Learning from marginalised mothers' experiences of midwifery care: not much Better Births

Tamsin Bicknell-Morel

Consultant Midwife in Public Health and Safeguarding, East London

My research looked specifically at mothers whose babies were taken into care following birth.
I audited cases, surveyed midwives, and interviewed women* with lived experience.

Today we'll look at the intersection between this experience and criminal justice involvement, and identifying some parallels in experience and opportunity

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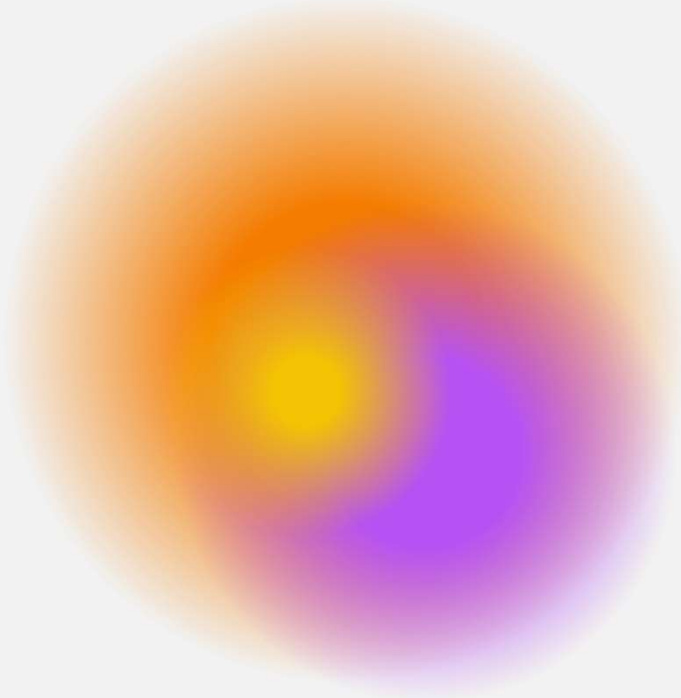
*a note on language: I have used 'women' throughout, as my research participants were all cis women. However, this was not part of my inclusion/exclusion criteria and I recognise there may be people becoming parents with complex social circumstances who do not identify as cis.

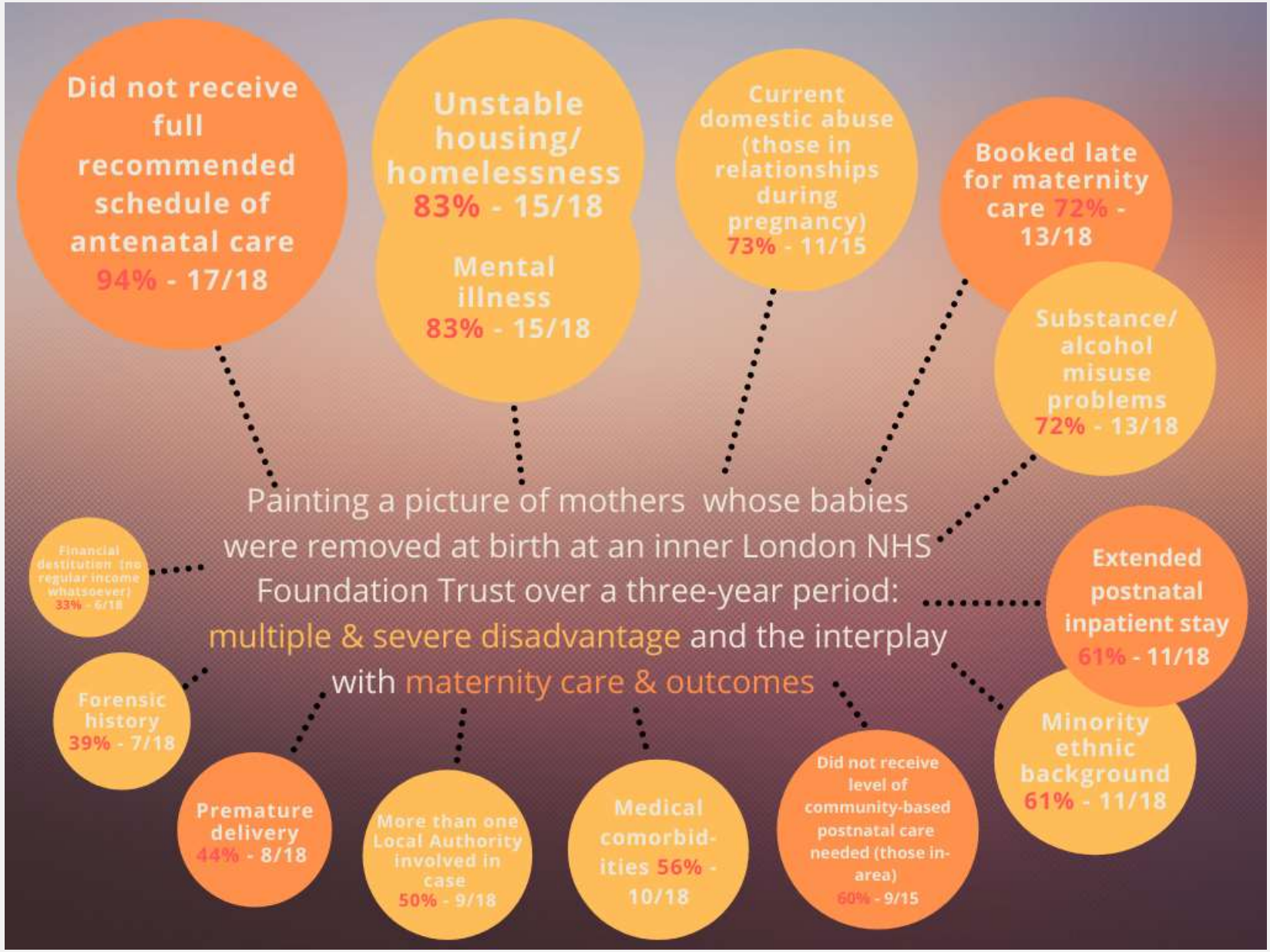
Rarely is criminal justice involvement a lone challenge

Women often experience multiple, severe disadvantage, of which CJI is one part



Audit of three years of cases at an inner London maternity unit – removals at birth.

18 cases included: small number compared to some areas – mirrors BIC national data



Factors preventing engagement with criminal justice issues in maternity care

- Not common practice to routinely ask about criminal justice involvement – often incidental.
- Midwives do not have any training, or guidance in working with the criminal justice system unless they seek this out themselves; most will have very little experience
- Probation officers or other CJ professionals are not common partners in the MDT; unknown contact/working together pathways. Solicitors/access to legal support are another unknown partner in the woman's team
- Anxiety/uncertainty about when CJ involvement becomes a safeguarding issue
- Fear of women with CJ involvement – safety planning

Women's experiences: more than the baby was lost

Where complex social issues were present, safeguarding planning took precedence over choice and personalisation of care

- Loss of 'normal' motherhood experiences
- Birth planning, infant feeding choice and support, debriefing services
- Loss of privacy and dignity
- Loss of time to connect with baby; time to say goodbye
- Loss of postnatal care – from midwives, health visitors, perinatal mental health teams
- Loss of future children/family life
- Loss of motherhood identity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Intersectionality in the maternity unit: marginalised women labour under many layers of inequality and prejudice

Maternity care culture: where a unit operates under patriarchal power dynamics, this power may be exercised by all professionals, regardless of gender

Race: disproportionate numbers of women from non-white backgrounds experienced removal at birth in my research; this is borne out in wider work on social care and criminal justice involvement[1,2,3]

Women are commonly living in poverty, with subsequent poor general health and experience difficulties in accessing healthcare

The great majority of women have their own histories of trauma, whether in childhood, adulthood, or both, that have led to maladaptive – if understandable - coping mechanisms. Many are care experienced.

Social stigma that comes with having subverted traditional expectations of women- or motherhood. Women are often put in the 'too hard' box by mainstream services

Opportunities for making care for marginalised women truly Better

1. Prioritising continuity of carer (in whatever form works best for this group), ensuring care meets the Better Births standards, and maximising opportunities to care for, and about, women.
2. The social assessment undertaken at booking should be expanded to elicit information regarding CJS involvement, amongst other topics (e.g. hx trauma/ACEs,), to enable an appropriate package of care to be devised.
3. Communication pathways between maternity services and CJS should be developed, with key professionals involved in birth planning and the timing of key events.
4. Care must be trauma-informed, delivered by a well-staffed, well-supported, trauma-informed workforce. This should include specialist mental health services, to be available regardless of diagnosis of a mental health condition.
5. Creating the right conditions for emotionally supportive care involves listening to midwives about simple, operational changes to care provision/ward management.
6. Support staff to recognise the opportunities they have to enact ‘everyday activism’ and take every opportunity to advocate for women.

Professionals have power

Each can choose to make a positive or negative difference.

Either way, it will be remembered.