheeler 2020; Mason and Wilkinson, 2021; Roberts et al., 2018). Specialist interventions typically took the form of longer-term, wrap-around services, which adopted flexible approaches to outreach and delivery, though they varied in terms of when they were offered within a family's journey, (e.g. pre-birth versus post-removal). These interventions typically consisted of intensive packages of tailored

support focused on parents' (most often mothers') emotional, psychological and physical needs, led by case keyworkers who typically delivered support themselves or proactively signposted families as part of a small specialist service (Cox, Barratt et al. 2017; Boddy and Wheeler 2020; Baxter, McPherson et al. 2025; Mason and Wilkinson, 2021). In some cases, specialist support for grief, loss and trauma related to child removal was included in interventions (Boddy and Wheeler 2020).

Demonstrating a positive impact of interventions for this population has been a challenge (Sleed, Byrne et al. 2024; Crawford et al., 2025; Mason and Wilkinson, 2021). However, the scoping review did identify some evidence that interventions for those undergoing care proceedings can be effective at improving mothers' emotional wellbeing, psychological functioning, capacity for relationships and self-esteem, with rates of rapid repeat pregnancies also decreasing. Mothers who received these services self-reported making positive life changes and described non-judgemental approaches as key for building their trust with services, though the findings also suggested that greater involvement of fathers could be beneficial to whole-family health outcomes.

The review recommended that interventions focus on building trusting relationships with parents, strengthening families' local networks of support, adopting strengths-based, trauma-informed and 'whole family' approaches, and providing advocacy for the rights of parents. Other research has emphasised the need for holistic, multi-faceted approaches in this context that include assertive outreach and ensure that families basic needs (e.g. around housing and debt) are met sufficiently for the necessary emotional work to take place (Lenain and Lever Taylor 2023; Mason and Wilkinson, 2021; Stanley and Penhale (2003) also argue that mothers find it easier to trust professionals who are not directly involved in statutory child protection assessment and decision making roles, such as mental health practitioners, and therefore propose that closer working between 'dyads' of community mental health and social workers may offer a way to promote trust and partnership in this population.

### **Giving HOPE**

The Giving HOPE project emerged directly from the Born into Care research, recognising the urgent need to mitigate the trauma of separation and promote compassion for all involved (Mason, Ward et al. 2023). A central part of this work and following an extensive period of co-production, are the HOPE Boxes, grounded in the need for recognition, connection, and compassionate care.

#### **The HOPE Boxes are a co-produced offer designed to:**

- Acknowledge the significance of maternal identity and the importance of the mother-baby connection that persists, beyond separation, holding the possibility of reunification in mind.
- Provide a connection to other women with lived experience, and help them process the stigma, distress and grief associated with loss.

- Support infants in understanding their life story if separated from their families in the longer term, ensuring that, as they grow, they have tangible links to their early life.
- Offer a tool to support compassionate professional practice helping maternity, neonatal, and social care professionals navigate separation with sensitivity and support.

Following a further phase of co-production work, led by Lancaster University in partnership with King's College London and Exeter and Essex Universities, a programme theory and training offer has been developed and piloted across three areas of the country with promising results (Easter et al. 2026 in preparation; Conroy et al. 2025, submitted). The HOPE Boxes offer is now being implemented by multi-agency partnerships across England. Key stakeholders include:

- Maternity, Obstetric & Neonatal Units
- Local Authorities, Children's Services
- Voluntary, Community and Social Enterprise (VCSE) Sector supporting holistic approaches to the care of women and people impacted by separation.
- Maternal Mental Health and Perinatal Mental Health Services.

### **Maternal Mental Health services**

Maternal Mental Health Services (MMHS) were introduced across England in 2021, as part of the NHS Long Term Plan commitment to transforming and improving access to perinatal mental health care (NHS England. 2019). They were established in response to NHS England led consultations which highlighted that some women with mental health difficulties relating to, or arising from, their maternity experience were falling through the gaps in perinatal mental health service provision.

This was especially the case for those experiencing Post-Traumatic Stress Disorder (PTSD) following birth trauma, perinatal loss (e.g. including early miscarriage, recurrent miscarriage, stillbirth, neonatal death, termination of pregnancy for any reason, parent-infant separation at birth due to safeguarding concerns), and tokophobia (severe fear of childbirth). It was recommended that women in these situations needed greater access to specialist psychological interventions, integrated within maternity and obstetric pathways, beyond the support provided by other mental health services, for women experiencing mild or non-complex psychological distress, such as NHS Talking Therapies.

MMHS have two overarching aims for women experiencing 'trauma or loss in the maternity, perinatal or neonatal context:

1. Offer timely access to specialist assessment and evidence-based treatment, with a focus on psychological interventions in line with NICE guidance.
2. Implement a holistic, personalised and trauma-informed approach to care both within and outside of the service.

The services were initially introduced to England in 33 Early Implementer and Fast Follower sites and are being scaled up so that all NHS Trusts in England have an established and sustainable MMHS.

## Section 2: Work to date

### Findings from Early Implementer and Fast Follower MMHS

The ESMI-III (Effectiveness and Implementation of Maternal Mental Health Services) study is a Realist Evaluation of the implementation of MMHS. The overall study aims to understand, what works for whom, and in what context to inform effective ways of implementing, sustaining and scaling-up MMHS.

Between September 2021 and February 2022, the ESMI-III team conducted an organisational mapping of Early Implementers and Fast Follower Sites, to identify core components of services and capture any early variation in service delivery in the early implementation phases (Easter, De Backer et al. 2022). Of the 18 MMHS (out of 33, 56% response rate) who responded, we identified wide variation in what and how services were being implemented.

Seven MMHS sites were offering, or planned to offer, a pathway specifically for women at risk of separation at birth due to safeguarding concerns. However, the referral criteria, type and intensity of support being provided varied considerably across sites.

A more recent report from the Maternal Mental Health Alliance (MMHA) in 2024, echoed these findings, indicating that of the 46 MMHS identified across England, less than a quarter (11 sites) were currently offering this pathway. A key recommendation arising from this report was the need for greater resources for MMHS to ensure expansion to meet needs across all pathways, and particularly for those at risk of separation at birth due to safeguarding concerns. This is especially important as it is also common practice currently for perinatal mental health services to reject referrals from mothers where there is a high risk of the baby being separated from their care. While some mothers may receive support from general adult mental health services, these are not always well tailored to the perinatal context (Lever Taylor, Mosse et al. 2019; Griffiths, Johnson et al. 2020; Rubio, Lever Taylor et al. 2021) and not all women will meet their eligibility thresholds. Access to services for women who have mental health difficulties and are also using substances is often particularly difficult. Specialist services supporting families after separation have been set up in some localities, usually delivered by local authorities or VCSE partners, but their availability, criteria and capacity is limited (Cox, McPherson et al. 2020; Mason and Wilkinson, 2021).

Very few services offer support to women in the immediate period following a separation whilst care proceedings are ongoing, and this period has been identified as particularly vulnerable time for perinatal women (Mason, Broadhurst et al. 2022a). The most recent MBRRACE report findings have shown 22% of deaths during the perinatal period concern women with Children's Social Care involvement, further highlighting the need for timely support and help (Felker et al., 2025). A significant proportion of maternal deaths among women with Children's Social Care involvement were among women facing multiple adversity, including domestic abuse, substance misuse and mental health problems (De Backer, Felker et al. 2025). The Birth Trauma Inquiry (2024) called on the UK Government to publish a maternity strategy including universal access to specialist maternal mental health services across the UK to end the 'postcode lottery' (All-Party Parliamentary Group on Birth Trauma, 2024).

In focus groups with MMHS sites during the early implementation phase, staff (psychologists, midwives, peer supporters) working within pilot services voiced several perceived challenges to providing this pathway (Easter, De Backer et al. 2022). These included concerns about the complexity of the psychosocial needs of individuals requiring support, and a sense this would require a very different way of working and use of resources and time.

***“(the) pathway is a very different way of working and it requires a different way of using your resource, which is much more time consuming. And I think that’s probably what we’re noticing, isn’t it, in terms of we probably need to go back to the drawing board a little bit and think about what we offer with that pathway in particular.”***

Participant FG001, ESM-III Study

***“So, when we’re taking on loss and separation due to Social Care on top of what we’re already doing, and we’re thinking about the complexity of the cases, they will probably come to me and there’s just not enough therapy support within the team.”***

Participant FG008, ESMI-III Study

In addition, staff responses suggested some trepidation and felt that a much wider systems and multidisciplinary approach was needed, highlighting the importance of ensuring the right skill mix to provide effective support.

***“Our service doesn’t have that pathway [safeguarding] at the moment; [...] I am concerned about launching that part of the service with the capacity of the number of Clinicians that you’ve got on the team, the types of Clinicians that you’ve got; I just think that although of course these families need support, I think their needs are very, very complex. Often, they need MDT input, and I guess they might need a lot of care co-ordination, you know need a lot of input from Social Care. And I guess my concern would be in a service where you just have Psychologists and Midwives mainly, that’s just very difficult to hold and I don’t think that you can work on that loss without everything else being taken into consideration and worked alongside.”***

FG008, ESMI-III Study

***“Looking at the other safeguarding aspect around women and birthing people who may eventually, unfortunately have their babies removed, I actually think that this needs to come back to the drawing board because it’s a far bigger pathway that needs all the relevant people in agreement to actually work with those particular cases, because they are far more complex than I think we’ve given time to really look at. And I think it would be really challenging for our staff to take those particular cases on board unless you’ve got that other support.”***

FG014, ESMI-III Study

### **Shared learning and implementation workshops**

Despite the concerns expressed by some participants, it is also clear from the ESMI-III study, that other MMHS have made significant progress and see the need to prioritise this pathway within their service.

Two learning and implementation workshops (hosted by NHS England) were organised to share examples of emerging good practice. The workshops also supported other services to consider ways of overcoming these challenges and to

explore how MMHS could respond to the unmet psychological needs of women who had or were at risk of experiencing separation from their baby close to birth. The first webinar (October 23) was aimed at all operational MMHS sites across the NHS England footprint. The event attracted over 250 attendees. Not all attendees worked within MMHS, some had roles within maternity and local authority settings. The webinar presented findings from the ESMI-III and Giving HOPE projects and invited trail-blazing MMHS colleagues to share their work developing clinical pathways for separation at birth.

At the end of the webinar attendees were invited to complete a short survey to capture their thoughts on the material and their insight into this area of work. Sixty-three attendees completed the survey. The responses gave an overview of current provision, service offers in development, the perceived barriers and training and support needs. There are limits to this data set, as some MMHS sites may not have attended this webinar, and multiple staff may have provided a response in an individual MMHS service, but it does provide valuable information.

### Key insights included:

**1. A strong desire to develop a pathway of support.** From those who responded, 30% said that there is an offer available in their area, 12% had an offer in current development, 39% did not but would like to, and 15% reported no offer and felt unlikely to develop one in the next year.

**2. Identification of barriers to implementation.** Amongst those who had no plans to develop an offer, the main barriers to development and implementation were lack of resources (time and money, 24%), skills and knowledge gaps (5%) and concerns about appropriateness of the offer for the MMHS (5%).

**3. A role for MMHS in supporting implementation of the HOPE Boxes offer.** Over 84% of responders saw a role for the MMHS in supporting delivery of the HOPE Boxes offer.

**4. Willingness to provide support and training to maternity services.** Overall, 71% of respondents felt they could offer training on Trauma Informed Care (TIC) or support sessions to midwives and social workers who are working with the HOPE Boxes. A further 8% suggested a range of other possible ways to support, with only a small number feeling unable to support the offer at all.

**5. Opportunities for shared learning.** 95% of attendees responded yes or maybe when asked if they would like to meet with other MMHS professionals and work collaboratively towards an offer.

Feedback from this workshop indicated a growing commitment among MMHS to develop an offer to meet the needs of women within a safeguarding pathway. Despite continuing concerns about knowledge, resources and skills gaps within the teams, there is a motivation to meet with other teams and consider how to provide further support via the MMHS in the future.

## Section 3: Consultations with Maternal Mental Health Services

Building on learning from the ESMI-III study and insights shared through the national webinars, a series of review consultations were held with MMHS sites who had developed an offer within a specific safeguarding pathway. The consultations explored how each MMHS was shaping and delivering their offer, and their key learning to date.

### Approach

Data drawn from the organisational mapping of MMHS sites were used to identify those who were currently or who were intending to offer in the near future, a service to women under the safeguarding pathway. The clinical lead of each of the MMHS was contacted and invited to meet with a member of the research team to share information alongside their reflections. Eight practitioners from six MMHS sites participated.

**Table 1 Participating MMHS sites**

Site number	Geographical region	Participant job role
1	North-East	Psychotherapist
2	North-West	Lead MMHS Midwife; Consultant Clinical Psychologist for Perinatal & MMHS service
3	East Anglia	Clinical Psychologist; Specialist Perinatal Mental Health Midwife
4	London	Clinical Psychologist/Clinical Lead
5	South-West	Safeguarding Midwife; MMHS Midwife
6	East of England	Clinical Psychologist

**Discussions covered the following key areas:**

1. Current service offers under the safeguarding pathway.
2. Details of that offer, including timing and modality
3. Key learning to date
4. Vision and development plans for the safeguarding pathway
5. Specific plans and reflections on the implementation of the HOPE Boxes

## Section 4: Findings

### What is currently being offered? Emerging models of practice

In the absence of a clear evidence base and influenced by local service gaps and existing provision, the MMHS sites developing services for women under the safeguarding pathway have taken different approaches in shaping their offer, resulting in considerable variation across sites.

#### a) Eligibility and timing of offer

The point at which the MMHS offer support to a woman during the perinatal journey varied across sites, reflecting local understandings of service gaps and needs. Service offers included:

1. Antenatal support – offering emotional preparation, stabilisation, and preventative interventions.
2. Postnatal support – addressing the psychological impact of removal and grief and loss and preparing for any future pregnancies.
3. Integrated antenatal and postnatal pathways – ensuring continuity of care across the perinatal period.

**Antenatal support** within MMHS commonly focused on emotional regulation, helping women manage the distress and anxiety associated with Children’s Social Care involvement and the fear of care proceedings and separation. Decisions to focus on an antenatal offer were driven by the need for earlier help, to provide opportunities for preventative support to mitigate the trauma of potential separation. In some cases, antenatal support was primarily midwifery-led but with psychological input as needed.

**Post-separation support**, primarily focused on managing the trauma and the immediate feelings of loss following the separation. This included both psychological interventions and stabilisation work.

The variation in when services were offered affected both the level of demand and the type of support provided. Practitioners in areas with a post-separation only approach noted that restricting earlier access may mean missing crucial opportunities to engage and support women. Services offering pre-separation support, however, were keenly aware of the complex balance between safeguarding responsibilities and therapeutic engagement.

Sites varied in their approach to offering support to mothers during the period of care proceedings. Some sites did not offer support, expressing concerns about being involved at this time and the boundaries of their role. This decision was in part led by a concern that they would be called as expert witnesses. However, some practitioners considered this a particularly important time to offer support, recognising it as a time when women were likely to be experiencing high distress.

There were also complex considerations around eligibility for MMHS support based on a woman’s access to other services. For example, one MMHS did not

accept referrals from women who were currently parenting their baby even though they believed these women's needs were closely aligned with the MMHS focus, because these mothers were eligible for support from the local perinatal mental health service. Similarly, another MMHS did not offer support antenatally, as pregnant women involved with Children's Social Care remained eligible for the perinatal mental health service in their locality. These decisions were based on a need to make best use of the MMHS limited resources.

Some MMHS adopted more flexible eligibility criteria in an effort to respond more appropriately to need. Practitioners described often receiving referrals for women who had already been passed between multiple services, and felt it was preferable to offer some form of support rather than risk further 'bouncing' between services. This was sometimes described as a 'no wrong door' approach, whereby signposting and other forms of support were prioritised even when the service was not able to meet the woman's direct clinical needs.

Sites offering both antenatal and postnatal support noted that ante-natal engagement helped to build trust, which in turn made postnatal interventions more effective. However, late referrals and engagement challenges remained a consistent barrier, reinforcing the need for flexible approaches tailored to women's circumstances, experiences and prior relationships and trust in state run services.

As well as the bespoke separation pathway offer, several MMHS sites had also aligned this offer with the other post-natal pathways in their service, i.e. loss and trauma pathways, recognising that separation at birth has comparable psychological impacts to experiences such as stillbirth or neonatal loss.

#### b) Local context

The consultation suggested that decisions regarding when to offer a service were often shaped by local understandings of service gaps. MMHS sites adapted their approaches based on local demographics, service infrastructure, and inter-agency relationships. Key influences included:

- Rates of parent-infant separation, higher rates led to a stronger emphasis on postnatal interventions.
- Established VCSE partnerships, with some examples of strong third-sector involvement, enhancing service reach and pathway development. This independence from state provision may also be critical for women who have very negative previous experiences and where trust in state-led services is low.
- Inter-agency collaboration, where relationships with Children's Social Care were more developed, services were more integrated.

Whilst a flexible approach that reflects and responds to local need was considered important, equally there were concerns that the lack of any national framework also led to inconsistencies and gaps in service availability and quality across the country.

### c) Modality of support

MMHS sites drew on a range of modalities and delivery models, including:

- One-to-one support, personalised interventions by midwives, psychologists, assistant psychologists or specialist mental health practitioners.
- Structured assessments and detailed psychological formulations, which could be shared with other agencies/professionals (e.g. Children's Social Care) with the woman's permission.
- Helping the woman to develop strategies to manage the difficult processes of child protection and care proceedings. This included emotional regulation to help manage difficult emotions in inter-agency meetings such as case conferences.
- Psychological preparation for the experience of birth and the possibility of care proceedings and separation.
- Group support, peer connection, shared experiences, and structured therapeutic input.
- Indirect interventions, including, practitioner consultations, reflective practice, and multi-agency collaboration.
- Facilitation of links to other community support (GP, VCSE partners etc.)

### d) Referrals and service take-up

MMHS sites reported that they do not currently receive a high number of referrals to the safeguarding pathway, partly due to the challenge of developing close links with those who would make the referrals, particularly Children's Social Care. Many services noted that rigid appointment-based models were ineffective, and that 'elastic engagement' was important (i.e. persistent outreach, trust-building and flexibility around non-attendance). Women who have experienced or are at risk of being separated from their babies often face significant trauma and high levels of mistrust in services is common. It was recognised that engagement strategies need to reflect these experiences and be more flexible, compassionate, persistent, and trauma informed. In consultations, MMHS practitioners observed that women accessing this pathway may never have known a safe, loving relationship and establishing trust with a key practitioner is essential but takes time. Services found that DNA (Did Not Attend) policies could act as a barrier, and many sites have adapted their approach to accommodate individual needs. Sites commented that, to work effectively with women in this situation, you need a 'community psychology' approach; and cannot expect women to attend sessions without additional support. Where possible, having a support or an outreach worker was considered very helpful, facilitating outreach or wrap around engagement work. Support from independent advocacy services or other third sector services was also considered helpful to relationship building.

Some MMHS practitioners noted that when engagement with a woman was successful, the absence of other trusted relationships could lead to them becoming her main point of contact for all support needs. While this highlighted the gap in current provision, it also created challenges. In some cases, anxiety

about being the only practitioner or service involved led to hesitation about offering support at all. At the same time, there was recognition that not every referral would result in intensive work, and that even limited input could be valuable. The central aim was to 'get alongside' women creating a sense of safety within the therapeutic relationship. Authenticity, transparency, and consistency were seen as critical to engagement, particularly given women's suspicion about what might be said or done without their knowledge. MMHS practitioners emphasised that, in contexts of low trust, being open and honest even when difficult was essential.

#### e) Therapeutic interventions

In the absence of an evidence base regarding effective mental health interventions for women in this situation the therapeutic interventions offered varied across sites. Most practitioners saw value in approaches that focussed on complex PTSD symptomologies and the need to support emotional regulation and stabilisation work. A challenge expressed was how to make modifications to existing support and interventions to ensure they are appropriate, sensitive and well-tailored for women in this support pathway. MMHS practitioners also highlighted that many of the women they work with have learning difficulties or disabilities, or are neurodiverse, often without a formal diagnosis, and that this was an important additional consideration in shaping support.

Approaches currently used in MMHS sites included:

- Dialectical Behaviour Therapy (DBT), helping women develop emotional regulation and distress tolerance.
- Eye Movement Desensitisation and Reprocessing (EMDR), addressing trauma responses.
- Skills Training Affect and Interpersonal Regulation
- Narrative Therapy
- Eclectic, trauma-informed interventions, drawing from multiple evidence-based models.

MMHS practitioners commented that psychological formulation was very valuable for women in this situation, helping mothers make sense of their experiences and reflect on their distress. Women were often receptive to formulations being shared with social workers and others in the wider network to enhance understanding of the woman's perspective, and to encourage practitioners to interpret difficult interactions or engagement struggles in a different light, recognising that this may be a defensive or protective strategy.

Offers such as DBT were also anecdotally felt to be well received by women and, in general, MMHS practitioners were positive about their observations of women's ability to benefit from support and build trusting relationships. However, formal evaluations had not yet been undertaken and there was some concern

amongst practitioners around how to define a 'successful' intervention in this context, and whether traditional outcome measures can capture 'effectiveness' on this pathway.

#### f) Duration of offer

For those MMHS services currently offering direct therapeutic support to women under the safeguarding pathway, the duration of support varied. Flexibility was again seen as important. Examples included antenatal support and up to 8 weeks postnatally; 12-16 post-natal sessions only with an extension up to 24 sessions.

#### g) Partnerships and broader pathways of support

MMHS sites emphasised that this work required interagency working, collaboration, and a focus on supporting the wider network around a woman. Strong relationships with VCSE organisations were seen as key, particularly given the low level of trust and fear of state-sanctioned services. One MMHS described a partnership with a local VCSE organisation whereby the MMHS was able to refer women to this organisation upon discharge. This service offered key-worker support, helping with practical and emotional support. However, there was also an agreement that the woman could later be referred back to the MMHS to resume psychological support if needed. This broader pathway allowed for longer-term support that was flexible over time. Other MMHS described much less knowledge or availability of VCSE support locally, and similarly local relationships with Children's Social Care and midwifery varied widely.

#### h) The role of the HOPE Boxes

There was broad support for the use of HOPE Boxes as a system-wide offer and recognition of the value they have as a psychologically informed initiative. Practitioners also stressed that implementation needed to be structured and integrated across the multi-agency system. The HOPE Boxes were considered by many to be an important part of a broader offer that could be integrated into wider therapeutic approaches within the MMHS and support multi-agency working. Some practitioners reflected on the importance of establishing who will be trained to deliver the HOPE Boxes offer and that sustainability of implementation should be ensured. There was also a desire to consider whether the HOPE Boxes could be developed for use with wider family members, with whom currently MMHS practitioners felt they were less successful in engaging.

#### i) Lead practitioners

Amid the fear and sense of threat that mothers often experience when facing state intervention at birth, the importance of trusted relationships within this pathway was strongly emphasised by participants. Whilst the practitioners leading the work varied, midwives were frequently identified as central to engaging and building relationships with the mother, acting as a key link between maternity, mental health, and safeguarding services, providing continuity.

## Key Findings: emerging models

- 1.** Supporting women both before and after separation offers the greatest potential, but local delivery was shaped by referral routes, capacity and service gaps.
- 2.** Emotional regulation work during pregnancy was seen as particularly valuable in helping women manage distress, navigate the ongoing involvement of agencies and prepare for what lies ahead.
- 3.** Post-separation interventions focused on stabilisation to help women manage the trauma of separation and the impact of care proceedings.
- 4.** Service design was shaped by local context, such as separation rates, existing partnerships, and inter-agency relationships, highlighting the need for flexibility but also exposing national inconsistencies.
- 5.** Rigid appointment-based models often failed to engage women; flexible, trauma-informed and outreach approaches were key to building trust and reducing barriers.
- 6.** In the absence of a defined evidence base specific to women under this pathway, services drew upon a range of trauma focused interventions.
- 7.** The HOPE Boxes were valued as a cross-agency initiative to support therapeutic engagement as part of a broader offer of support.
- 8.** Trusted relationships are essential to effective support. MMHS midwives often played a key role linking across services.
- 9.** Strong VCSE partnerships can be crucial in helping navigate mistrust and fear in state services.

## Practitioner experience, motivation, and support needs

### a) Seeing beyond the challenges: commitment to support

In line with findings from the ESMI-III study, consultations revealed a strong motivation across MMHS practitioners to offer support under this pathway. Despite resource constraints and competing demands, practitioners expressed deep commitment to supporting women experiencing or at risk of separation from their babies and identified a clear role for the MMHS in this work. Those already involved in service delivery under this pathway highlighted that even small-scale offers could have significant impact, cautioning against using perceived challenges as a reason for inaction:

***“You can do this work; you just have to try.”***

(MMHS Scoping Consultation, 2024)

While all participants acknowledged the need for greater support, they emphasised that providing compassionate, trauma-informed care and validating women’s experiences was meaningful, even within constrained service environments. The absence of alternative services acted as a further motivator to develop an offer within their MMHS:

***“An important question though is, where is the workforce for working with these women?”***

(MMHS Consultations, 2024)

Practitioners recognised that only by offering something could they begin to build an evidence base for effective support, and develop a clearer understanding of what works, for whom, and in what contexts. For those determined to act despite the challenges, accepting the limitations of their offer was essential. They viewed the MMHS contribution as one part of a broader pathway not a complete solution to women’s therapeutic needs, but a meaningful step in the right direction. The importance of ‘holding hope’ and recognising opportunity was a recurring theme. Participants stressed the value of beginning somewhere and building.

***“Sometimes just doing something is really helpful.”***

(MMHS Consultation, 2024)

Finally, practitioners emphasised the importance and value of the therapeutic relationship itself. Demonstrating genuine care, transparency, and commitment was seen as key to making a difference.

***“If they see you’re genuinely trying to help them, that helps. The therapeutic relationship is paramount. Being open about where you’re at, where you’re from, what you’re doing and why is crucial.”***

(MMHS Consultation, 2024)

### b) Navigating uncertainty: professional anxiety in the absence of guidance

Whilst motivation and commitment to offer a service were high, consultations also revealed several barriers that made work within this pathway feel particularly challenging. Practitioners frequently reported feeling underprepared, with limited access to specific training and a reliance on personal experience or

self-directed learning. This led to anxiety for some, particularly in MMHS sites without established pathways, where hesitancy contributed to fragmented services and missed opportunities for early support. Practitioners described the work as complex and emotionally intense, shaped by system-level challenges, limited capacity, and uncertainty about their role. The emotional toll was evident, with some staff describing feelings of being overwhelmed and the moral injury associated with the work.

Concerns about legal processes and professional boundaries further compounded this uncertainty. Practitioners expressed confusion about their potential role in care proceedings and for example whether their clinical notes might be shared in care proceedings. This highlighted a clear need for training focused on the family justice processes, information-sharing, and professional responsibilities.

### c) Interagency roles, emotional impact and reflective practice

Systemic anxieties regarding accountability were also evident, particularly in the absence of national direction. Inter-agency relationships, especially with Children's Social Care, were sometimes strained, hindering coordination and shared decision-making.

MMHS practitioners acknowledged the significant challenges social workers face in their roles, with frequent changes in staffing compounding these difficulties. Practitioners noted the tensions in holding both the parent(s) and baby in mind, with a perception that social workers tended to focus primarily on the baby, while the MMHS focuses primarily on the mother. Some MMHS practitioners saw part of the MMHS role as bringing together key players in the network, to allow these different perspectives to be better understood, so both the mother and babies need could be considered simultaneously. This included for example, ensuring that decisions around any potential separation are planned and properly supported, and helping alleviate current issues where recommendations are made during pre-birth assessment or care proceedings for mental health support that is not available locally.

Practitioners also voiced a need for high quality support structures specifically focused on this pathway. Witnessing a separation was very difficult for practitioners who emphasised that the women often 'stay with' them. Concerns regarding injustice and discrimination added to these complicated feelings. The potential impact of moral injury and vicarious trauma was clear. Regular supervision, and peer reflection, to manage the emotional demands of the work and ensure safe, informed practice were emphasised.

## Key Findings: Practitioner, experience, motivation and support needs

1. Practitioners across MMHS sites show strong commitment to develop a support offer for women facing /experiencing separation, even when resources were limited.
2. MMHS involvement is seen as necessary particularly in the absence of other services.
3. Offering support was viewed as essential to begin building an evidence base.
4. Practitioners recognise the limits of their role but valued their contribution within a wider support pathway.
5. The work is emotionally and professionally demanding, with risks of burnout and moral injury. Structured supervision, and peer support, are vital.
6. National guidance and training are needed to build practitioner confidence and capability.

## Section 5: Focused practice examples

### Example 1: Ocean, East London NHS Foundation Trust

This pathway was developed to support women and birthing people who have experienced trauma and loss in relation to Children's Social Care involvement and/or court proceedings that may lead to separation or removal of their baby.

#### Who is the pathway designed for?

The pathway is for women and birthing people whose baby was separated or removed within the first year of life. There is no time limit on when the separation occurred within that period. The pathway includes women who are currently in care proceedings as well as those who have experienced historical separations.

#### Entry points and timing

Referrals are accepted from health and social care professionals, VCSE organisations, and via self-referral. Women referred early in the court proceedings process are prioritised on the waiting list.

#### What the pathway offers:

##### 1. Antenatal

- Psychological support and consultation to midwives
- Support with trauma-informed birth planning
- Introduction of HOPE Boxes for the mother and baby

##### 2. During court proceedings

- An initial 8-week pre-engagement phase, involving proactive work to engage the woman in partnership with the referrer
- 8–16 sessions of stabilisation-focused therapeutic work to support women navigating court proceedings, separation and contact with their infant
- The duration of therapeutic input aligns with the typical 16-week period between initiation of proceedings and final decision
- Ongoing HOPE Box support where accepted by the woman

##### 3. Post-proceedings / historical separations

- Access to the trauma and loss pathway for further psychological intervention, reviewed on a case-by-case basis according to clinical need
- Access to a monthly drop-in peer support group for women who have experienced removals, delivered in partnership with a VCSE partner organisation

## Practice example 2: Lotus, Norfolk and Suffolk NHS Foundation Trust

### Pathway context

This pathway was developed as part of the service's initial MMHS offer, with a focus on facilitating compassionate, trauma-informed perinatal care and strengthening cross-system working. Lotus have a three tiered offer, Universal, Targeted and Enhanced.

The offer also includes system level offer – working with practitioners in Health and social care providing, psychologically informed training, consultation and support.

### Who is the pathway designed for?

The pathway supports pregnant women with children's services involvement and a likelihood of separation at birth, as well as women seeking to process previous separations and consider the impact on future pregnancies. The Universal offer also includes an offer of trauma informed training to midwives and social care colleagues.

### Entry points and timing

Referrals occur antenatally or postnatally. The timing of assessment and allocation (before or after 35 weeks' gestation) determines the level of direct MMHS involvement.

### What the pathway offers

The pathway offers differs depending on the tier of the offer but includes

#### 1. Universal (assessment and allocation prior to 35 weeks)

- Extended assessment and psychological formulation, including brief psychoeducation (up to 3 sessions)
- Midwifery-led Trauma Informed Care Training delivered to Social Care and Maternity colleagues

#### Targeted

- Allocation of specialist MMHS midwife
- Extended assessment and psychological formulation
- Psycho-education
- Multi- disciplinary team consultation
- Emotional and practical support to manage child protection processes
- Stabilisation work and safety planning
- Integrated care planning, including MDT consultation, trauma-informed birth planning, postnatal safety planning and contraception discussions
- Peers support and psychology input on an individual basis
- Advocacy for trauma-informed and compassionate care
- Support with the use of HOPE Boxes

## 2. Ante-natal assessment and allocation after 35 weeks gestation:

Consultation with the professional system only to facilitate a more compassionate trauma informed perinatal experience

- Trauma-informed care recommendations
- Support to facilitate compassionate removal where relevant
- Safety planning where possible

## 3. Postnatal (up to 8 weeks)

- Specialist MMHS midwifery support
- Emotional support, stabilisation, risk assessment and safety planning
- Support to ensure routine postnatal health checks and monitoring of mental wellbeing
- Support with the use of HOPE Boxes
- Integrated care planning and signposting to recurrent care, mental health and third-sector services
- Contraception and family planning advice prior to discharge where appropriate
- Review with a therapist or mental health practitioner depending on need and the woman's wishes
- Peer support and psychological input decided on an individual basis

## Enhanced offer

■ Individual (1:1) psychological therapy input (12–24 sessions, depending upon therapy), which may include:

- EMDR/TF-CBT for PTSD relating to birth trauma/loss
- Compassion Focused Therapy (CFT)
- Cognitive Analytic Therapy (CAT) for complex trauma
- Mentalisation-based approaches with a focus on continuing bonds
- PSW input running alongside other treatment options (no timescale)
- Joint work with adult mental health services where appropriate
- Integration of HOPE Boxes work into postnatal psychological therapy where used earlier

## Practice Example 3: Silver Birches, Mersey Care NHS Foundation Trust

### Pathway context

This pathway was developed as part of a broader midwifery and psychological therapy offer within MMHS, with an explicit focus on both direct support to women and system-level work to promote trauma-informed practice. The pathway involves close partnership working with maternity and neonatal services, local authorities, adult mental health services and third-sector organisations.

### Who the pathway is designed for

The pathway supports:

1. Pregnant women with a clear local authority plan to issue care proceedings at birth or where the baby will enter care of the local authority through s20 arrangements.

2. Pregnant women who have experienced previous removal of their children and where these experiences are affecting the current pregnancy. They may or may not have active Children's Social Care involvement

3. Women choosing to relinquish parental responsibility

4. Women seeking psychological treatment following completion of care proceedings resulting in removal (temporary or permanent)

Some women may access the pathway antenatally (groups 1–3) and again postnatally following proceedings (group 4).

### **Entry points and timing**

Access is supported through pre-referral consultation to confirm consent and choice, upskill referrers, and clarify the role of MMHS and partner services in treatment planning. Post-proceedings referrals are usually accepted following completion of care proceedings, typically around 26 weeks postnatal.

### **What the pathway offers**

#### **1. Antenatal (Groups 1–3)**

- Specialist midwifery-led intervention
- Support to manage distress during Children's Social Care assessments and child protection processes
- Preparation for the birthing environment to promote psychological safety and agency
- Trauma-informed birth planning
- Preparation for potential separation and support with managing associated distress and risk

#### **2. Post-proceedings (Group 4)**

- Individualised psychological assessment and formulation to underpin treatment planning
- Therapeutic interventions tailored to individual need, which may include:
  - Safety planning, risk management and stabilisation
  - Grounding and psychoeducation
  - Trauma-focused interventions (e.g. CBT, EMDR)
  - Mentalisation-based approaches with a focus on continuing bonds
  - CAT formulation and intervention
- Joint work with adult mental health services where appropriate
- Integration of HOPE Boxes work into postnatal psychological therapy where used earlier
- System-level offer (across antenatal and postnatal periods)
- Case consultation to maternity, neonatal and local authority professionals
- Support with trauma-informed birth planning and psychologically informed practice
- Sharing of resources to promote psychological safety
- Training and facilitation of trauma-informed and compassion-focused practice

- Support for the use of HOPE Boxes across maternity and local authority settings
- Facilitation of a community of practice for professionals working with women at risk of separation

## Practice Example 4: Paths, South West Yorkshire NHS Foundation Trust

### A. Pathway context

This pathway sits within the Paths service and is specifically designed to support pregnant women who are in the pre-proceedings process (sometimes referred to as PLO). The offer focuses on providing structured antenatal support prior to the baby's birth.

### B. Who the pathway is designed for

Pregnant women who have been issued with a letter before proceedings and therefore are at risk of the local authority issuing care proceedings when their baby is born.

### C. Entry points and timing

Women are referred during pregnancy following the issuing of a letter before proceedings. Support is provided during the antenatal period only, and involvement concludes once the pregnancy, birth and beyond plan has been developed.

### D. What the pathway offers

#### Antenatal

The pathway operates at two levels of support:

#### Level 1: Mental health and midwifery assessment

- Appointment with a psychological professional
- Exploration of current emotional wellbeing and mental health needs
- Identification of appropriate mental health support
- Signposting or guidance to other services where appropriate
- Assessment of whether Level 2 support within Paths is indicated

#### Level 2: Creation of a pregnancy, birth and beyond plan (with a specialist midwife)

The plan was co-designed with women who have experienced similar circumstances. The specialist midwife will:

- Support emotional wellbeing
- Help build confidence to express needs and preferences
- Support planning for pregnancy, birth and beyond, including options and choices
- Provide practical advice and guidance tailored to the woman's situation
- Work alongside other professionals to ensure the woman's voice is heard
- Identify other services that may be accessed whether the baby remains with the mother or they are separated.

**Postnatal / post-proceedings**

No direct postnatal therapeutic or midwifery support is provided within this pathway. Involvement ends prior to birth once the pregnancy, birth and beyond plan has been created.

## Section 6: Starting somewhere – building compassionate responses in a complex system

The consultation provides a clear indication that a small number of MMHS sites are pioneering innovative approaches to working with mothers who have experienced or are at risk of being separated from their babies close to birth. Whilst service development remains varied, and resourcing limited, practitioners consider the work to be an important component of the MMHS offer.

To improve care of women under the MMHS safeguarding pathway the findings suggest that action is required at both a *local* and *national* level. Based on these emerging findings, we provide some suggested approaches. Whilst recognising the differences in local need, priorities, limitations in workforce capacity, knowledge, and infrastructure, the examples included above show that MMHS can make meaningful contributions to improving the compassionate care of women and babies at risk of or have experienced separation due to safeguarding concerns. Services are encouraged to see themselves as part of the solution, helping to address the gaps in care and support.

**Below we offer a set of practice components that services may draw upon. All are offered as reflections from the learning, not as prescriptions.**

### 1. Supporting women and the team around them

A range of approaches have been identified through consultation, from brief emotional regulation work to longer-term therapeutic support. Some MMHS teams can offer more intensive input, while others contribute through shorter, focused interventions. What emerged clearly is that even limited time-bound interventions can provide meaningful support when it is offered with consistency and care.

#### The offer may include:

- Antenatal psychoeducation and emotional regulation to support women during pre-birth assessment and their involvement with Children's Social Care.
- Emotional preparation work where separation is expected or planned.
- 1:1 or group post-separation support to help with stabilisation and recognise and support the impact of trauma, grief and loss.

Whilst MMHS teams may be well placed to work directly with women at particular time-points, or on specific issues, it is important to recognise that MMHS should not and cannot be the only offer. The consultation emphasised that this work needs to sit within a clear, coordinated, multi-agency pathway of care and support. MMHS input should complement and enhance wider partnership working. MMHS teams may use their knowledge and skills to encourage other practitioners working directly with women to provide more trauma informed and compassionate care. Some possibilities include:

- Supporting psychological formulation to help underpin and plan coordinated support
- Helping to develop trauma-informed and compassionate birth plans that reflect the woman's emotional needs and choices.
- Help develop separation plans and post-separation support plans if a separation is the local authority plan and the outcome of the court hearing.

These combined activities not only provide direct emotional support to women but also strengthen professional confidence, reduce fragmentation, and help hold a psychologically informed lens across multi-agency work.

## 2. Helping to build a system-wide offer of compassionate support

Whilst many MMHS teams felt system change was needed, finding ways to influence other practice often felt difficult. Some practitioners felt frustrated about their limited ability to affect broader change and that their sphere of influence was limited. However, some MMHS had used their knowledge and skills to influence practice more broadly through a training and/or consultancy offer.

### Some examples include:

- Providing training or consultancy offer for midwifery and Children's Social Care practitioners working with women facing separation such as trauma-informed practice or using psychological formulation.
- Developing and sharing emotional regulation toolkits for professionals who hold long-term relationships with women.
- Supporting the implementation of the HOPE Boxes as part of a wider conversation about multi-agency care or facilitating quarterly reflective groups for practitioners supporting mothers with the HOPE Boxes.
- Building pathways for longer -term support through partnerships with the VCSE sector.
- Supporting reflective groups for practitioners involved in this work to help manage emotional impact and prevent burn-out, and vicarious trauma.

## Additional reflections

### **Building the evidence base to drive sustainable and compassionate practice**

Regardless of the level of offer all MMHS can play a vital role in building the evidence base with regards to meeting the support needs of women under their safeguarding pathway. This may include for example developing local mechanisms for collecting data and evaluating the support and modalities **to develop an evidence base for interventions offered to women under safeguarding pathways.**

### **Supporting staff and recognising emotional labour**

The consultation made clear that the interface with child protection processes and the family courts may lead to heightened anxiety for staff. Training, structured supervision and peer support could help negate some of this anxiety.

### **National co-ordination of the work**

Whilst locally co-ordinated activity and pathways of support are essential. Embedding and sustaining this work across MMHS sites would be helped by national co-ordination, resource and infrastructure. National action could help to ensure a national evidence base is developed to support a more sustainable and co-ordinated approach.

### **Implementing the HOPE boxes**

There was clear support for the HOPE Boxes offer as part of the wider support available to women and babies. However, it is important to recognise the time and resources required to implement this effectively. For the HOPE Boxes to achieve their ambition, a well-defined multi-agency pathway is needed, alongside investment in the training and support required to deliver this work

## Section 7: Conclusion

Only a small number of MMHS services currently support women at risk of separation from their baby at birth due to safeguarding concerns, and provision remains uneven. This variation reflects the early and tentative nature of development, alongside the determination of teams to act, even where resources and confidence are limited.

This learning review draws on emerging practice, shared learning events, and consultation with existing teams. It is not systematic research, and there is not yet sufficient evidence to identify the most effective models. What it does illustrate is that progress is possible and that an evidence base can only be built if MMHS start somewhere, learn, and adapt together.

The challenges are clear. Delivering this work well requires skilled practitioners, adequate resourcing, and strong support structures. Services also highlighted the need for national coordination to reduce inconsistency, avoid duplication, and ensure shared learning. Without these, provision risks being fragile and overstretched. Yet the greater risk is to do nothing, leaving an underserved and marginalised group of women to fall through gaps with no clear responsibility for their psychological care.

While MMHS cannot and should not be the sole response, it offers a distinctive contribution when embedded within a wider multi-agency pathway. Its role in this pathway is consistent with the original remit of these services and addresses the specific trauma of separation at birth.

With national leadership, adequate resources, workforce development, and a commitment to learn together, MMHS can play an important role in shaping a joined-up response and improving outcomes for mothers and babies at this critical time.

### Research ethics approval

The ESMI-III Study (phase 1) received ethical approval by the King's College London Ethics Committee in July 2021 (REC Reference: MRA-20/21-25656), and NHS Approval was granted by the Southwest – Central Bristol Research Ethics Committee (Reference: 19/SW/0218). HRA approval for the study was also granted.

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