The Hidden Cost of Trauma: Maternal Mental Health and Child Removal

Katy Cleece *is a qualified social worker and currently the Social Work Research Lead for Lancashire and South Cumbria NHS Foundation Trust. She has extensive experience in mental health, with particular interests in trauma and whole-family approaches. Katy has worked across both adult and children's services, and previously qualified and practised as a substance misuse practitioner, supporting children, adults, and families on the edge of care.*

A Rising Trend in Child Removals

The number of children being removed from their families and placed into state care in the UK continues to rise year on year. Increasingly, parental mental ill-health—particularly maternal mental health—has become the leading reason for safeguarding assessments. This trend is not occurring in isolation: evidence consistently shows that socioeconomic disadvantage significantly heightens the risk. These patterns demand urgent attention. Services and practitioners must look beyond presenting symptoms to understand the deeper, structural causes—and commit to implementing preventative, trauma-informed approaches before families reach crisis point.

Understanding the Trauma Beneath the Diagnosis

But who are the women behind these numbers? To truly understand the rise in child removals linked to maternal mental health, we must first confront the gendered and traumatic experiences that often lie at the heart of their distress.

Working in substance misuse and then adult mental health, my professional experience is that many of these women have experienced trauma perpetrated by men - specifically, intimate partner violence, sexual assault or abuse, or rape. Often, it is a combination of all these experiences, which

has led to long-term post trauma symptoms, resulting in problematic drug or alcohol use, mental health intervention, or both.

A 2014 study by the UCL and Kings College London found that 40% of women with severe mental illness had been victims of rape or attempted rape, compared with 7% in general society. The figures were drawn from a random sample of psychiatric patients and compared with the 2011/12 National Crime Survey of 2011/12. The National Crime Survey 2021 found that 63% of women who had been subject to rape or assault by penetration experienced mental health problems. The mental health impact was reportedly more prominent than any physical or social impact. Similarly, a 2017 report by the Mental Health Foundation 2017 found that 61% of women surveyed had experienced sexual violence in adulthood.

Shame and guilt are common responses to sexual trauma, often delaying help-seeking. Secrecy and fear frequently accompany these experiences, especially if they occurred in formative years. According to Rape Crisis England and Wales, five in six women who have been raped do not report this to the police.

Traumatised or disordered?

In my professional experience, the response women receive typically depends on their socioeconomic standing. Women educated to a higher level and occupying higher-class status more readily receive diagnosis linked to their trauma, such as PTSD or CPTSD, which facilitates access to evidence-based treatment provided by NHS mental health trusts.

Woman with lower levels of education, from minority ethnic backgrounds, or from lower socioeconomic groups are more likely to receive a diagnosis of Personality Disorder(s). This diagnosis often excludes them from access to trauma-focused treatments. Women in this group are also more likely to be viewed by mental health professionals and children's social workers as presenting higher risk to themselves and others.

Personality Disorder diagnoses have existed since the publication of first DSM in the 1950s. Community treatment is typically managed by Community Mental Health Teams (CMHT), while crisis presentations - such as suicide attempts, suicidal ideation, or self-harm – are handled by Home-Based Treatment Teams (HBTT). The British Medical Association reports that the numbers of adults aged 16 to 74 accessing mental health services rose by 71% between 2000 and 2014. Referrals increased by a further 22% from 2019-2022, and in 2021, the waiting list was estimated at 1.4 million people.

Gaps in Mental Health Services

Despite the wide implementation of the Family Safeguarding model which aims to integrate adult mental health practitioners into children's social care teams - the impact on this group of women is limited, or absent. The threshold for service involvement is lower-level mental health difficulties, treated by brief intervention of up to 12 sessions. The risk associated with this presentation is too great for those teams to manage, plus the identified treatment is longer term, therefore they fall beyond the scope of this integrated service.

Traditional service models mean that children's social care and adult mental health services, employed by different organisations, work in silo, each concentrating on the symptoms or risks present, but rarely having the opportunity to identify and treat the root cause while simultaneously meeting the needs of the child. Timescales for children in the statutory social care arena are limited, with guidelines set at 26 weeks for completion of court processes.

With caseloads at record highs and a staff retention crisis, children's social workers are working with the highest-need families and have little to no opportunity to offer therapeutic, whole-family or preventative interventions. Treating the underlying causes of trauma is a slow process. Unlike the most common mental health problems, such as depression or anxiety, medication or solution-focused brief therapy are not the primary treatments. NICE guidelines recommend psychological therapies, which should not be brief intervention (less than three months), and that treatment should be part of a process in which the recipient can form a trusting relationship. This is not compatible with the timescale constraints for the family courts, nor with the reality of waiting times for NHS mental health assessment, care planning and therapy lists.

The Consequences of Removal

Forced removal of children from their birth families causes trauma for both mother and child. Research shows that one in four women in the UK who has had a child removed will face further care proceedings within seven years. The loss of a child can exacerbate maternal mental health issues. Coupled with the stigma of being a mother living apart from her children, it often creates further trauma, negatively affecting future pregnancies and parenting capacities.

Mental health exists on a broad spectrum, and it is estimated that 1 in 4 people will experience mental health difficulties at some point in their lives. Experiencing poor mental health, in and of itself, is not a reason for children's social care to intervene in family life - and for the vast majority of people, it does not lead to such involvement.

However, the stigma surrounding mental illness is intensified for mothers who are parenting alone and living in poverty. Fear of intervention from children's social care and ultimately fear of having their children removed often forces women to hide their symptoms and avoid seeking help.

The Overlooked Link: Trauma, Diagnosis, and Child Removal

Despite growing awareness of trauma-informed practice, there remains a significant gap in research exploring the relationship between women's mental health diagnoses—particularly Personality Disorders—and the removal of children through safeguarding interventions. To my knowledge, no published data systematically tracks the mental health profiles of women whose children are removed following social care involvement. This absence of evidence obscures a critical pattern: women with histories of sexual trauma often have unmet psychological needs, are misdiagnosed or excluded from trauma-specific services, and disproportionately become subject to care proceedings.

One such case I encountered involved a woman whose own childhood was marked by removal from her family due to her mother's struggles, including involvement with children's social care. As an adult, now reunified with her mother, she has had three children of her own. Her eldest now lives with their father, while the two youngest have recently been court-ordered to be separated—one placed in long-term foster care and the youngest adopted. This woman's mental health difficulties are longstanding and stem from severe sexual and physical violence experienced in her intimate relationships. Despite repeated contact with children's services, she has never been offered dedicated, trauma-focused treatment. Her story is not unique—it reflects a system that fails to see past behaviour to underlying harm, and that too often pathologizes women instead of supporting their recovery.

Summary

- Shame and guilt connected to being a victim of sexual harm can delay women in accessing services to treat trauma symptoms.

- Maternal guilt, shame and stigma can lead women to mask their mental health symptoms.
- The intersection of past trauma, being female and socioeconomic disadvantage increases the likelihood of a Personality Disorder diagnosis, which excludes many women from certain treatment pathways.
- NICE guidelines recommend a long-term therapeutic intervention to treat trauma.
- The recommended timescale for concluding family court proceedings is 26 weeks.
- NHS waiting times for assessment and therapy often exceed the timescales required by the family courts.
- Adult mental health practitioners and children's social workers are often ill-equipped and under-resourced to manage the risks associated with mental health crises.
- Children are removed, and mothers face further traumatisation. The children themselves also experience trauma through this process.

Recommendations

Current provision for mothers who have experienced trauma is wholly inadequate. Rigid, risk-averse, and time-driven service pathways actively perpetuate harm. Social workers are expected to manage risk without the necessary training, resources, or systemic support to address complex trauma.

There must be an urgent and systemic overhaul toward a truly trauma-informed, integrated approach. This model must give women the time, therapeutic support, and stable relationships necessary for healing—while simultaneously ensuring children are nurtured and safeguarded.

Policymakers, service commissioners, and leaders must act decisively to fund, design, and implement services that reflect the complexity of these women's lives.

Katy Cleece

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