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Giving HOPE and minimising trauma: An intervention to support women who are separated from their babies at birth due to safeguarding concerns

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Abstract

Whatever the circumstances, the separation of infants from their mothers at birth is a traumatic experience for all concerned. The paper reports on a study designed to improve practice in this highly sensitive area. An analysis of data collected through semi-structured interviews with 38 mothers who had experienced removal at birth identified four common themes: isolation and unacknowledged support needs; shame, stigma and the failure of others to acknowledge their maternal identity; acute trauma, immediate downturn and disenfranchised grief following infant removal; and strategies to mitigate their pain and grief. These last themes included the use of artefacts both as transitional objects to help mothers come to terms with the permanent loss of a baby, and as a means of keeping maternal identity alive and connecting with an infant who might eventually return home. In response to these findings, and in collaboration with a group of women with lived experience, HOPE boxes were designed to ameliorate the trauma and psychological burden borne by women in this situation. The contents of the boxes have been chosen to reflect the changing experiences of the women's journeys but also the range of possible potential outcomes. The intervention has considerable potential to minimise the trauma of this painful experience.

KEYWORDS
artefacts as transitional objects, birth mothers of adopted children, child protection, disenfranchised grief, infant removal at birth

Key Practitioner Messages

- Almost all mothers whose infants are removed at birth for safeguarding reasons experience acute trauma, shame and overwhelming grief.
- They require sensitive, non-judgemental care, attuned to their support needs, that acknowledges their maternal identity and the enormity of their loss.
- HOPE boxes may both enable mothers to retain a connection and preserve their maternal identity while an infant has been temporarily removed and help mitigate their grief following a permanent removal.

INTRODUCTION

Whatever the underlying reasons, the separation of an infant from his or her birth mother in the first year of life can be a source of enduring grief and have long-term repercussions for all parties involved: the parents, the child and in many

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cases the professionals tasked with overseeing the removal (Geddes, 2021; Mason et al., 2022a; Neil, 2013). There is, however, increasing evidence that, in both low-, medium- and high-income countries, high numbers of infants are, for complex of social and economic reasons, relinquished, voluntarily placed away from home or compulsorily removed from their families in response to child protection concerns (Wulczyn et al., in press), and that this is an issue of considerable concern in the United States (Wulczyn et al., 2013), the United Kingdom (Mason et al., 2022a), Scandinavia (Hestbæk et al., 2020), Australia (O'Donnell et al., 2019) and parts of Africa (Rosenberg, 2020). It also seems likely that these concerns are even more widespread (Backhaus et al., 2019).

In countries with extensive child protection systems, the majority of parent/infant separations are compulsory in response to concerns regarding maltreatment and neglect (Browne et al., 2005). In England, the authors of this study (2018) found that over the 10 years between 2007–2008 and 2016–2017, 27 per cent of all children who entered care proceedings were infants under the age of one. Within this age band, the number of newborns (infants aged under one week old) in care proceedings had more than doubled, from 1093 to 2447, the percentage had increased, from 32 per cent of all infant cases in 2007–2008 to 42 per cent in 2016–2017 and there were large regional variations.

The removal of newborn infants from birth parents is an extremely contentious issue, raising questions about ethics, social justice and the ideology behind child welfare policy. On the one hand, disparities between regions and high numbers of newborns in proceedings may indicate a disregard for parents' rights and raises concerns regarding fairness and equality. Those parents most likely to be party to proceedings in respect of their children are also most likely to be impacted by intersectional inequalities (Bywaters et al., 2018; Doebler et al., 2021; Johnson et al., 2021) On the other hand, serious case reviews into the avoidable deaths and serious injuries of infants make clear the vulnerability of young children and their need for particular attention and protection (Brandon et al., 2020). Whilst the underlying issues are undoubtedly complex, regardless of the circumstances, separation at birth is undoubtedly a traumatic experience with far-reaching consequences for all involved (Marsh, 2016; Mason et al., 2019, 2022a).

This paper explores evidence concerning the experiences of birth mothers who have suffered the removal of an infant, it identifies four themes that emerge from their common experiences: isolation, shame, disenfranchised grief and trauma, and strategies to ease the pain. It then demonstrates how their stories have been used to develop an intervention (the HOPE boxes) designed to mitigate their trauma and grief.

The project discussed in this paper is part of the *Born into Care* programme, funded by the Nuffield Family Justice Observatory. It was preceded by two evidence reviews, one on birth parent and professional perspectives on pre-birth assessment and the removal of infants at birth (Mason et al., 2019), and one on perinatal loss (McGrath-Lone & Ott, 2022), an issue that was explored in depth because the experiences of parents who lose a baby to adoption are in many ways similar to those of parents who experience a miscarriage or stillbirth (Geddes, 2021). This paper is informed by the findings from these reviews.

METHODS

The findings reported in this paper are drawn from a qualitative study which aimed to understand current challenges when safeguarding action is taken at birth. The study culminated in a set of draft best practice guidelines currently being tested for feasibility in the participating sites (Mason et al., 2022b). Extensive background research preceded the study, including statistical releases (Alrouh et al., 2019; Broadhurst et al., 2018), two reviews of relevant published literature (Mason et al., 2019; McGrath-Lone & Ott, 2022), and a review of national and local area protocols (Ward et al., 2022).

The process of data collection and analysis adhered to recognised standards for robust qualitative research (Daly, 2007; Davies & Dodd, 2002).

The project was approved by the ethics committee at Lancaster University and by the governance groups within the participating local authorities and the Health Research Authority. The project was supported by two advisory groups: one comprising mothers with lived experience and the second comprising policy, practice and academic experts.

Eight local authority areas and seven corresponding Health Trusts in England and Wales were selected to participate in the study, chosen because of high incidence of infants in care proceedings (Alrouh et al., 2019; Broadhurst et al., 2018).

A range of relevant professionals were invited to participate in focus groups and parents with lived experience were invited to take part in interviews. Principles of voluntarism informed participant recruitment as outlined by the British Sociological Association (2017). Parents who had previously required the services of the official solicitor within care proceedings or who the local authority felt were not able at this point to participate in interviews without harm were excluded. Following the sharing of participant information documents and prior to data collection, written consent was obtained. Procedures were put in place to respond to parental distress/disclosure following interviews, and a similar approach was adopted for the lived experience advisory group.

Due to the challenges presented by the COVID-19 pandemic, focus groups were conducted online but interviews with parents were conducted face-to-face with necessary safety measures in place. Focus groups and interviews were semi-structured and were video or audio recorded with the consent of participants and securely stored.

The final sample is set out in Table 1 below:

Initial coding was informed by reading of the literature and engagement with the focus group and interview material. Consistency of coding was compared using a data capture tool. First stage coding resulted in a large number of open codes and comparisons between these codes enabled themes to be developed.

The research team also paid attention to conditions of practice which were particular to the pandemic. Overall, practice constraints were evident prior to the pandemic but had been exacerbated during the pandemic.

FINDINGS

The full findings from the project can be found in a report by the authors. For the purposes of this paper, we present those specifically relating to the HOPE boxes innovation, taken from interviews with mothers that provided important insights into how an intervention might help to mitigate some of the acute distress experienced. While the broader study also collected data from fathers and this informed the development of the draft guidelines, this paper focuses specifically on the experiences of mothers, because of the particular woman-centred issues surrounding child birth and separation. More work is currently being undertaken to consider inclusion of fathers and consequent adaptations of the HOPE boxes.

MOTHERS

Thirty-eight mothers from eight local authority areas participated in the study. All the mothers had experienced state intervention following the birth of at least one of their children, either a separation close to their birth from a maternity setting or a period of formal assessment in a residential assessment centre or mother and baby foster placement. Interviews revealed the extent of loss, trauma and multiple adversities experienced throughout their lives, as well as their social isolation. They also revealed many common experiences in the three periods on which the study focussed: before the birth, within the maternity setting after the birth, and after they had returned home without the baby following discharge from hospital. While several issues emerged from the mothers' narratives, the following dominant themes particularly informed the intervention:

- Isolation and failure to acknowledge support needs
- Shame, stigma and denial of maternal identity
- Acute trauma, immediate downturn and disenfranchised grief following infant removal
- Strategies to mitigate pain and grief: empathy, artefacts and preserving connections

Isolation and failure to acknowledge support needs

In view of their past histories and current situation, the mothers were in particular need of sensitive, attuned care. However, despite the best will of many professionals, there were numerous barriers to them receiving it. These included pressures on midwives' capacity, shift patterns disrupting continuity of care, lack of specialist training, resource constraints, discharge protocols and bed space pressures.

TABLE 1 Study participants

	Stakeholder groups	No. focus groups/interviews	Total no. participants across sites
Focus Groups	Social workers	16	105
	Foster carers	9	46
	Midwives	19	81
	Cafcass	4	22
Individual interviews	Principal lawyers (LA)	8	9
	Mothers	38	44
	Fathers	6	
Total participants			307

Midwives on the wards were generally over-stretched and did not have time to give sufficient support to mothers, however much they might have wished to do so. This was acutely felt by the women who were often left alone while waiting for their first court hearing, wondering whether they would be separated from their baby:

> *She just said to me, 'How do you feel about tomorrow?' It just triggered me off. I was crying for hours. She put her arm around me for about five, ten minutes and then she was obviously busy*. (Mother 403)

Many mothers described feeling invisible at the point of removal and thought that the impact on them went unacknowledged.

Most mothers had minimal support networks, and in some instances the only people present at the point of separation were the social worker who had come to remove the baby and the midwife currently on shift, with whom they may have had little previous contact. In the most extreme examples, women were also faced with police officers or security guards:

> *Like, I put her in the car seat, then fastened her in, then put the blanket over her, asked what I wanted, I just looked at them. I was crying my eyes out, I could not really speak, to be honest. The two police were standing there in case I kicked off. I've just been in theatre, had stitches, just given birth to a baby two days ago. Then in the next breath she gone. Like, I did not know when my contact was going to be, they did not tell me any of this, like, 'Oh, we'll be in touch', that was it. Then as soon as the bairn was gone, someone in the hospital was like, 'Right, you can go home'*. (Mother 820)

The mother's account of her separation from her baby vividly depicts the lack of recognition of the women's own support needs at such an acutely distressing time. That contact arrangements had not been put in place, which further added to her perception that neither her identity as the baby's mother nor the distress she was facing had been acknowledged.

Shame, stigma and denial of maternal identity

Denial of Maternal Identity

McGrath-Lone and Ott's (2022) evidence review of perinatal loss found that mothers who lose a baby through stillbirth or miscarriage often suffer feelings of failure in both their female and maternal roles. Many of the women in the study had their life chances limited through intersectional disadvantage. Positive accounts of education or work rarely featured in their interviews, which often indicated disrupted educations. A study by the authors (2020) pointed out that many women in this situation have fragile and restricted social statuses; the removal of an infant at birth can be doubly devastating, not only because they lose the baby, but also because they lose their parental status – and motherhood is one of the few roles for which they felt recognised.

> *I said, I literally just went to court and then they just said obviously I wasn't having her. Then for me I was just like, I'm just getting used to being a mum. Where is she going to go? Where am I going to go? Where does this leave me now?* (Mother 302)

Some mothers desperately wanted to breastfeed but felt insufficiently supported and most wanted to undertake other tasks which reinforced their maternal identity. Being recognised as the baby's mother was central to their sense of self. As a result, some mothers found it particularly painful when they felt their maternal role was marginalised. In the quote below a mother describes her devastation when she visits her baby a few days after giving birth and finds a foster carer, whom she has not previously met, holding her baby. This baby had been transferred to a special care unit for observation following the mother's own discharge.

> *Now me and (father) walked into the hospital one day and in the room, in this room I am walking in to see my baby, which I'd done every single day, there is a strange woman holding my baby. She has got no… She is not a doctor. She is not a nurse. It's just a strange woman. What's she doing with my baby? I did not know who she was. Now this was supposed to be, I was supposed to meet this foster carer beforehand and that absolutely knocked me for six. Me and (father) walk into a room and, 'Oh hi, I'm the foster carer. I'm (baby's) new carer'. 'Hold on a minute. You are sitting holding my baby, you have taken my baby out the crib so basically I've got no say whatsoever over my baby'*. (Mother 703)

Shame and stigma

McGrath-Lone and Ott's (2022) evidence review also found that parents who lose a baby through miscarriage or stillbirth experience feelings of 'shock, anger, regret, emptiness, loneliness, helplessness, and guilt' (p.15). These are very similar to the reported feelings of mothers in this and previous studies of the lived experiences of infant removal (Broadhurst & Mason, 2017, 2020). However, while the shock, anger and loss of maternal identity may be similar for mothers whose infant is stillborn, these feelings are further complicated by the acute shame and stigmatisation experienced by women whose children are removed by the state (Neil et al., 2010; Morgan et al., 2019; Morriss, 2019; Geddes, 2021).

Research about mothering in marginalised contexts – amidst violence, substance misuse, poverty, young age and mental health difficulties – overwhelmingly reports that women actively construct stories through which they self-identify as 'good' mothers and they fit themselves into the socially constructed stock or formula story of ideal motherhood (Medina & Magnuson, 2009). When an infant is removed by the state, this idealised identity is challenged. The mother experiences shame because she has publicly been judged as having failed to fulfil the role that society has given her. She herself may feel guilty, but she may also experience rejection by others who judge her as a 'failed mother'. The associated shame and stigma she experiences may lead to a corrupted sense of self and add to the psychological burden following separation (Abrams, 2015; Morriss, 2019).

Many of the mothers in the study were acutely aware of the stigma they were likely to encounter. Though not always granted, many expressed a preference for a side room, where other mothers could not see the social workers visiting them or overhear their conversations. They also appreciated attempts to disguise the fact that the infant was being removed from their care:

> *They actually let me go in the car to the house from the hospital. So, it was like I got to take him home, in a way.… It looked normal, because we'd all just got in the car, it wasn't plain as day that he was being taken into care*. (Mother 103)

And when they returned home without the baby, they sometimes felt compelled to keep up the deception:

> *I slept. I wasn't eating properly, I just slept most of the day. I did not see anyone for about a week and that's when I started going out. Everyone was like, 'Oh, where is she?' Then I'd be like, 'Oh, she's just with her dad. She's with her dad'. Then eventually I had to just obviously tell my friends that obviously I did not have her, but I was getting her back. Obviously, I knew for definite I was getting her back*. (Mother 302)

Some women felt they had to continue to hide or find ways to conceal what had happened for lengthy periods. In the quote below a mother describes the ways in which she tried to prevent people in her community from knowing the truth surrounding her separation from her baby.

> *(I was) all over the place, every time I spoke about her, tears, I was putting a brave face on …, so when I was out I was trying to put a brave face on, but if people asked me how she was I'd say, 'Yes, she's fine'. 'Where is she?' 'She's just with my mum'. I could not physically tell them, there's only so many people know what's happened to her, like close friends, family members, people I treat like family, they know. A person that I only see once in a blue moon, they do not physically know. Yes, like she's with my family, she's in school, because I do not want everybody knowing my business*. (Mother 401)

Although the grief experienced by parents who have had a still birth or a miscarriage is still not adequately acknowledged, they can expect some professional support, albeit sometimes insensitive or inadequate (McGrath-Lone & Ott, 2022). However, apart from routine post-partum midwifery care, practitioners rarely have a formal role in supporting mothers whose infants have been removed by the state. It was not uncommon for the mothers in this study to leave the hospital unaccompanied and return home alone to a flat that was filled with the equipment they had bought in the hope of demonstrating their commitment to an infant who had then been removed from their care.

Most mothers suffered acute experiences of grief in the immediate aftermath.

> *And it was like – I just could not live in that house without them. And my mental health, when I look back now, I'd had a breakdown. I was – I'd had a breakdown. I was wearing the same clothes for months. Months. Not bothering. I wasn't even claiming benefits, I had no money to my name. I could not go and claim benefits, I could not do anything.…* (Mother 105)

Despite the obvious levels of acute psychological distress caused by the separation, the findings demonstrate the lack of consistent or specialist care offered to women in this situation. The social worker focusses on the baby, now in alternative care, and midwives, for the most part, are unable to provide care beyond the standard post-natal offer. Thus, mothers fall into a support vacuum leaving them vulnerable to an acute downturn in their mental health functioning.

> *No, they did not give me nothing. Once they take your kids they leave you alone. That's what I mean… That's when they mess people then. They'll take their kids off them, cause so much damage, like emotional, it messes them up*. (Mother 404)

Unsurprisingly, many mothers turned to problematic coping strategies such as the misuse of alcohol or drugs.

> *I got the bus home, and then that night, I just decided, I went back to my old ways, drinking. I thought it was the only way I was going to handle getting through it*. (Mother 201)

Disenfranchised grief

Intertwined with feelings of acute distress at the separation, the interview data also show how the failure to acknowledge the mothers' grief served as a further complicating factor. As several researchers have found (Abbott et al., 2021; Broadhurst & Mason, 2020; Brodzinsky & Smith, 2014; Geddes, 2021; Memarnia et al., 2015), the literature on disenfranchised grief (Corr, 1999; Doka, 1999) provides a valuable lens through which the experiences of mothers whose infants have been removed can be better understood.

> Disenfranchised grief can be defined as the grief experienced by those who incur a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported. Isolated in bereavement, it can be much more difficult to mourn. (Doka, 1999, p. 37)

The mothers in this study had, to all intents and purposes, lost a baby but in circumstances regarded as shameful by the general public, as well as by some professionals (Mason et al., 2022a; Morriss, 2019). They were disenfranchised mourners. Their grief was not publicly acknowledged. They had little or no social support and there were none of the mourning rituals that are normally helpful in resolving grief (Doka, 1999). Moreover, theirs was an ambiguous loss (Boss, 1999) in that their infants were still alive. Although many of the infants would eventually be adopted, whilst care proceedings were ongoing the outcome remained unclear. Even after a permanent separation, as other studies evidence, the babies would remain physically absent, but psychologically present to their mothers (Fravel et al., 2000), who continued to nurture hope of a reunion (Broadhurst & Mason, 2020; Geddes, 2021; Neil et al., 2010). Morriss (2019) describes their state as 'a haunted motherhood', awaiting an imagined future with their child. This type of ambiguous loss, which brings little closure, is more difficult to recover from than the permanent loss of death (Boss, 1999). With few opportunities to resolve their grief, it is not surprising that, as other studies have found (Broadhurst & Mason, 2020; Cox et al., 2020; Neil et al., 2010; Wall-Wieler et al., 2018), mothers in this situation experience acute mental distress which may result in self harm and in some cases attempted suicide:

> *I went home and I took an overdose, because I did not want to be alive without my children*. (Mother 103)

Strategies to mitigate grief: empathy, artefacts and preserving connections

To some extent, the mothers' trauma could be mitigated by actions which legitimated their loss. Small gestures by professionals showing empathy and understanding were greatly valued:

> *She (midwife) was really supportive. She got down on my level and she just held me hand. I remember her holding my hand. I'll never forget it. She was lovely. … She literally bent down on her knees and she actually held my hand. (*Mother 102)

Taking part in everyday activities which acknowledged their parental role helped to validate their identity as mothers and strengthen their sense of self-esteem.

> *… you are showing your child that it's just something normal, 'I'm giving you a bath'. A bath might be nothing to them, but to the mum, it's, 'I'm actually looking after my child, I'm trying to show you that I can do it'.* (Mother 301)

Being consulted about their preferences over details regarding routine care, the choice of formula and what the baby would wear when they were handed to the foster carer, or when they attended contact sessions, acquired symbolic significance to parents.

Transitional objects and symbolic artefacts

The importance of transitional objects and artefacts in parents' management of their grief, evident in the findings, resonate with the broader literature on peri-natal loss (McGrath-Lone & Ott, 2022) and with Geddes' (2021) recent findings regarding parents whose children have been adopted. Gibson (2004) discusses how, just as children use transitional objects such as teddy bears and blankets to help them negotiate the process of becoming separated from their mothers, so those who grieve may similarly use objects to negotiate the process of separating themselves from the person who has died. Clothing can be of particular symbolic significance because:

> through the evocation of smell as well as image, [it] might be more effective in momentarily bridging (though never entirely) the space/time separation distancing the living from the dead. (Gibson, 2004, p. 290)

Some mothers derived similar comfort from clothing that connected them with infants who had been removed:

> *I slept with the first babygro she wore the whole four weeks. I slept with her blanket that she had before she went*. (Mother 302)

Other 'melancholy objects' might act as mementoes of the infant who was psychologically present but no longer physically there:

> *I've still got their stuff, their first shoes, dummies, dummy clips and stuff, just what they had actually used and stuff. Yes. I can go through it with her. I can talk about it and say, so when she's old enough she knows that she has got siblings. … (it's) just comfort…. Just knowing that you have got something still of theirs.* (Mother 102)

Thus, in synergy with perinatal loss and adoption research, such artefacts were described as mitigating the overwhelming grief, bringing comfort and affirming maternal identity (Geddes, 2021). However, for women recently separated from their baby at birth, our findings also suggest another and distinctive role for such artefacts: to keep a connection to the infant.

Preserving connections and motivation post separation

Until the final court order has been granted, separation is an interim measure. It will be at least six months before care proceedings are concluded, at the end of which approximately 15 per cent of separated infants will return to birth parents on supervision orders (Broadhurst et al., 2018). Others, whilst subject to a care order, may remain with or be returned to their parents' care. It is therefore of great importance to ensure that mothers have every opportunity to bond with the baby and to hold on to their parental identities during this interim phase. However, as we have argued elsewhere (Broadhurst et al., 2022), far from creating the conditions to encourage bonding and eventual reunification, an interim separation may feel like a *fait accompli* for it may and set in motion a train of events which create the conditions for permanent removal, as parents turn to self-destructive behaviour patterns to try to lessen their pain. The process of care proceedings and the impact on parents, as Morriss (2019) attests, have the power to *make futures*.

Nevertheless, findings from both this and other studies (Broadhurst & Mason, 2017; Ward et al., 2012, 2019) demonstrate how the temporary or permanent removal of a child can act as an important motivator for change, and can lead to some parents overcoming difficulties and becoming able to provide safe and nurturing homes for infants who had previously been at risk of significant harm, or for later children after others have been removed:

The adoption really shook me. That is what made me think, 'Right, come on. I need to sort my life out now for all of the kids. Then I can explain to (child 4) in the future that she was the reason I sorted my life out'. (Mother 202)

It is therefore critically important for mothers in this situation to retain an ongoing connection with the infant post removal. Some form of connection is necessary for the psychological health of most mothers who experience infant removal, and particularly where there is a chance of eventual reunification. Finally, as this quotation clearly illustrates, an ongoing psychological connection with a child who has been removed, and the thought of proving she 'was the reason I sorted my life out' can be a powerful motivator for change. Indeed, after she worked intensively with Children's Social Care and drug and alcohol services to resolve the difficulties that had led to previous removals, this mother did go on to have another child who remained in her care.

THE HOPE BOXES

Our analysis of the data identified four dominant themes emerging from women's experiences of being separated from their baby at birth. In the second part of our paper, we move on to describe the intervention grounded in these findings. The HOPE boxes were co-produced with a group of women with lived experience of separation at birth who formed an Advisory Board for the study. Meeting at approximately six weekly intervals, throughout the project the group have played an important role in shaping the study. Building on established midwifery practice and drawing on their own personal experiences and the research findings, the women in this group were central to the development of this particular intervention.

The HOPE boxes design

The intervention consists of two boxes: one for the mother and one for the baby. They build on learning from perinatal loss literature and charities and practice gleaned from some midwives who have adapted 'bereavement memory boxes' to offer to women separated from their babies. The content of each of the HOPE boxes has been specifically chosen to respond to the findings from this project and to reflect the psychological challenges associated with different points of the mother and baby's journey. The boxes have been designed for flexible use, to reflect both the diversity of experience and the range of possible longer-term outcomes for the mother and the baby. In this section we describe their content and illustrate its significance.

The name HOPE, an acronym for 'Hold on Pain Eases', was chosen by the group to reflect their empathy for the woman's situation, her need for support but also to engender a sense of hope that things can get better. The image on each box, designed by a woman in the group, is of two adult hands and two babies' feet, and is intended to show inclusivity in terms of ethnicity and is deliberately ambiguous in its symbolism to reflect the diversity of parents' situations.

A specialist midwife (or other identified professional) will be asked to introduce the concept of the HOPE boxes to the woman via a letter from the Lived Experience Group. The letter precedes the boxes and provides an explanation of their purpose and an overview of their content. Encouraging professionals to engage women in a conversation about the HOPE boxes aims to convey a sense of care and provides an acknowledgment that the mother is worthy of being offered specialist attention and support. The letter offers an immediate opportunity to recognise the mother's pain and to provide a connection to other mothers who have experienced similar forms of loss, thus mitigating the acute feelings of isolation, stigma and shame expressed by many women in this and other studies.

Drawing on the learning from the parent interviews, and previous work (Geddes, 2021), many items in the mother's box have been included to help promote the woman's maternal identity and capture early memories whilst still with her baby. However, they also offer an opportunity for psychological connection when her baby is physically absent and no longer in her care. For example, the boxes include a baby first book – one for each box allowing the mother to capture and also share with the foster or kinship carer the baby's early days of life whilst in her care. This both offers an opportunity for the mother to convey her own knowledge and expertise in relation to her baby and also ensures that this is shared with the alternative care giver, thus creating an opportunity to build a relationship. The foster carer or kinship carer is subsequently encouraged to update the book and share this with the mother at family time, so she remains involved in her baby's developmental journey.

The boxes also include items to support midwives' conversations regarding memory-making activities in the baby's first few days whilst still in the maternity unit. Included in both boxes are kits to produce baby and mother's hand and foot prints, a photo frame to encourage a photographic keepsake and a box to hold a lock of the baby's hair. Duplicate

cot cards and ankle and wrist name bracelets are also included. Each of these items are typically preserved by any new parents, providing opportunities to capture those precious early moments of their baby's life; however, opportunities to make memories in this way are frequently overshadowed by the demands of a complex legal process with which this group of women must engage. Whilst at this stage, memory-making may be important because it represents 'normal parental activities', these items may take on a new significance if mother and baby are separated. As Lavelle (2020) describes, objects that have been physically close to the baby speak of intimacy and 'enable a moment of the past to manifest in the present' (p. 7). For women at risk of permanent separation, these manifestations of their baby whilst physically apart may prove important in maintaining motivation to continue engagement with both the legal process and support services.

In the absence of the physical presence of her baby and at a time of acute psychological distress, these items become representations of the baby and important testaments to the mother's maternal identity (Geddes, 2021; Marsh & Leamon, 2019). In the interviews many mothers reflected on the significance of such items and felt aggrieved at being denied the opportunity to keep them. Such items may also serve to preserve psychological connection between mother and baby between physical contact visits. Matching items in both boxes such as a soft toy (an elephant chosen because 'they never forget') and a baby blanket provide a sensory connection. Chosen for their tactile quality and their ability to hold the scent of the other, the items can be swapped at contact sessions and may help settle the baby in their alternative placement as well as provide comfort to the mother. Such sensory stimulation may be of particular importance for women who wish to continue breastfeeding The baby's box also contains a small children's book with the opportunity for the mother to record her voice reading the story on a memory card. This can be played to offer the baby the additional comfort of their mother's voice.

Such carefully chosen items convey empathy and preserve a connection between mother and baby, but they may also serve as important artefacts if, following care proceedings, there is a permanent separation. The boxes may become repositories of memories and other keepsakes for both mother and child. The boxes and their contents may support loss and grief processing and help with future life story and narrative identity work with children and adults (Geddes, 2021; Watson et al., 2020).

The boxes also include items that aim to support the mother through the pain of the separation: a scented candle to help bring calm and a poem written by the Lived Experience group acknowledging the pain and giving hope that it will ease and encouraging the mother to seek support from others. A list of national and local organisations and contact numbers is also included to help signpost the mother to professional help.

CONCLUSION

The findings from this study illustrate the importance of sensitive attuned practice when a baby and mother are separated at birth due to safeguarding concerns. In keeping with the extant literature regarding parents who have experienced state-ordered child removal, the women's accounts in this study demonstrate the complexity of the psychological task as they attempt to negotiate their separation from their baby and the associated stigma and shame. The concept of disenfranchised grief is a useful framework for helping us to understand the complexity of the loss and the challenges in holding on to a 'compromised' maternal identity. The findings also point to the important part that capturing early experiences and memories through artefacts may play in supporting women through this journey, both to keep connection to the baby and engagement in the immediate period following separation and, in the longer term, to support loss and grief work should a permanent separation be ordered by the court. The HOPE boxes, linked to a broader set of Best Practice Guidelines emanating from the research, are currently undergoing feasibility testing in a small number of sites in England and Wales. They offer an important opportunity to reduce the human and economic cost caused by the trauma of separation at birth. Professionals working with mothers facing separation at birth will play a crucial role in embedding and utilising the HOPE boxes and require support and training to enable the intervention to be of optimum benefit. Funding is currently being sought to develop and embed training and evaluation of this intervention.

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ETHICS AND INTEGRITY

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