



Report focus
Rapid evidence review
identifying birth parent and
professional perspectives
on pre-birth assessment
and infant removal at birth.

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Pre-birth assessment and infant removal at birth: experiences and challenges

A literature review



About this review

This rapid evidence review aims to identify key messages from research concerning birth parent and professional perspectives on pre-birth assessment and the removal of infants at birth.

This paper is linked to *Born into care: newborns in care proceedings in England* (2018) and *Born into care: newborns and infants in care proceedings in Wales* (2019), published by the Nuffield Family Justice Observatory, which looked for the first time at the number of newborns subject to care proceedings in England and Wales, using population-level data held by Cafcass. The number of newborns subject to proceedings prompted considerations and questions about, among other things, practice in relation to pre-birth assessments and removal at birth and the legal framework and court decision making in such cases. A separate paper will report on court decisions in relation to pre-birth assessments and removal at birth.

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About the Nuffield Family Justice Observatory
The Nuffield Family Justice Observatory (Nuffield FJO) supports better outcomes for children in the family justice system in England and Wales by improving the use of data and research evidence in decision-making. We do this by:

- Supporting the analysis of national data and linking data from different sources to better understand the experience of children and families in the family justice system.

- Researching issues facing children and families and collaborating with others to bring about change in practice.
- Enabling decision-makers to access the latest data and research evidence.

Central to the Nuffield FJO's operation is a data partnership with the Centre for Child and Family Justice Research at Lancaster University and the SAIL Databank at Swansea University.

The Nuffield FJO has been established by the Nuffield Foundation, an independent charitable trust with a mission to advise social well-being. The Foundation funds research that informs social policy, primarily in Education, Welfare, and Justice. It also funds student programmes for young people to develop skills and confidence in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Ada Lovelace Institute and the Nuffield Council on Bioethics.

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1. Introduction

This rapid evidence review aims to identify key messages from research concerning birth parent and professional perspectives on pre-birth assessment and the removal of infants at birth. In addition, research evidence that provides a window into system-level challenges through retrospective case file analysis, ethnographic observation or analysis of procedures and guidance, is included. Although the national and international literature on pre-birth assessment and infant removal at birth is of variable scope and quality, by reading across different bodies of literature, it has been possible to distil some consistent messages which are of immediate relevance for practitioners, policy makers and researchers.

As might be expected, when birth parent (typically birth mother) perspectives on pre-birth assessment and removal of infants at birth are sought, there are some difficult messages for policy and frontline practice. However, what is notable from this review, is the extent to which professional and family perspectives cohere. Concern about a late response to pregnancy was shared by birth mothers and professionals alike. A late response to the unborn child simply leaves too little time to prompt or evidence change in parenting capacity. It also misses an opportunity to support the health and well-being of the unborn child. Regarding the removal of an infant at birth – again, studies report similar messages whether they were shared with researchers by birth mothers or by professionals. The separation of an infant at birth from his or her mother, father and indeed wider family network, is an acutely distressing experience for all concerned.

Research which reports the perspectives of birth parents and professionals is largely drawn from qualitative interview data. First-person experiential accounts are a vital source of insight into pre-birth assessment and the removal of an infant at birth. However, insights can also be drawn from research which seeks to understand practice through direct observation, or retrospectively through file review. Given that this review has been based on topics which are under-researched, we can be more confident in key messages where they are confirmed by different types of study or research evidence. From detailed reading of case files, researchers have provided supporting evidence that pre-birth assessment is not always timely, adding weight to parent and professional concerns about a delayed response to the unborn child, parents and wider family.

Overall, the review has identified many gaps in the literature and a number of the identified studies are very small scale in nature. Further research is needed to respond systematically to the concerns raised in this review and to ascertain the extent to which shortfalls in practice are widespread, remain current and equally to identify good practice.

The approach taken to reviewing the evidence and search strategy are set out in full in [Appendix 1](#). The following three research questions underpin the research strategy and have structured this review

- 1) What are birth parents' experiences of pre-birth assessment and removal of an infant at birth?
- 2) What are professionals' experiences of pre-birth assessment and removal of an infant at birth?
- 3) What can be learned about system-level challenges from descriptive studies of practice?

2. Background

Local authorities and related agencies can intervene in pregnancy where there are safeguarding concerns regarding an unborn child. Intervention in pregnancy aims to both assess the future risk to an infant following birth, but also to alleviate risks by providing tailored support to improve parenting capacity. Where local authorities determine that the concerns are so great that, following birth, an infant cannot remain safely in his or her parents' care, action may be taken to remove the baby.

Although multi-agency assessments and care plans may be drawn up prior to the infant's birth, in most jurisdictions, including England and Australia, care proceedings cannot be brought until after birth, when the foetus gains 'personhood' within the law. For the same reason, States do not generally have the right to compel mothers to engage with child protection services during pregnancy, although voluntary engagement is encouraged. However, in the absence of effective assessment and support at a timely point in pregnancy, intervention at birth is likely to be poorly planned and risks instability for the new baby and huge distress for all family members. The separation of mother and baby at birth has been described as a severe form of intervention in family life by some judges in courts in England (e.g. *R (G) v Nottingham City Council (2008)*) and the Council of Europe (2015). Issuing care proceedings at, or close to, a baby's birth is fraught with moral, ethical and legal challenges given the vulnerability of infants and their mothers in the immediate post-natal period.

Despite the challenging nature of practice in these circumstances and considerable concern from frontline practitioners, to date there has been a surprising lack of attention paid to the issue of state intervention during the perinatal period. In particular, there is a lack of synthesis of experiential evidence from either birth parents or professionals regarding pre-birth assessment or infant mother separation at birth.

In the UK, child welfare policy has placed increasing emphasis on early intervention to prevent developmental harm (Ward *et al.*, 2012). Two recent reports have provided firm evidence of the increasing number of care proceedings that concern new-born babies in England and Wales (Broadhurst *et al.*, 2018; Alrouh *et al.*, 2019, forthcoming). Although empirical evidence regarding the scale of newborn removals in other jurisdictions is limited, there is firm evidence that infants aged less than 12 months are more likely than any other category of children to enter out of home care (Wulcyzyn *et al.*, 2002; 2011). In this context, this rapid evidence review was conducted to review the published literature on birth parents' and professionals' (healthcare professionals, midwives and social workers) experiences of the pre-birth assessment process and infant removal at, or soon after, birth.

3. Methodology

Database searches were conducted in August 2018 and two additional searches in October 2018. Literature was included if studies were published between 1990 and 2018, written in English, and conducted in the UK or other countries with similar child protection systems i.e. Australia, Canada, New Zealand or the US. A search of grey literature was not conducted due to time available to conduct this review.

A total of 27 studies were included in the final sample. The empirical studies were primarily conducted in England ($n = 14$) and Australia ($n = 7$) but also included Canada ($n = 1$), USA ($n = 2$) Northern Ireland ($n = 1$) and Scotland ($n = 2$). Most papers were qualitative ($n = 12$), nine were mixed methods studies and six were quantitative studies. The studies had varied, and often multiple foci: birth mothers ($n = 11$), birth parents (including birth mothers and fathers in the sample) ($n = 4$), midwives ($n = 11$), health care professionals ($n = 5$) social workers¹ ($n = 6$). The majority of the papers focussed specifically on the perinatal period (as specified in the inclusion criteria)², however four studies where the focus was broader but the sample was predominantly infants or part of the findings related specifically to pre-birth assessment or infant removal were also included. (Ward *et al.*, 2012; Whittaker *et al.*, 2016; Broadhurst *et al.*, 2017, Neil *et al.* 2010)³. Two of the studies included were published doctoral theses (Marsh, 2016; Hodson, 2011). Seven papers included in this review focussed specifically on parents who misused substances and opioid users specifically were the focus of three of these seven studies. Two studies focussed specifically on the experiences of women in prison (Chambers, 2009; Wismont, 2000). Following inclusion screening all papers were

¹ The term social worker is used throughout this review to denote those workers who had statutory responsibility for child protection assessment and intervention. In the Australian studies this role was undertaken by Family and Community Services workers (FACS).

² See appendix 1 for details

³ In Broadhurst *et al.*'s (2017) study of 'Vulnerable Birth Mothers and Recurrent Care Proceedings', just over half ($n = 37$) of the 72 birth mothers interviewed had had their child/children removed at birth. In Ward *et al.*'s (2012) longitudinal study, case files relating to 57 babies were analysed with 37 infants followed up to their fifth birthdays. In Whittaker's *et al.*'s (2016) focus group study of healthcare professionals, practitioners were asked broadly about their experiences of parental drug misuse but a key focus was on pressures during pregnancy. The Neil *et al.*'s study 'Helping Birth Families' investigated the experiences of 73 birth relatives (44 mothers and 19 fathers, 10 grandparents) whose child or grandchild had been adopted. Of these children 64% had left birth family care as an infant (under 1 year)

quality appraised using the Critical Appraisal Skills Programme or the Mixed Methods Appraisal Tool⁴.

Full details of the methodology can be found in [Appendix 1](#) and a summary of included papers, their methodology, sample size, findings, and limitations can be found in [Appendix 3](#).

⁴ The CASP criteria comprises a checklist of thirteen questions covering design, sampling strategy, data collection and analysis. There are separate checklists for qualitative studies, case control studies and systematic reviews. CASP checklists have been used in the health and social sciences fields for systematic reviews involving qualitative studies. See: <https://casp-uk.net/>

The MMAT is a mixed methods study appraisal tool first developed in 2006. The latest 2018 version was developed on the basis of findings from a literature review of critical appraisal tools, interviews with MMAT users, and an eDelphi study with international experts. See:
http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

4. Key Findings

Assessment of the Literature

This review provides evidence of the overall sparsity of literature concerning pre-birth assessment and infant removal at birth. The bulk of existing evidence is qualitative and derived from focus groups, questionnaires and interviews with professionals and birth parents. The qualitative work has tended to focus on birth mothers, with limited coverage of birth fathers or the extended family. This birth parent research is largely focused on birth mothers in the community, although two studies are included concerning removals at birth from mothers in prison. A substantial proportion of literature is based on the perspectives of birth mothers with drug and alcohol problems.

Regarding professional perspectives, the literature is weighted towards midwives and other health professionals with a smaller number of studies concerning social workers. Of the six studies that do include the perspectives of social workers, five focus on pregnancy with only one study documenting the experiences of social workers involved in parent-child separation at birth. Thus, the actual detail of *practice* surrounding state intervention in pregnancy or following the birth of an infant, is poorly documented within the literature. However, a limited body of literature is published about system-level challenges based on case file review, real-time observation, analysis of administrative data or review of guidance and protocols.

The final selection of studies included in the review varied in sample size and scope; however reading across the literature it was possible to identify some consistent themes. The sample size in some included studies was small which limits generalisability. For further details see [Appendix 1](#).

Findings have been grouped according to the research questions that underpin this review.

A: What are birth parents experiences of pre-birth assessment and removal of an infant at birth?

In keeping with the broader literature of parental experiences within the family justice system, the bulk of the research evidence is based on the perspectives of birth mothers. Eleven of the studies included in the review reported directly on mothers' perspectives whilst only four included the views of fathers'. In each of these studies fathers' views were reported alongside those of mothers.

Birth Mothers

i) Stigma, judgement and lack of trust in professionals (n = 11)

The most prominent cross cutting theme within the literature (11 articles) and pertinent to both pre-birth assessment and removal of an infant at birth centred on stigma and lack of trust in professionals. Findings regarding trust and women's fear of being negatively judged help to explain women's reluctance to engage with professionals, or to reveal the true nature of the difficulties they faced (Klee *et al.*, 2002; Phillips *et al.*, 2007; Finney Lamb *et al.*, 2008; Neil *et al.*, 2010; Morris *et al.*, 2012; Ward *et al.*, 2012; Chandler *et al.*, 2013; Harvey, 2015; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.* 2018). Women felt that workers used stigmatised concepts and labelled them as unsuitable or failed parents (Finney Lamb *et al.*, 2008; Harvey *et al.*, 2015). Stigma was felt acutely by women with substance misuse issues, who described a sense of discrimination, when accessing services (Klee *et al.*, 2002; Morris *et al.*, 2012; Harvey *et al.*, 2015). Parents' sense of being judged and discriminated against, was reported as a key barrier to attending appointments and impacted negatively on women's perceptions of themselves during pregnancy (Klee *et al.*, 2002; Finney Lamb *et al.*, 2008; Chandler *et al.*, 2013; Harvey *et al.*, 2015). When involved with child protection agencies, parents may be expected to attend a wide range of appointments. The research suggests that pregnant women, and particularly those misusing drugs, found these multiple demands overwhelming and struggled to manage the volume of professional requirements, alongside their other responsibilities and difficulties. This frequently resulted in many missed appointments which counted negatively against women in child protection reports (Klee *et al.*, 2002; Chandler *et al.*, 2013; Broadhurst *et al.*, 2017).

In interviews with 64 pregnant women in drug services, Klee *et al.* (2002) reported that women's experiences of previous, insensitive practices, had a longer-term impact on their engagement with professionals in the context of a subsequent pregnancy. Women who were using drugs and alcohol in pregnancy, stated that they just wanted to be treated with respect, and to be seen as a 'normal pregnant woman', instead they feared that their identity was tainted by the label of drug user (Klee *et al.*, 2002; Morris *et al.*, 2012; Phillips *et al.*, 2007). Practice approaches that were experienced as insensitive and lacking respect, included the use of labels on the cover of personal maternity files that indicated women were using drugs, and blood sample bottles labelled (for example) "danger infection" (Klee *et al.*, 2002). In a study exploring 13 women's perceptions of an opioid treatment service, who were either pregnant or who had experienced the loss of custody of a child, Finney Lamb *et al.* (2008) reported that most women would not make a complaint about the quality of health care they had received, because they did not feel they would be believed.

Trust in social workers was noted as a particular difficulty for mothers who had previous children removed from their care, or who had themselves been in care as children (Klee *et al.*, 2002; Ward *et al.*, 2012; Broadhurst *et al.*, 2107). Interviews suggested that their

previous negative experiences led to understandable suspicion and a reluctance to work collaboratively (Klee *et al.*, 2002; Ward *et al.*, 2012; Broadhurst *et al.*, 2017). Women spoke of wanting the assessment to be a “clean slate” but feared that their history within child protection services, prejudiced decisions (Ward *et al.*, 2012, Broadhurst *et al.*, 2017).

Birth mothers’ concerns about their relationships with professionals spanned all professional groupings. Although research on birth mothers’ perceptions of their relationships with midwives and healthcare professionals is limited, the published literature suggests that birth mothers were unlikely to disclose problems to their midwife during pregnancy, because of a fear of being judged, or of being referred to children’s services (Harvey *et al.*, 2015; Marsh, 2016). Conversely, a strong relationship with staff underpinned by respect and non-judgemental professional behaviour, acted as a motivating factor and supported women’s access to healthcare services and disclosure of substance misuse during pregnancy. Studies demonstrated that empathic treatment by healthcare professionals and a supportive professional relationship influenced the likelihood of attending maternity or other health appointments. These relationship qualities were valued in all professional relationships and could also motivate change in women’s lives (Klee *et al.*, 2002; Phillips *et al.*, 2007; Neil *et al.*, 2010; Morris *et al.*, 2012; Harvey *et al.*, 2015; Broadhurst *et al.*, 2017).

Two studies emphasise the importance of continuity of care in helping to build relationships based on trust, particularly with midwives (Morris *et al.*, 2012; Phillips *et al.*, 2007) but also with social workers and health visitors (Ward *et al.*, 2012). In Morris *et al.*’s (2012) longitudinal study of 20 chemically dependent pregnant women accessing antenatal care, participants described how the relationship with their midwife, built over time, and the consistency of this support helped to cement trust and collaboration.

ii) Fear of referral to child protection services and infant removal as a barrier to engaging with services and professional help in pregnancy (n=9)

A further cross-cutting theme linked to the findings described above, was women’s fear of being referred to child protection services and the potential removal of their babies at birth. This was reported in nine articles, which focused on pregnancy and pre-birth assessment. Fear and anxiety were key reasons why women were reluctant to access antenatal services, and to share the full extent of their difficulties (Klee *et al.*, 2002; Phillips *et al.*, 2007; Finney Lamb *et al.*, 2008; Radcliffe, 2011; Ward *et al.*, 2012; Chandler *et al.*, 2013; Harvey *et al.*, 2015; Marsh 2016; Broadhurst *et al.*, 2017). For example, Harvey *et al.*’s (2015) small-scale narrative enquiry, which focused on women accessing an opioid treatment service, identified that women’s fear of their baby being removed by child protection services was consistently expressed in interviews by participants. Similarly, Klee *et al.*, (2002) report that in 64 interviews with pregnant women who used substances, fear was consistently reported as a barrier to service engagement. The study revealed that women’s anxieties were confirmed by stories of other substance using women in their communities, having infants removed

from their care. Both Marsh (2016) and Phillips *et al.* (2007) also reported that fear inhibited women from disclosing the full extent of presenting problems.

Although there are very few studies focused on women who have experienced multiple sets of care proceedings, a mixed-methods study by Broadhurst *et al.* (2017), which included a large sample of 72 mothers drawn from seven local authority areas, reported that anxieties regarding engagement with services were consistently reported and heightened where women had lost a child previously through care proceedings (2017). These findings were echoed by Ward *et al.* (2012). Studies also note that anxiety about the possible removal of a baby can overshadow pregnancy, and in some cases impact on women's bonding with the unborn child (Klee *et al.*, 2002; Ward *et al.*, 2012; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018).

It is also important to note that, studies also report that some vulnerable women did proactively seek antenatal care, despite their concerns about child protection services. This engagement was motivated by concerns for the health and wellbeing of their unborn baby (Phillips *et al.*, 2007; Harvey *et al.*, 2015). Other researchers also point out that the fear of a baby being removed, was the key reason why some women worked co-operatively with Chandler *et al.*, 2013; Harvey *et al.*, 2015). Early engagement was also noted as common for women who had experienced previous child removal. This was motivated by a desire to maximise her opportunity to evidence changes in her circumstances and behaviours and alleviate professional concern (Broadhurst *et al.*, 2017).

iii) Pre-birth assessment – poor information giving and communication (n = 5)

Five studies in this review highlight birth mothers' lack of understanding of the child protection and family justice processes in the pre-birth period, due to limited or poor communication between professionals and birth parents (Klee *et al.*, 2002; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018). These studies suggest that birth parents are often unclear about the reasons for their involvement with child protection services or the process that is being followed (Ward *et al.*, 2012; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018). Qualitative work undertaken by both Marsh (2016) and Broadhurst *et al.* (2017), reports that birth mothers were unclear about the intentions of the local authority, during pre-birth assessment or even at the point of infant removal.

Late pre-birth assessments and pre-birth child protection case conferences mean that birth mothers were afforded less opportunity to influence the care plan or demonstrate their capacity to change (Brown and Ward, 2014; Broadhurst *et al.*, 2017). Marsh *et al.*'s (2018) narrative analysis of birth mothers' experiences of infant removal at birth, highlights how

poor communication from professionals can leave women feeling ‘out of the loop’, and in some cases deceived, which deepened feelings of mistrust and isolation.

In Broadhurst *et al.*’s (2017) study of women in recurrent care proceedings, women spoke openly of the anxiety caused by the delay in pre-birth assessment. Even early self-referral, did not necessarily equate to an early response from services. In interviews, women reported that despite early notification of their pregnancy, their pre-birth assessments were frequently delayed until the third trimester of pregnancy. This resulted in heightened anxiety and frustration. Similar feelings of being left “in limbo” resulting in high levels of anxiety was also reported by birth mothers in Ward *et al.*, (2012)

iv) Shortfalls in inclusive planning and sensitivity in cases of removal at birth (n = 6).

Research focused on women’s experiences of removal at birth is scant. Searches identified only six studies that included this issue. The studies conducted in England, Australia and the USA, all reported the lack of emotional support afforded to birth mothers when a baby was removed (Ward *et al.*, 2012; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018; Wismont, 2000). From the perspective of birth mothers, professional practice was often experienced as lacking in empathy. In part, the insensitivity resulted from lack of timely and inclusive planning as discussed above, which meant that in the immediate aftermath of birth, women were not prepared for the removal of their baby (Broadhurst *et al.*, 2017; Marsh *et al.*, 2016; Marsh *et al.*, 2018). In some instances, women reported that they only became aware of the plan to remove the baby at birth, after the baby was born (Ward *et al.*, 2012; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018). Marsh’s (2016) small-scale study with birth mothers recommended that there should be a greater focus on engaging with mothers through pre-birth planning to ensure they are clear about what will happen to them in hospital and, if their baby is to be removed, how that will happen. The studies also highlight that birth mothers considered there to be a lack of attention given to their privacy needs with child protection visits often taking place on main maternity wards with little consideration given to confidentiality. Such practice was described by the birth mothers as adding to their trauma and shame (Marsh, 2016; Broadhurst *et al.*, 2017).

In the work of Broadhurst *et al.* (2017), a minority of mothers gave examples of good practice in maternity settings, which set their experience apart. For example, in some instances, birth parents were offered a private room in the maternity ward. Similarly, Marsh *et al.* (2018) highlight examples of midwives providing women with the opportunity to create memories of their baby and the birth, despite the fact that the baby was to be shortly removed. For example, women were encouraged to take photographs of the baby and keep the cot card. However, examples of good practice in the literature are limited, and appeared to result from the initiative of individual practitioners, rather than being formalised in any organisational protocols or guidelines. Marsh (2016) and Broadhurst *et al.* (2017) state that where birth parents’ wishes and feelings are carefully included in pre-birth planning, this can

alleviate some of the trauma associated with removal. Examples included, a choice as to whether women left the hospital before or after the baby was removed, who they would hand the baby to at the point of separation, and choice of what the baby would wear. Whilst seemingly small choices, these qualitative findings suggest that they could be important in building a more humane experience for the birth parents.

Two studies were identified that focused specifically on the separation of newborn babies from mothers who are in prison at the time of birth (Chambers, 2009; Wismont, 2000). In common with women in the community, incarcerated mothers also report insensitivity on the part of prison staff, late planning and a lack of certainty about alternative carers for their babies (Wismont, 2000).

v) *The psychological impact of removal at birth (n = 7)*

Whilst the emotional impact of separation has been explored in some detail in the now historical published literature on mothers who have relinquished children for adoption, (Logan 1996; Howe and Hining, 1992) there has been very limited focus on the psychological impact of compulsory removal at birth. Given the particular physiological and practical challenges faced by women in the period following birth, this lack of attention is perhaps surprising.

The limited literature included in the review demonstrates that the impact of removal at birth is acutely traumatic, and has a far-reaching impact (Neil *et al.*, 2010; Ward *et al.*, 2012; Marsh, 2016; Broadhurst *et al.*, 2017; Marsh *et al.*, 2018). The literature reveals both the immediate intensity of loss and grief, which heightens women's vulnerability, but also the enduring nature of this loss. In Marsh *et al.*'s (2018) study, in depth interviews with seven Australian women who had experienced the removal of their infant at birth revealed the impact of deep-felt grief, guilt and shame. This led to their further social isolation and a reliance on problematic coping strategies such as substance misuse. Broadhurst *et al.*'s (2017) study reported very similar findings. Women described a removal at birth as deeply distressing and de-humanising. Women's loss compounded existing problems, including emotional disconnection from others and misuse of substances. Comparisons are drawn within the literature between women who have experienced stillbirth and removal at birth – but with important distinctions. Regarding the removal of an infant at birth, grief takes a different form, as mothers hold onto a sense of reunification with their child sometime in the future – which is different from the death of a baby (Neil *et al.*, 2010; Ward *et al.*, 2012; Marsh, 2016; Broadhurst *et al.*, 2017). A number of authors also refer to shame and stigma as complicating factors for parents. The construct of disenfranchised grief (Doka, 2002), captures the lack of social acceptance of this particular form of grief and the additional emotional burden that stigma adds (Broadhurst *et al.*, 2017; Marsh, 2016; Marsh *et al.*, 2018;

Neil *et al.*, 2010). Work by Neil, *et al.* (2010) which focused on parents whose children were subject to adoption because of child protection concerns, reported that feelings of loss, anger, guilt and regret threatened their identity and had long-term psychological effects. Clinical depression among parents in their interview sample was common, along with reports of self-harm and feelings of hopelessness (Neil *et al.*, 2010).

Women who give birth in prison report similar experiences of shock and profound grief if the infant is removed immediately and placed with alternative carers (Wismont, 2000; Chambers, 2009). Separation of an infant from an incarcerated mother is however a distinct experience, given that for at least some women, reunification with their child is a realistic prospect, once their sentences are concluded. Thus, Chambers (2009) reports that imagined futures of reunification with their children, also featured strongly in the narratives of women separated from their babies through incarceration.

1 (b): Birth father and wider family perspectives (n = 4)

Although there is a broader body of literature which focuses on fathers in child protection or care proceedings (e.g. Featherstone and Peckover, 2007; Ferguson, 2012; 2016; Philips *et al.*, 2019), this review identified only a very small number of studies which included birth-father perspectives (n = 4). In each of these studies, fathers' perspectives were included alongside the experiences of birth mothers or other relatives (Neil *et al.*, 2010; Ward *et al.*, 2012; Chandler *et al.*, 2013; Masson and Dickens, 2015). Within this limited literature, many of the themes emanating from the birth mother literature were mirrored. Themes included the fear of child protection involvement as a barrier to engaging in substance misuse treatment services (Chandler *et al.*, 2013), interactions with professionals being marred by experiences of stigma and fear (Chandler *et al.*, 2013) and insensitivity of practice (Ward *et al.*, 2012). As part of a study focusing on the support needs of birth relatives after adoption, Neil *et al.* (2010) interviewed a group of 19 fathers, following the adoption of their child. In addition, a standardised measure called the *Brief Symptom Inventory* (Derogatis and Spencer 1983) was administered at two time points to assess their level of mental distress. Findings indicated that like mothers, fathers' experienced a high degree of enduring psychological distress. In addition, the 'coping with adoption' measure developed by the researchers, suggested that when compared to birth mothers, fathers were less likely to improve over time. The paucity of studies focused specifically on birth fathers' experiences adds weight to the claim that the father's role is marginalised during pre-birth assessment and proceedings (Hart, 2001; Hodson, 2011; Masson and Dickens, 2015).

Although, the traumatic impact of state intervention is not confined to the birth parents but likely reverberates throughout the kin network, there is only one included study that reports on the experiences of family members other than birth parents. In addition to birth parents, ten grandparents were also interviewed as part of Neil's study (2010). The findings suggest

that grandparents also experienced high levels of psychological distress following their grandchild's separation from the family's care.

2 (a). Professional experiences of the pre-birth assessment process, and removal at birth

Midwives' Perspectives (n = 11)

A number of research papers (11 in total) from Australia (n = 4), England (n = 5), Northern Ireland (n = 1) and Scotland (n = 1) report on studies that have explored midwives' perspectives in relation to their safeguarding roles and experiences of pre-birth assessment and infant mother separation at birth (two of these papers Everitt *et al.*, 2015 and Everitt *et al.*, 2017 report on different aspects of a single empirical study). When reading across this literature it is possible to identify some important themes.

i) Midwifery practice: relationships, continuity and role conflict (n = 5)

Regarding the role of the midwife with women at risk of infant removal at birth, two particular lines of enquiry are evident in the literature. The first is on the midwife's approach to his or her role within child protection processes. The second is on the direct experience of midwives who have been involved with women in pregnancy and the removal of an infant at birth in maternity settings.

Whilst aware of their safeguarding responsibilities, studies stress the importance midwives place on also remaining woman-centred (Phillips *et al.*, 2007; Everitt *et al.*, 2015; Everitt *et al.*, 2017; Marsh 2016; Marsh *et al.*, 2018.) and emphasise the building of positive working relationships with the women based on trust. Studies report that midwives stress the importance of open, honest and non-judgemental communication where child protection concerns must be addressed at birth (Klee *et al.*, 2002; Phillips *et al.*, 2007; Everitt *et al.*, 2017; Marsh *et al.*, 2018). In addition, some midwives consider a relationship-based approach as key to promoting women's on-going engagement with the wider health care system (Phillips *et al.*, 2007; Everitt *et al.*, 2017). Phillips *et al.* (2007) conducted interviews with ten midwives in two antenatal clinics in an Australian maternity hospital, again, the findings were that building rapport and a sense of trust encouraged the sharing of problems of substance use. Elements of positive relationship-based practice included a one-to-one model of care, continuity of care, privacy and adequate time in appointments (Phillips *et al.*, 2007; Cross-Sudworth *et al.*, 2015; Marsh, 2016). Marsh (2016) stated that the current evidence base relating to 'caseloading' confirms that one-to-one midwifery care is

advantageous to women and midwives (cites RCM, 2007; Midwifery 2020, 2010; Sandall *et al.*, 2015).

However, studies within this body of literature (4) also report that midwives can feel their woman-centred approach is compromised when there are child protection concerns. This role conflict was frequently described within the literature as a clear cause of professional distress. Emphasis was placed on the need for support and training to enable midwives to manage role tensions when child protection services are involved (Marsh *et al.*, 2018, Marsh 2016, Everitt *et al.*, 2015; Wood 2008).

vi) *Experiences of mother baby separation at birth (n = 4)*

This small body of literature on midwives' experiences of their involvement of separation of mother and infant at birth, reveals high levels of professional distress (Wood, 2008; Everitt *et al.*, 2015; Marsh, 2016; Everitt *et al.*, 2017). Everitt *et al.* (2015) described the emotional labour associated with removing a baby from his or her mother's care at birth. They described this as "being in the heart space" (p.97) because midwives witnessed directly, birth mothers' high levels of emotional distress and shared in their "emotional rollercoaster" (p.98). Interviews with eight midwives in Marsh's (2016) study, illustrated the array of emotions experienced as they provided care to a mother whose baby had been removed; these included guilt, sadness, anger and shock. Midwives in four studies (Wood, 2008; Everitt *et al.*, 2015; Marsh 2016 and Marsh *et al.*, 2018) described a sense of betraying mothers, particularly if pre-birth planning had not been completed or shared with the mother in advance of the birth. Midwives reported feeling challenged by their role and their sense of powerlessness in such cases particularly if insufficient information was shared to enable effective preparation for the separation of an infant at birth (Everitt *et al.*, 2017; Marsh *et al.*, 2018).

Midwives also considered that their role could be undervalued or overlooked by other agencies (Wood, 2008; Everitt *et al.*, 2017; Marsh *et al.*, 2018). In some studies midwives considered it important to have a clear distinction between the role of the social worker and that of the midwife (Wood, 2008; Everitt *et al.*, 2017). In all four studies, midwives reported lasting personal distress as a result of their experience of infant removal at birth, which underscores the importance of adequate training and support.

v) *Knowledge, training and resources (n = 7)*

There is a body of literature focused more broadly on midwives' knowledge and understanding of child protection procedures in Australia, England, Northern Ireland and Scotland. The importance midwives placed upon their role in safeguarding infants was emphasised across the literature (Wood, 2008; Lazenbatt, 2010; Cross-Sudworth *et al.*, 2015; Marsh 2016; Marsh *et al.*, 2018) However, the literature suggests variation regarding

midwives' levels of confidence and knowledge of child protection procedures (Lazenbatt, 2010; Cross-Sudworth *et al.*, 2015; Whittaker *et al.*, 2016; Everitt *et al.*, 2017). For example, in Lazenbatt's (2010) Northern Irish study focused on domestic violence, questionnaires returned by 488 midwives indicated that community midwives were much more aware of the procedures for reporting child protection concerns compared to those who worked in a hospital setting; 60% of hospital midwives reported being unsure or not knowing mechanisms for reporting child protection concerns. Furthermore, midwives reported a lack of confidence in asking pregnant women questions concerning child protection risk factors such as domestic violence. Similarly, an English study (Cross-Sudworth *et al.*, 2015), which surveyed 213 midwives, found that although midwives reported high levels of confidence in dealing with child protection pathways generally, they were less confident where particular sub-set of issues were present, for example, those involving parents with learning disabilities or families from migrant communities (Cross-Sudworth *et al.*, 2015). Despite being expected to contribute towards child protection assessments, midwives sometimes felt ill equipped and considered specialist training to be essential (Lazenbatt, 2010; Radcliffe *et al.*, 2011; Cross-Sudworth 2015; Everitt *et al.*, 2017; Marsh, 2016; Whittaker *et al.*, 2016; Marsh *et al.*, 2018).

vi) *Collaboration with Child Protection Agencies (n = 6)*

This body of literature provides insights into midwives' perspectives of collaborative working. Midwives consistently valued working collaboratively with child protection agencies (Lazenbatt 2010; Cross Sudworth *et al.*, (2015); Everitt *et al.*, 2017; Marsh 2016; Marsh *et al.*, 2018). However, some studies report that many midwives perceived significant difficulties in collaborating and communicating effectively with social workers and reported a sense of power inequalities (Everitt *et al.*, 2017; Marsh *et al.*, 2018; Wood, 2008). Analysis of 213 questionnaires completed by midwives in England suggests that midwives considered multidisciplinary safeguarding pathways to be insufficiently clear, and this impacted on the quality of multi-agency practice (Cross-Sudworth *et al.*, 2015). Marsh (2016) found that midwives experienced challenges in working with child protection agencies, because they felt that their views were often not taken into account in assessments and court proceedings. Similar themes regarding lack of information sharing between statutory child protection agencies and midwives were also identified within the Australian studies (Everitt *et al.*, 2017; Marsh *et al.*, 2018). Everitt *et al.* (2017) report midwives' sense of power imbalances between the agencies. Despite considerable investment in establishing lines of effective communication with child protection agencies, at times midwives felt there was a limited reciprocal response, which resulted in delayed, and ineffective planning and assessment (Everitt *et al.*, 2017). The additional workload involved in child protection cases and the number of additional meetings was also noted as a difficulty for midwives (Everitt *et al* 2017; Marsh 2016).

2 (b) Social Worker Perspectives (n = 6)

i) *Lack of guidance and specialist tools for assessment*

Six studies identified in the review were focused on the perspectives of social workers. Three of these studies focused on pre-birth assessment (Hodson, 2011; Lushey *et al.* 2018; Masson and Dickens, 2015). Tensions between balancing the responsibilities to the unborn child and the parents, were reported across the three studies. Practitioners emphasised the need for more in-depth national and local guidance to aid pre-birth assessment. They also highlighted the lack of specialist child development knowledge and access to specialised tools and measures, as obstacles to improving the quality of pre-birth assessments (Hodson, 2011; Ward *et al.*, 2012; Lushey *et al.*, 2018). Work by Klee *et al.* (2002) includes the perspectives of social workers alongside other professionals. A key finding is that social workers, working with pregnant women who use drugs, held insufficient knowledge about the impact of drug use in pregnancy.

Short-timescales for pre-birth assessments were described by social workers as challenging, particularly in more complex cases. Three studies (Ward *et al.*, 2012; Lushey *et al.*, 2018; Masson and Dickens 2015) all reported that practitioners delayed the start of pre-birth assessment until the later stages of pregnancy, given high caseloads. This finding indicates that unborn children can be given less priority in busy social work teams. Consideration of the viability of the foetus was also cited as a common reason for not intervening in the early weeks of pregnancy (Ward *et al.*, 2012; Hodson 2011; Lushey *et al.*, 2018).

ii) Emotional nature of the work (n = 4)

The difficult nature of this type of work was noted by child protection practitioners in four studies, with workers referring to their awareness of their professional power and the potential impact on birth mothers during pregnancy (Marsh *et al.*, 2018; Hodson 2011). In interviews with 15 social workers and drug workers, Klee *et al.*, (2002) report that child protection practitioners were aware that anxiety about service involvement was common among mothers using drugs and alcohol and could deter service engagement.

Marsh *et al.*'s (2018) Australian study covered the perspective of child protection practitioners involved in removals at birth. The practitioners described the experience as "traumatic" and highlighted their awareness of the power imbalance between them and the families with whom they worked. Other studies refer to the importance of support for social workers practising in this field, and suggest that this is often lacking (Hodson 2011; Marsh *et al.*, 2018)

Whilst across a number of studies, social workers emphasise the importance of working collaboratively with professionals from other agencies, they note the challenge of achieving

effective multi-agency working and information sharing within short time-scales (Klee et al., 2002; Hodson, 2011; Ward *et al* 2012).

2 (c) Healthcare Professionals' Perspectives (n = 5)

Five studies collected data regarding the perspectives of a broader group of health care professionals (including GPs, paediatricians, nurses, drug workers). Four of these five studies report both midwives' and healthcare professionals' experiences of working with substance using parents (Klee *et al.*, 2003; Finney *et al.*, 2008; Radcliffe, 2011; Whittaker *et al.*, 2016) and, additionally, one study included healthcare perspectives of pre-birth assessment or practice guidance in England (Lushey *et al.*, 2018).

Whilst these studies differ in focus, and sample sizes are small, there is consistent emphasis on relational approaches when working with birth mothers/parents and the development of appropriate knowledge and skills for working with families at risk of removals at birth (Klee *et al.*, 2002; Whittaker *et al.*, 2016). In particular, Whittaker *et al.* (2016) emphasise the need for skill and knowledge development to address parents' complex and long-standing issues, before a baby is born.

Given that four of the five studies focused on substance misuse in pregnancy, it is not surprising that the need for antenatal services to specifically engage with substance misusing parents is highlighted. For example, Radcliffe *et al.* (2011) noted that *specialist* midwives and drug workers had more understanding of the multiple demands faced by drug-using pregnant women when attempting to meet the demands of agencies, than generically trained workers.

3. System Level Challenges (n = 12)

Twelve of the studies included in the sample report important insights regarding system-level challenges derived from ethnographic observations of real time practice, case file review and routine administrative data. Many of the findings reported in this body of literature resonate with those drawn from interviews with parents and professionals and hence add weight to the messages reported in this review.

System level challenges can be grouped according to the following two categories: (i) lateness and delay in pre-birth assessment and decision-making; (ii) inadequate pre-birth assessment guidance, tools, training.

- i)* *Delays in pre-birth assessment and decision-making (n = 9)*

Delay in both commencing a pre-birth assessment and in subsequent decision-making was identified as an issue in nine of the studies. This was rarely attributed to one causal factor but rather a combination of factors. These included: a lack of clarity about the correct process or statutory requirements regarding unborn babies (Hodson, 2011; Lushey *et al.*, 2018) as well as difficulty in prioritising pre-birth cases in the context of high social work caseloads (Brown and Ward, 2014; Lushey *et al.*, 2018). Parents were also described as “difficult to engage” in the pre-birth assessment process (Hart, 2001; Lushey *et al.*, 2018; Broadhurst *et al.*, 2017). Ineffective communication between agencies within pre-birth processes was also identified as a causal factor in delay (Seneviratne *et al.*, 2003; Hodson, 2011).

In England, studies reported that in an attempt to manage stretched resources, social workers might delay the pre-birth assessment process until the risk of miscarriage has passed and the pregnancy is deemed ‘viable’ (Hart, 2001; Hodson, 2011; Brown and Ward 2014; Lushey *et al.*, 2018). A large-scale file study of recurrent care proceedings by Broadhurst *et al.* (2017) concluded that a large proportion of pre-birth child protection conferences⁵ happened late in pregnancy, with some taking place even after the baby was born (61.8% within eight weeks of birth or after birth). Consistent with this finding, Brown and Ward (2014), concluded that pre-birth assessments were completed on average only nine weeks before birth and not undertaken *at all* in 18.8% of cases. These observations were drawn from a longitudinal study of 57 infants, identified before their first birthdays as likely to suffer significant harm (2006 - 2015). Masson and Dickens (2015) also reported that pre-birth child protection conferences were typically held after 30 weeks’ gestation, which limited any opportunity for diverting cases from court. Similarly, Taplin *et al.* (2017) reported that most pre-natal reports to child protection services took place in the second (40.8%) or third trimester (52.6%) of pregnancy. Furthermore, nearly 20% of cases were not reported to child protection agencies until the third trimester, and very often within a few days of delivery. Overall, the literature indicates that practice is variable, but weighted towards the later stages of pregnancy (Hart, 2001; Seneviratne *et al.*, 2003; Broadhurst *et al.*, 2017; Lushey *et al.*, 2018; Taplin *et al.*, 2017).

Seneviratne *et al.*’s (2003) analysis of outcomes for 61 mothers and babies in a perinatal mental health unit points to the importance of early assessment. A lack of antenatal planning was associated with increased rates of separation of mother and infant before the assessment. The findings illustrate the need for improved co-ordination between

⁵ In England, the *Working Together to Safeguard Children* guidance stated that the purpose of an initial child protection conference is ‘to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child’ (Department for Education, 2018, p. 47). This guidance does not state when child protection conferences should take place for unborn children in England.

professionals in mental health and child protection agencies to ensure early planning for mothers and infants at risk. The importance of early inter-agency co-operation is also highlighted by Bull (2008) following her analysis of 29 referrals made by midwives to child protection services.

Assessing parental capacity for change, when children are not yet born, was consistently reported as challenging in the literature, and compounded by a short window for intervention, where pre-birth intervention is delayed (Hart, 2001; Hodson, 2011; Ward, *et al.*, 2012; Masson and Dickens, 2015; Taplin *et al.*, 2017; Lushey *et al.*, 2018). Broadhurst *et al.* (2017) highlighted this as a particular issue for mothers who had previously had a child removed from their care before. Case file analysis indicated that frequently assessments for infants born subsequent to the removal of an older sibling started later in pregnancy and resulted in much shorter reports which may contain information recycled from previous assessments. Two studies suggested that the short time-frames in pre-birth assessments can also lead to standard child protection processes being curtailed or not taking place at all, for example pre-proceedings meetings (Masson and Dickens, 2015), child protection conferences and strategy meetings (Hart, 2001).

The case for earlier intervention is further strengthened by Wall-Wieler's (2018) important population-level retrospective cohort study of 53,565 women in Manitoba, Canada. This study demonstrated that many of the characteristics identified as predictors of a mother having her baby removed from her care at birth, are modifiable or could be mitigated with appropriate services.

ii) Inadequate pre-birth assessment guidance, tools, training and resources (n = 5)

Inadequacy of pre-birth practice guidance for social workers in England was reported in four studies (Hart, 2001; Hodson, 2011; Ward *et al.*, 2012; Lushey *et al.*, 2018). An analysis of guidance provided by Local Safeguarding Children Boards in 147 localities in England in (2012/13) found that the level of detail regarding referral timescales and the assessment process varied greatly (Lushey *et al.*, 2018). Hodson (2011) and Lushey *et al.*, (2018) have both reported that although some Local Authorities have developed specific pre-birth protocols, in most local authorities, differentiated assessment or guidance specific to pre-birth assessment was not available.

Consistent with the literature drawing on midwives' perspectives, Bull (2008) noted that in most of the case files reviewed in which there had been a referral to the child protection agency, pregnant women self-reported personal difficulties to their midwives. The study concluded that midwives need advanced level child protection training in order to respond appropriately.

Several studies also draw attention to the lack of social work training and experience in conducting pre-birth assessments (Hart, 2001; Hodson, 2011; Ward *et al.*, 2012) and, in particular, the lack of consideration of parental behaviour on the developing foetus (Ward *et al.*, 2012; Lushey *et al.*, 2018).

5. Summary

1. Appraisal of the literature

This rapid evidence review sought to summarise and draw from the published literature consistent messages regarding intervention during pregnancy or following birth, where there are child protection concerns. It set out to answer three specific research questions as listed in the introduction to this review. 27 papers were included in the final review. Regarding the scope of the literature:

1. The literature on pre-birth assessment is limited, and there is a paucity of literature on infant removals at birth.
2. A number of studies of parent and professional perspectives are based on small samples.
3. Regarding system challenges, further research is needed based on representative or full-service population samples.
4. The limited research on birth parents' perspectives, is largely focused on experiences of birth mothers and, in particular, pregnant women with problems of substance misuse. There is a paucity of literature on the experience of fathers and extended family members.
5. Despite the key role that social workers perform in both pre-birth assessment and removals at birth, the literature which specifically documents the perspectives of social workers is very limited.

2. Key messages across the literature

Reading across the literature and *integrating* findings from research on the perspectives of birth parents, professionals and system level challenges, the following key messages can be drawn:

- a) Delay and insufficient time for robust pre-birth assessment

A delayed response in pregnancy from child protection agencies is consistently reported across the literature. This delay appears to be due to unborn babies being considered a lower priority than other children. Studies report that intervention too early in pregnancy can be viewed by agencies as potentially a poor use of resource, if the pregnancy does not continue, due to either miscarriage or termination.

Qualitative interviews provide clear insights into the consequences for all parties where help comes too late. The shortened window for assessment provides insufficient time for parents and professionals to make changes/support change in parenting capacity and promote the health and wellbeing of the unborn child. A delayed professional response to pregnancy also raises questions of fairness, quality of assessment and effective planning. Further studies that report a relationship between the timing of assessment and outcome are needed.

Although there is variation in practice across jurisdictions, the literature does suggest that workers may not always possess enough knowledge or access to guidance and tools, to support effective early assessment and intervention in pregnancy. This finding suggests that at present, opportunities to promote the well-being of the unborn child and to intervene effectively to divert cases from care proceedings may be overlooked. Further research to examine practitioner knowledge, confidence and competence in working preventatively in pregnancy with a focus on the unborn baby, parents and wider family is needed. Some of the literature included in this review is now dated and it is important to ascertain whether concerns reported in the research persist, but also to surface good practice examples.

b) Collaborative working and the value of relationship-based practice

The importance of effective relationships between professionals and birth parents, was a prominent theme within this literature. Both professionals and birth families valued practice predicated on trust, honesty and openness. Birth mothers were sensitive to feelings of being judged by practitioners and consistently, both health professionals and social workers placed significant emphasis on non-judgemental practice in building more positive relationships. Both midwives and birth parents emphasised the importance of continuity of worker-parent relationships, to foster the conditions for more positive, trusting relationships.

The importance of collaborative professional relationships was also stressed in the literature. Professionals from health and child protection agencies recognised the importance of both collaborative working and effective information sharing. However, the studies in this review suggest more work is required to achieve this more consistently, with issues of inequality of power, role conflict and lack of guidance at local and national levels being cited as key obstacles. It should be noted that issues such as lack of communication, poor co-operation, and tensions between agencies concerning status and perspectives identified in studies reflect well-known and entrenched difficulties in inter-agency working (see Davies and Ward, 2012).

c) The psychological impact of intervention in pregnancy and removals at birth

The qualitative studies in this review unequivocally demonstrate both the psychological impact that state intervention during pregnancy and following the birth of an infant, has on birth mothers – and therefore the unborn baby. The immediate intensity of loss in cases of

removal at birth is coupled with unresolved grief, guilt and shame. Where there is poor planning regarding the placement of the baby in out of home care, this compounds mothers' anxieties.

The literature also points to the emotional impact that this challenging work has on professionals, with studies noting the importance of support and supervision for all staff involved. The tension between balancing the safety of the unborn baby, or young infant, whilst also respecting the rights of birth parents, raises important ethical and practice issues for all professionals. This tension is felt most acutely by midwives given the centrality of woman-centred practice for this particular professional group.

d) Insufficient guidance and training for professionals

Across the literature the insufficiency of current levels of professional knowledge and guidance is highlighted. Whilst there is considerable variation within and between jurisdictions, findings suggest gaps in both professionals' substantive knowledge (relevant to assessment processes) and in the case of midwives, the mechanisms of child protection processes. Reading across the different bodies of literature, variation in national and local guidance pertaining to pre-birth assessment and intervention following birth, is noted as contributing to a lack of clarity.

3. Topics for further research

Although it has been possible to identify some key and important messages that cut across the published research, there remain some significant gaps in the extant literature. In this final section we point to some key topics warranting particular attention:

- a) *Birth fathers' experiences*: There was a complete dearth of research that solely focussed on birth fathers' experiences of the pre-birth assessment process and removal at birth. Relevant research is underway by a team led by Professor Marion Brandon (Bedston *et. al.*, 2019) focussing on fathers in recurrent care proceedings which is due to report next year. However, there remains a lack of knowledge of birth fathers' involvement in the pre-birth assessment process or their experiences of removal at birth.
- b) *Removal at birth: practice and experiences*: There is very little evidence of birth parents' and professionals' experiences specifically where an infant is separated from his or her parents at, or near, birth. Regarding birth parents, there are gaps in our understanding about what might constitute good practice and the longer-term impacts of state intervention at birth for all family members.
- c) *Collaborative working in the pre-birth assessment process*: Whilst the literature in this review emphasises the importance of good communication and positive working relationships between all agencies and birth families, studies consistently claim that our

understanding of good partnership working in this challenging area of practice remains insufficient.

d) *Social workers' experiences of pre-birth assessment and removal at birth.* Given the central role played by social workers in state intervention during pregnancy and at birth, it is surprising that there is a scarcity of literature regarding the experiences of this professional group.

6. Conclusion

Research with a focus on pre-birth assessment and infant removal at birth is limited, as an international trend. Given the gravity of professional decision making and the consequences for families and infants where the State intervenes at birth this evidence gap needs addressing. In particular, further collaborative research is needed to develop best practice principles regarding ‘removals at birth’. An inclusive approach to the development of best practice principles would serve to ensure the voice of families helps shape service intervention in the challenging circumstances of both pre-birth assessment and removal of infants at birth.

Although published evidence regarding pre-birth assessment is limited, consistent themes raised in the research do provide some immediate and important messages for policy and practice. The review indicates that frontline agencies need to ensure a consistent and earlier response to pregnancy to ensure that mothers and fathers and wider family members are given the support needed at a timely point, which may catalyse change. A review of existing local area protocols and multi-disciplinary dialogue and reflection on both pre-birth assessment and planning, would also deliver insights into opportunities and challenges at a local level.

Further mixed-methods research is clearly needed to ensure fair, consistent and effective practice, particularly in the context of high volumes of infant entry to care/care proceedings and marked local area variation (Wulczyn *et al.*, 2002; 2011; O’Donnell *et al.*, 2016; Broadhurst *et al.*, 2018; Alrouh *et al.*, 2019).

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8. Appendices

Appendix 1: Methodology

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)⁶ statement, which sets out an evidence-based minimum set of items for reporting in systematic reviews, has been used to structure this rapid evidence review process.

A review protocol was created by the authors at the outset of the review, outlining the key research questions, inclusion and exclusion criteria for the literature search, search strategy and search strings.⁷

An initial search of key words conducted in August 2018 to scope the available literature (see search 1 in appendix 1) found very few studies relating specifically to removal at birth and therefore the scope of the review was broadened to focus on pre-birth assessment and removal at birth (see appendix two for the final review protocol which was amended during the review process to include the revised research questions).

Inclusion and Exclusion Criteria

Table 1 lists the inclusion and exclusion criteria adopted in the search. A decision was taken to include literature emanating from jurisdictions with cognate child protection systems. These included Australia, Canada, the UK and the USA. Initially, the research team was also interested in learning from jurisdictions in Western Europe which take a different approach to child protection and family justice. However, after screening the search results, only one Western European paper (Poinso et al., 2002) met the inclusion criteria and so a decision was taken to limit the review to countries with cognate systems. Given the focus on the perinatal period, studies were only included if they focused on infants under one year of age⁸. In order to ensure the review was relevant to current practice, papers were also only included if they were published between January 1990 and August 2018.

⁶ See the adapted tool for reporting systematic reviews of qualitative and quantitative evidence: http://toolkit4mixedstudiesreviews.pbworks.com/w/file/fetch/107458323/Reporting_template_MSR.pdf

⁷ See appendix 1

⁸ Neil (2010) included experience of birth families who had had children of all ages removed from their care and placed for adoption. However as 60% of sample had had children removed as infants a decision was made to include this study. Similarly Broadhurst *et al.*, (2017) study also had a broader focus but included findings particularly focussed on women's experiences of removal at birth. Furthermore, 70% of recurrent care proceedings included an infant less than 1 year old.

There is a larger body of literature on perinatal loss and voluntary relinquishment. Whilst the team noted the synergy between this body of work and the focus of the review given time and resource constraints, a decision was made to exclude this work for this particular scoping review.⁹ Following the initial stage of screening, a decision was also made to exclude evaluation studies or trials of interventions.

Table 1: Inclusion and Exclusion Criteria

Inclusion criteria:
(i) Written in English
(ii) Study conducted in UK, US, Canada, New Zealand, Australia
(iii) Published between 1990 and 2018
(iv) Removal at birth and/or pre-birth assessment focus
(v) Study relates to infants under one year old
Exclusion criteria:
(i) Voluntary relinquishment or perinatal loss literature
(ii) Evaluation studies and trials of interventions

Information sources

A comprehensive search of electronic, academic databases was conducted in August 2018 including: Cochrane Library¹⁰; Scopus; SocIndex; Child Development and Adolescent Studies; Web of Science Core Collection; Proquest Social Science Premium Collection; EBSCO Psych Info and Psych Articles; and Social Care Online. Google Scholar was also

⁹ The authors note the important contribution the perinatal loss and voluntary relinquishment literature offer to our understandings of the experiences of families. A further literature review of this work will form part of the next stage of this special interest project.

¹⁰ We used the Cochrane Library to search for previous reviews only.

searched; however, given time and resource constraints, we limited the papers screened to the first one hundred papers ordered by relevance for each search. A search of grey literature was not included as part of this rapid review due to time limitations.¹¹

Search strategy

An initial search was conducted in August 2018 (using search string 1, Appendix 1); however, this led to the identification of very few papers specifically on infant removal at birth. In keeping with an iterative search process (Brunton *et al.*, 2017) a decision was taken to broaden the scope of the review to include the pre-birth assessment literature, as much of the literature covered both processes. Additionally, we conducted two extra searches in October 2018 to ensure we had not missed any papers that focused on (i) social workers (search string 7, Appendix 1) or (ii) used other terminology connected to removal at birth used in other jurisdictions for example “out-of-home placement” and “out-of-home care” (search string 8, Appendix 1). During this iterative process, where possible search strings were searched in the fields; *titles, topics, abstracts or key words only*.¹² The searches included all sources including empirical studies as well as practice or legal commentaries, conference papers and systematic and literature reviews. This was done in order to identify practice context literature as well as to widen the scope of the searches for the purposes of snowballing¹³. However, during screening, only papers that included empirical research published in peer reviewed journal articles or books and PhD theses were included in the review (see Figure 1 below). Where relevant systematic reviews were identified, their reference lists were used to source primary studies. The initial searches in August 2018 identified 2933 records, which after a duplicate check using Mendeley referencing software was reduced to 2397. The supplementary searches in October 2018 led to the identification of a further 284 papers and 142 papers after a duplicate check with the records found in search 1 to 6.

¹¹ A review of grey literature will form part of the next stage of this special interest project

¹² Where the database included year, language and country of origin options, the searches were narrowed to fit our inclusion criteria (see table 1). This means that the number of search results may have been higher for databases where we were not able to refine the search by country and to English papers only (Cochrane Library, SocIndex, Child Development and Adolescent Studies, Social Care Online and Google Scholar).

¹³ Snowballing refers to the process of hand searching bibliographies of studies included in the review to search for other studies that may fit the criteria but had not appeared in the original searches.

Selection

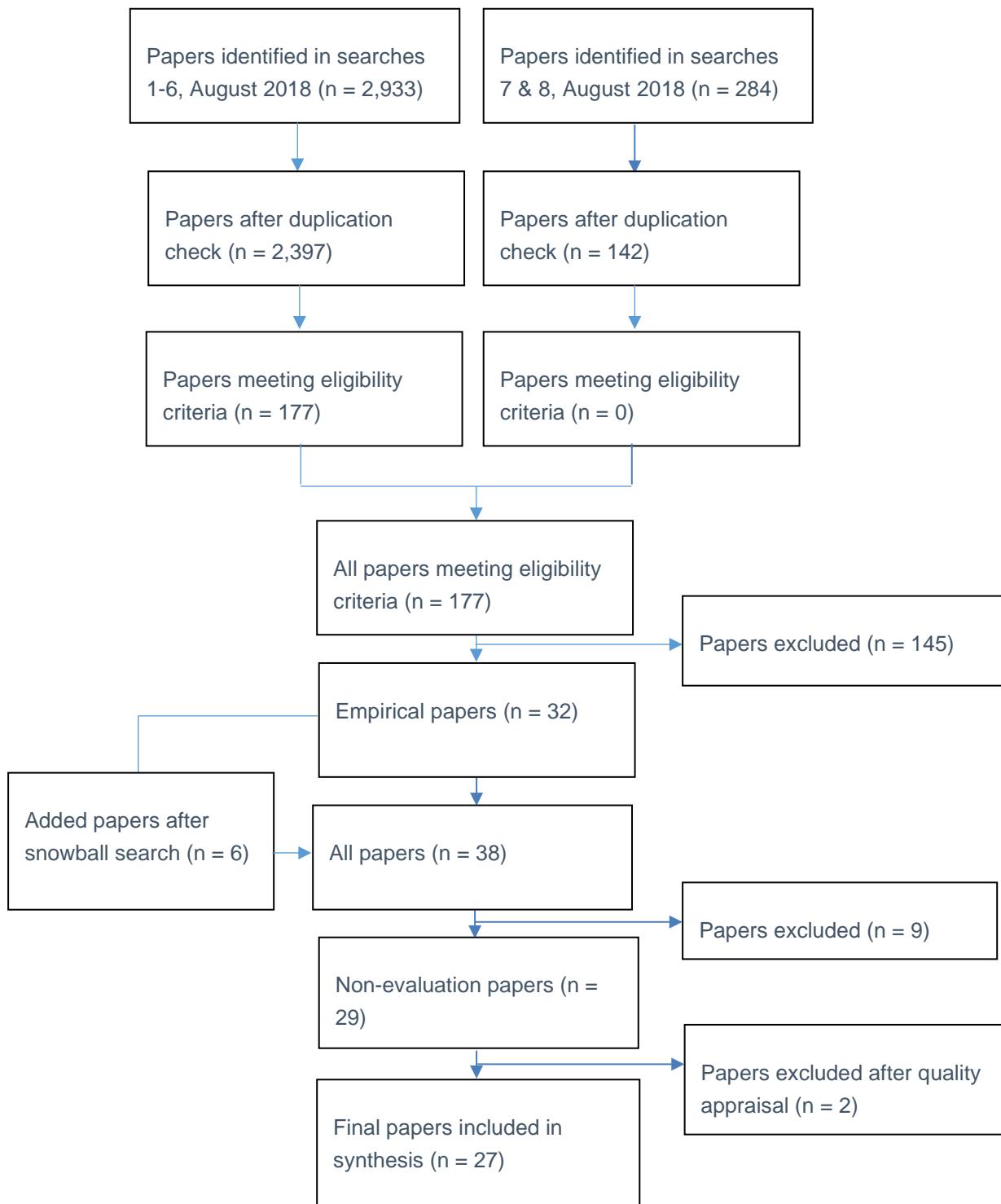
As recommended by PRISMA, Figure 1 provides a flow diagram of the screening process. Source titles were initially reviewed against the inclusion/exclusion criteria for relevance. After reviewing the titles against these criteria, 178 relevant records were identified including empirical studies, practice and legal commentaries and systematic and literature reviews. The majority of articles were excluded as their primary focus was medical issues or child development. There were several examples of studies with multiple publications and in this case only one of the papers was included in the review.¹⁴

A second screening of titles and abstracts was undertaken by the research team with the aim of refining the scope of the literature further to include empirical studies only. At this stage, a decision was taken to exclude perinatal mental health and drugs related studies where they did not specifically relate to removal at birth or pre-birth assessment. Reference lists were also checked in order to identify any potential key sources omitted in the database search. This led to the identification of a further three studies that met the criteria.

Following further team discussion, a decision was taken that studies that reported on the outcomes of specific interventions should also be excluded. A third round of screening therefore excluded any studies which encompassed evaluations of specific services or trials of interventions. Studies that involved a specialist setting to recruit participants (i.e. a mother baby unit) were included as examples of broader practice. Limitations of the generalisability of these studies are noted in [Appendix 3](#).

¹⁴ There are two exceptions to this – Everitt et al.'s (2015, 2017) and Ward *et al* 2012 and Brown and Ward 2014. In each case two papers emanating from the same study are included due to the difference in data included.

Figure 1: Flowchart



Critical Appraisal

Critical Appraisal Skills Programme (CASP) quality assessment checklists¹⁵ and the Mixed Methods Appraisal Tool (MMAT)¹⁶ were utilised to appraise individual empirical studies. CASP provides appraisal tools for qualitative and quantitative studies and systematic reviews but does not currently provide an appraisal tool for mixed methods research designs. Therefore, a similar appraisal tool, MMAT (2018 version), specifically designed as a checklist for appraising mixed method studies, was utilised. The CASP and MMAT were utilised to appraise the methodological quality and relevance of individual studies. Unlike other appraisal tools for assessing the quality of quantitative studies, such as the EPPI-Centre and the Maryland Scale, CASP and MMAT do not use a weighted, scoring system, but are adaptable for a range of research designs.

The quality of the individual studies was independently assessed by one researcher and a sub sample of six studies reviewed by a second member of the team in order to confirm or dispute inclusion or exclusion. Where there was any discrepancy a fuller discussion took place before a conclusion was reached.

Following the appraisal process two studies were excluded based on quality. Quality concerns included a lack of detailed description and explanation of research design and procedure as well as insufficient data to address the research questions.

Assessment of evidence

Appendix 3 provides a summary of the methodological limitations of each of the studies. As anticipated, the majority of the studies included were qualitative in nature ($n = 13$). Many of the qualitative studies met a number but not all of the CASP quality criteria which limits the generalisability of findings. For example, the use of small samples (e.g. 6 of the 13 qualitative studies included samples of fewer than ten participants) in many of the studies reviewed, the use of convenience or purposive sampling strategies within all of the studies

¹⁵ The CASP criteria comprises a checklist of thirteen questions covering design, sampling strategy, data collection and analysis. There are separate checklists for qualitative studies, case control studies and systematic reviews. CASP checklists have been used in the health and social sciences fields for systematic reviews involving qualitative studies. See: <https://casp-uk.net/>

¹⁶ The MMAT was first developed by a group of academic in 2006. The latest 2018 version was developed on the basis of findings from a literature review of critical appraisal tools, interviews with MMAT users, and an eDelphi study with international experts. See:
http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

and the use of interviews/focus groups as a single source of data weakens the evidence base.

Of the quantitative ($n = 5$) and mixed methods ($n = 9$) studies, statistical analysis was largely descriptive, and the samples small (six studies included samples with fewer than 75 participants). Six studies also included case studies of a specific services or area limiting the generalisability of findings.

Analysis

A thematic analysis of all the selected studies was subsequently undertaken using NVivo11¹⁷ for data storage and to support coding. Initial coding of a small sub-set of papers was conducted separately by two members of the research team to establish a primary set of codes and sub-codes, before the remainder of the papers were coded. The research team then discussed the initial set of codes and revised and condensed these to create a final set of meta-categories (i) birth mothers' experiences; (ii) birth fathers' and relatives' experiences; (iii) midwives and healthcare professionals; and (iv) system challenges. The final stage of thematic analysis was undertaken by two researchers coding the data simultaneously.

Results

A total of 27 empirical studies were included in the final sample. The empirical studies were primarily conducted in England ($n = 15$) and Australia ($n = 8$) but also included Canada ($n = 1$), Northern Ireland ($n = 1$) and Scotland ($n = 2$). The majority of the papers were qualitative ($n = 12$), nine were mixed methods studies and only six were quantitative studies. The studies had varied, and often multiple foci: birth mothers ($n = 13$), birth parents (including birth mothers and fathers in the sample) ($n = 4$), midwives ($n = 12$), health care professionals ($n = 6$), social workers ($n = 6$), legal professionals ($n = 2$), birth relatives ($n = 1$) and carers ($n = 2$). The majority of the papers focussed specifically on the perinatal period (as specified in the inclusion criteria), however four studies where the focus was broader but part of the findings related specifically to focus on pre-birth assessment or infant removal were also included. (Brown and Ward, 2014; Whittaker et al., 2016; Broadhurst et al., 2017, Neil et al 2010). Seven papers included in this review focussed specifically on parents who misused substances and opioid users specifically were the focus of three of these. Two studies focussed specifically on the experiences of women in prison (Chambers, 2009; Wismont, 2000)

¹⁷ a computer assisted qualitative data analysis software package

Rapid Evidence Review Protocol for Infant Study August 2018

Research questions

- 1) What are birth parents' experiences of pre-birth assessment and removal of an infant at birth?**
- 2) What are professionals' experiences of pre-birth assessment and removal of an infant at birth?**
- 3) What can be learned about system-level challenges from descriptive studies of practice?**

Inclusion (sample, methods, outcomes, comparison groups)

Inclusion criteria:

Written in English

Study conducted in UK, US, Canada, New Zealand, Australian or Western Europe

Published between 1990 and 2018

Removal at birth and/or pre-birth assessment focus

Study relates to infants under one year old

Exclusion criteria:

Voluntary relinquishment or perinatal loss literature

Evaluation studies and trials of interventions

Definitions

Removal at birth: state intervention at or near birth resulting in parent infant separation.

Pre-birth assessment: Multi-agency assessment of the level of danger/risk to an unborn child.

Professionals: include medical professionals (midwives, paediatricians) and social care (social workers, family support workers, foster carers)

Search strategy (databases, websites, journals, personal contacts)

Academic databases including Cochrane Library¹⁸; Scopus; SocIndex; Child Development and Adolescent Studies; Web of Science Core Collection; Proquest Social Science Premium Collection; EBSCO Psych Info and Psych Articles; and Social Care Online as well as Google Scholar.

Search strings (synonyms, combinations, wildcards, brackets)

infant* or baby or babies or postnatal or perinatal AND "infant removal*" OR "removal at birth"

infant* OR baby OR babies OR postnatal OR perinatal AND "infant removal*" OR "removal at birth" AND "birth parent*" or "biological parent*" or mother or father

infant* OR baby OR babies OR postnatal OR perinatal AND "infant removal*" OR "removal at birth" AND "foster care*" OR adoption OR "care proceeding*" OR "foster family" OR "foster parent" OR "family foster home" OR "kinship care" OR "child* in care" OR "out-of-home care" OR "looked-after"

infant* OR baby OR babies OR postnatal OR perinatal AND "infant removal*" OR "removal at birth" OR "foster care*" OR adoption OR "care proceeding*" OR "foster family" OR "foster parent" OR "family foster home" OR "kinship care" OR "child* in care" OR "out-of-home care" OR "looked-after" AND "professional experience"

infant* OR baby OR babies OR postnatal OR perinatal AND

¹⁸ We used the Cochrane Library to search for previous reviews only.

"residential assessment*" OR "mother baby unit*" OR "pre-birth assessment"

"child protection" or safeguarding or "child welfare" AND midwives or midwife or midwifery

infant* OR baby OR babies OR postnatal OR perinatal AND "infant removal*" OR "removal at birth" OR "foster care*" OR "adoption" OR "care proceeding*" OR "foster family" OR "foster parent*" OR "family foster home" OR "kinship care" OR "child* in care" OR "out-of-home care" OR "looked-after" AND "social work" or "social worker"

infant* OR baby OR babies OR postnatal OR perinatal AND "out-of-home care" OR "out-of-home placement" OR "substitute care" AND "birth parent*" OR "biological parent*" OR "mother" OR "father" OR "professional experience"

Appendix 2: Review Timeline

Date	Task
August 2018	Initial search (search string 1) conducted
	Literature search of databases (using search strings 1-6 in Appendix 1)
September 2018	Screening of titles by first researcher
	Screening of title and abstracts by both researchers – excluded evaluations or trials of interventions and broader literature on prenatal mental health and drugs
October – November 2018	Two additional database searches conducted (using search strings 7 & 8 in Appendix 1)
	Quality appraisal of individual studies
January– March 2018	Analysis of articles using NVivo

Appendix 3: Description of studies

Author, (Year), Country	Focus	Research objectives	Methodology	Sample	Limitations
Broadhurst, K.; Mason, C.; Bedston, S.; Alrouh, B.; Morriss, L.; McQuarrie, T.; Palmer, M.; Shaw, M.; Harwin, J.; Kershaw, S. (2017), England	Birth mothers and Professionals	<ul style="list-style-type: none"> (i) Provide the first national (England) picture of the scale and pattern of recurrent care proceedings, (ii) Identify and explain the factors or processes associated with a woman returning to court and the implications for her children, (iii) Identify opportunities where policy and practice might make a difference. 	<p>Mixed methods - Descriptive statistics and survival analysis of administrative data.</p> <p>Semi-structured interviews with birth mothers and case file review.</p>	<ul style="list-style-type: none"> (i) Statistical descriptive analysis of administrative records concerning approximately 65,000 birth mothers (ii) 72 semi-structured interviews with birth mothers (iii) Case file review of court records relating to 354 recurrent mothers. 	Key limitations in relation to court case files included incomplete court files and variation in the depth and detail of information included.
Brown, R.; Ward, H. (2014), England	Birth parents, Carers and Professionals	(i) How far is there a mismatch between timeframes for early childhood development and those built for responses to evidence of abuse and neglect from professionals with safeguarding responsibilities?	Mixed methods – longitudinal - descriptive analysis of quantitative data from children's social care case files collected annually; case specific interviews held at regular intervals with birth parents,	(i) Case files relating to 57 babies from ten local authorities (43 followed 3-years-old and 37 until their fifth birthdays)	Low recruitment to study resulting in limited sample of infants. Attrition during the study leading to smaller sample at age 5 years. Study sample is therefore skewed towards infants who are at a higher risk of

		<p>(ii) If a mismatch exists, why has it occurred?</p> <p>(iii) How might the issues identified be addressed?</p>	<p>carers, child protection agency workers and team leaders and, where appropriate, with children's guardians and non-case-specific interviews held with senior managers, judges, magistrates and local authority solicitors, and focus groups with health visitors.</p> <p>(see <i>Infants Suffering, or likely to Suffer, Significant Harm</i>, Ward et al., 2012).</p>	<p>(ii) See Ward et al. (2012) for summary of interviews.</p>	<p>experiencing abuse and neglect than the eligible population.</p>
Bull, L. (2008), England	Birth mothers and Midwives	To explore the characteristics and cause(s) of concern that led midwives to refer patients to a child protection advisory service for further assessment over a 10 month period.	Quantitative – descriptive study adopting case series method	Case referrals of 29 pregnant women referred to a child protection advisory service by midwives based at one Primary Care Trust.	Small sample limited study to descriptive analyses only. Case referrals examined from one antenatal clinic in London.
Chambers, A. N. (2009), USA	Birth mothers	To examine the experience of women in prison who know they will be separated from their babies	Qualitative semi structured interviews	12 post-delivery women in prison in Texas USA	Small sample limited to one prison in Texas USA

<p>Chandler, A.; Whittaker, A.; Cunningham-Burley, S.; Williams, N.; McGorm, K.; and Mathews, G. (2013), Scotland</p>	<p>Birth parents</p>	<p>To examine the ways in which drug-dependent parents accounted for their experiences of both parenting and parenting support, with a focus on the antenatal and postnatal periods.</p>	<p>Qualitative – longitudinal – semi-structured interviews with birth parents, opioid dependent service users at 32 weeks' gestation during pregnancy and twice in the baby's first year.</p>	<p>45 semi-structured interviews with 19 opioid dependent service users (14 female, 5 male).</p>	<p>Purposive sampling of service users through NHS services in south east Scotland. Accounts of parents reflect local policies and practice regarding OST. Limited male sample size limits comparative analysis.</p>
<p>Cross-Sudworth, F.; Williams, M.; Gardosi, J. (2015), England</p>	<p>Midwives</p>	<p>To investigate how well community midwives considered themselves able to deal with social issues and care.</p>	<p>Mixed methods – questionnaires with community midwives working in partnership trusts in the West Midlands between 2008 – 2009.</p>	<p>Questionnaire responses from 213 midwives sent to all community midwives working in partnership trusts in West Midlands). (Response rate 77%)</p>	<p>The findings represent views from the West Midlands, which may not be generalisable to the rest of the UK. The study was also conducted between 2008 and 2009, which may not reflect current workload, attitudes and care.</p>
<p>Everitt, L.; Fenwick, J.; Homer, C. S. E. (2015), Australia</p>	<p>Midwives</p>	<p>To explore the experiences of midwives who had been involved in the assumption of care of a baby soon after birth or in the early postnatal period.</p>	<p>Qualitative – in-depth interviews with midwives who had been involved in assumption of care within the past three years.</p>	<p>Ten midwives</p>	<p>Small purposive sample of participants predominantly from metropolitan areas, New South Wales, Australia.</p>

Everitt, L.; Homer, C.; Fenwick, J. (2017), Australia	See above	See above	See above	See above	See above
Finney Lamb, C. E.; Boers, M.; Owens, A.; Copeland, J.; Sultana, T. (2008), Australia	Birth mothers and Professionals	To explore the experiences and attitudes of opioid-dependent women in making health care complaints during pregnancy and early motherhood and the experiences and attitudes of staff in receiving and responding to these complaints at the Opioid Treatment Service.	Qualitative – semi-structured interviews with opioid-dependent women and staff at an Opioid Treatment Service.	13 pregnant women and ten staff	Research conducted in New South Wales, Australia and in one opioid service. This research describes the opinions of women who were more stable and less likely to be using illicit drugs.
Hart, D. (2001), England	Child protection agency workers	To describe and analyse the process of pre-birth assessment on a number of levels.	Mixed methods – retrospective study of social work case files.	Case files relating to 31 babies.	Study conducted between 1996 and 1998. Analysis of records was undertaken solely by the researcher who had been involved in a decision-making capacity regarding some of the case files she was analysing.

Harvey, S.; Schmied, V.; Nicholls, D.; Dahlen, H. (2015), Australia	Birth mothers	To examine how mothers accessing opioid treatment programmes in the perinatal period make meaning of their interactions with universal and targeted health services.	Qualitative – face-to face interviews, on two separate occasions, with pregnant women recruited through five methadone clinics in a metropolitan local health district in Sydney, Australia.	Six pregnant women (12 interviews)	Very small, self-selected sample from one metropolitan health district in Sydney. Interviews conducted by a child and family health clinical nurse consultant employed by the Local Health District in which the research took place.
Hodson, A. (2011), England	Child protection agency workers	To explore what is currently known about pre-birth assessment within the context of Local Authority social work practice.	Mixed methods – documentary analysis of national documents and LSCB procedures and case study of one local authority comprising an audit of pre-birth referrals, analysis of case files and interviews with child protection agency workers.	(i) Six-month audit of 56 pre-birth referrals (ii) Documentary analysis of 7 case files and interviews with child protection agency workers who wrote files.	Case study of one local authority. Findings may not be generalisable to other local authorities out with this setting.
Klee et al., , H. 'Antenatal care: expectations and experiences'	Birth mothers and professionals		Mixed methods – longitudinal – semi-structured interviews with women from pregnancy to	(i) Interviews with birth mothers: interview 1 (n = 54), interview 2 (n = 51),	Attrition rate of women meant that analyses of key themes over time used data from the first three

Jackson, M. and Klee et al., , H. 'Practitioner views of pregnant drug users' In <i>Drug Misuse and Motherhood</i> (2003), England			18-months post-birth (including descriptive analyses of sample) and interviews and focus groups with healthcare professionals and child protection agency workers.	interview 3 (n = 50) and interview 4 (n = 32). (ii) Interviews and focus groups with 49 health care and child protection agency workers (34 maternity staff and 15 drug workers and child protection agency workers).	interviews only. Small sample size limited quantitative analysis.
Lazenbatt, A. (2010), Northern Ireland	Midwives	To compare and contrast: (i) how midwives working in either hospital or community settings are currently responding to the co-occurrence of domestic and child abuse; their perceived role and willingness to identify abuse; (ii) record keeping; (iii) reporting of suspected or definite cases of child abuse; (iv) training received.	Quantitative – survey questionnaire – descriptive analysis, cross-tabulation and exploratory factor analysis.	488 midwives completed questionnaire (57% response rate).	Non-random, purposive sample of midwives in Northern Ireland. Findings may not be generalisable to similar groups of participants outside this setting. Overall response rate was 57% limiting the ability to extrapolate the results of this study to those who did not respond.

Lushey, C. J.; Barlow, J.; Rayns, G.; Ward, H. (2018), England	Professionals	To explore pre-birth assessment guidance and practice in England.	Mixed methods – documentary analysis of Local Safeguarding Children Board (LSCB) guidance, semi-structured interviews with practitioners from nine localities and online survey to all LCSBs in UK.	(i) Documentary analysis of the guidance issued by all 147 LCSBs (ii) Interviews with 22 practitioners (2 midwives, 9 child protection agency workers, 2 psychiatrists, 5 healthcare professionals and 4 family support workers (interviewed collectively). (iii) Online survey to all LCSBs in UK (less than 20% response rate).	Low response rate to online survey (less than 20%) limiting scope for quantitative analysis. Results of survey not reported in article. Small sub-samples of professional groups interviewed.
Marsh, C. A.; Browne, J.; Taylor, J.; Davis, D. (2018), Australia	Birth mothers and Professionals	This research studied childbearing women's and professionals' experiences of Assumption of Care at birth to increase understanding of individual participants' stories, how they made sense of meanings and how these experiences framed their lives.	Qualitative – narrative inquiry interviews with pregnant women, midwives, child protection agency workers and case managers.	20 participants (3 women, 7 midwives, 5 child protection agency workers and 5 case managers).	Small sub-samples of participant groups interviewed. Study conducted in New South Wales, Australia. Findings may not be generalisable to other settings.

Marsh, W. (2016), England	Birth mothers and Midwives	To explore mothers' experiences of having their babies compulsorily removed at birth and to explore any interventions or elements of their midwifery care that may, or may not, have been helpful to them during their experience. It also aimed to explore midwives' experiences of providing midwifery care to these women at this time and to identify any areas that may require further training or education.	Qualitative - narrative inquiry interviews with birth mothers interviewed four times each and focus groups with midwives incorporating oral and photo-elicitation techniques.	Four birth mothers Six focus groups with a total of 8 midwives	Small sample size of mothers and midwives.
Morris, M.; Seibold, C.; Webber, R. (2012), Australia	Birth mothers	To explore the extent to which a specialist clinic meets the needs of chemically dependent women.	Qualitative – critical ethnography – interviews with chemically dependent pregnant women (two interviews preceding the birth and one post-birth) and observations of the interactions between the women and clinic staff over a 25-month period as well as chart audits.	20 chemically dependent women	Purposive sample of 20 clinically dependent women who attended one specialist antenatal clinic at a metropolitan hospital in Melbourne, Australia. Findings may not be generalisable to other settings. Study is focused on chemically dependent pregnant women but was

					included to focus women's antenatal experiences.
Masson, J. and Dickens, J. (2015), England	Birth parents and Professionals	To describe the 'pre-proceedings process' and the findings of recent research on its use and effect, focusing on planning before birth.	Mixed methods – quantitative analysis of pre-proceedings and/or care proceedings cases; observations of pre-proceedings meetings; interviews with parents, parents' lawyers and local authority child protection agency workers, managers and lawyers; and a focus group with judges. Study conducted in six local authorities. See Edge of Care study (Masson et al., 2013).	(i) Quantitative analysis of a random sample of 207 cases (ii) Observations of pre-proceedings meetings for 33 cases (iii) Interviews with 24 parents, 19 parents' lawyers and 51 local authority child protection agency workers, social work managers and lawyers (iv) One focus group with judges	
Neil, E.; Cossar, J.; Lorgelly, P; Young, J. (2010), England	Birth parents and relatives	To understand birth relatives' subjective experiences and to measure service use and outcomes looking at relationships between these.	Mixed methods – longitudinal - survey of referral and take up information from eight participating agencies;	(i) Survey related to 495 birth relatives (ii) Interviews with 73 birth relatives (44 birth mothers,	

			interviews and a mental health questionnaire measure with birth relatives at two points in time and economic analysis comprising collection of data from birth relative support workers and the collection of data about service use over a 12-month period.	19 birth fathers and 10 birth grandparents).	
Phillips, D.; Thomas, K.; Cox, H.; Ricciardelli, L. A.; Ogle, J.; Love, V.; Steele, A. (2007), Australia	Birth mothers and Midwives	To examine the factors that motivate or act as barriers to disclosure of substance use by pregnant women.	Qualitative – semi-structured interviews with midwives and pregnant women.	10 midwives and 10 pregnant women.	Participants recruited from two antenatal clinics at an Australian maternity hospital in Melbourne. Findings may not be generalisable to other settings. Five of the women interviewed were recruited from the Young Women's Clinic and did not report using drugs.

Radcliffe, P. (2011), England	Birth mothers and Healthcare professionals	Examines the reproduction of stigma in maternity services by exploring the workplace discourse of antenatal staff in three hospital trusts.	Qualitative – semi-structured interviews and group interviews with antenatal staff (community midwives, specialist midwives, postnatal ward staff and sonographers) and semi-structured interviews pregnant women or women who had given birth in previous two years. Also included non-participant observations of clinical settings and staff meetings. Study conducted across three hospital trusts.	22 antenatal staff 24 women	Impact of non-participative observation of clinical settings and staff meetings not made explicit.
Seneviratne, G; Conroy, S; Marks, M. (2003), England	Birth mothers and Professionals	To describe the referral pathways and outcomes at discharge and subsequently of a sample of mothers referred for parenting assessments in the Mother and Baby unit.	Quantitative – longitudinal study - descriptive analysis of parenting assessment cases admitted to a mother and baby unit between 1993 and 1998.	61 parenting assessment cases	Given limited sample size it was not possible to examine the contributions of any environmental and social factors influencing outcome on whether mother continues to care for child. Other shortcomings of this study are that the

					information is derived from a single assessment service which attracts the most severe cases; and the differing length of time between discharge and the date when follow-up information was obtained.
Taplin, S. (2017), Australia	Birth mothers	To explore the characteristics of and the timing, reasons and outcomes of prenatal reports.	Quantitative – descriptive and between group analysis of administrative data examining the characteristics of two samples of pregnant women who had had a prenatal report made.	(i) data from case files of 38 cases reported in 2012–13 (ii) administrative data from 117 cases reported prenatally in 2013	Limitations with administrative data include lack of detail on what and how prenatal services were provided. Absence of a comparison group limits conclusions which can be made regarding the impacts of prenatal reporting.
Ward, H., Brown, R. And Westlake, D. (2012), England	Birth parents, Carers and Professionals	(i) How far is there a mismatch between timeframes for early childhood development and those built for responses to evidence of abuse and	Mixed methods – longitudinal - descriptive analysis of quantitative data from children's social care case files collected	(i) Case files relating to 57 babies from ten local authorities (43 followed 3-	Low recruitment to study resulting in limited sample of infants. Attrition during the study leading to smaller sample at age 5 years.

		<p>neglect from professionals with safeguarding responsibilities?</p> <p>(ii) If a mismatch exists, why has it occurred?</p> <p>(iii) How might the issues identified be addressed?</p>	<p>annually; case specific interviews held at regular intervals with birth parents, carers, child protection agency workers and team leaders and, where appropriate, with children's guardians and non-case-specific interviews held with senior managers, judges, magistrates and local authority solicitors, and focus groups with health visitors.</p> <p>(see <i>Infants Suffering, or likely to Suffer, Significant Harm</i>, Ward et al., 2012).</p>	<p>years-old and 37 until their fifth birthdays)</p> <p>(ii) See Ward et al. (2012) for summary of interviews.</p>	<p>Study sample is therefore skewed towards infants who are at a higher risk of experiencing abuse and neglect than the eligible population.</p>
Wall-Wieler, E.; Roos, L. L.; Brownell, M.; Nickel, N. C.; Chateau, D. (2018), Canada	Birth mothers	To determine which maternal events and diagnoses in the two years before childbirth are associated with higher risk for having a first child taken into care at birth by child protection services.	Quantitative – cohort study of women whose first child was born in Manitoba, Canada between 2002 and 2012 using linkable administrative data.	483 women	Analyses are limited to Manitoba, which has one of the highest rates of taking children into care in the world (Gilbert et al., 2012); findings need to be

					replicated elsewhere to determine external validity.
Whittaker, A.; Williams, N.; Chandler, A.; Cunningham-Burley, S.; McGorm, K.; Mathews, G. (2016), Scotland	Healthcare professionals	To explore the views and experiences of healthcare professionals in relation to providing parenting support for drug-using parents, predominantly those receiving opioid substitution therapy.	Qualitative – focus groups with healthcare professionals	Four focus groups with 18 healthcare professionals (3 GPs, 4 Community Midwives, 3 Public Health Nurses (Health Visitors), 1 Specialist Health Visitor (Substance Misuse), 1 Child Protection Advisor (Health Visitor trained), 5 Community Addiction Nurses (Mental Health Nurse trained) and 1 Consultant Psychiatrist in Addictions).	Purposive sampling in one Health Board area in Scotland which has areas of significant socio-economic deprivation that have a high prevalence of problem drug use. Specific narrow focus on healthcare professionals' views and experiences of working with drug using parents, predominantly those using opioid substitution therapy.
Wismont J.M. (2000), USA	Birth mothers	To understand the experience of child-bearing women in prison	Qualitative- journal entries and interviews	12 women in one prison in mid-west state in USA	Small purposive sample

Wood, G. (2008), England	Midwives	To explore the experiences of midwives in child protection and protecting vulnerable families.	Qualitative – semi-structured interviews	9 midwives	Small, purposive sample in one geographical location
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