Resolving hurts: Working with birthmothers to avoid multiple, successive removals of children at birth

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Abstract

Multiple, successive removals of children from birthparents continues to be a widespread concern in the UK. While there appears to be a gap in current procedures and national policies to address this pressing issue, there has been a recent emergence of pilot schemes focusing on the rehabilitation of the birthmother who continues to have her children removed from her care. Through the lens of a social worker, an exploration of the mother's loss and the meaning of repeat pregnancies highlights that practitioners must take into consideration the mother's needs, not only in the best interests of her child, but also her subsequent children. A case study will be used to explore the impact of the child protection worker on the mother in the process of assessing and removing children deemed at risk. While the study shows there is a demand for an independent, post removal service for birthparents, the author argues the necessity for greater attention to how social work practice engages with repeat losses of children to care and adoption. Central to this argument is the need for practitioners to take a longitudinal approach which takes into account the past, present and future of the family.

Keywords: recurrent care proceedings, motherhood, parental loss, repeat pregnancies, social work

Introduction

Birthmothers trapped in recurrent care proceedings with multiple children are now of national concern (Broadhurst et al., 2015). A recent feasibility study based on data from the Children and Family Court Advisory and Support Service (Cafcass) (2014) identified that between the years 2007-2013, out of 46,094 birthmothers in care proceedings, 7,143 appeared in 15,645 recurrent care applications concerning 22,790 children. This equates to 25% of all children in care proceedings. These figures demonstrate that approximately 1 in every 3 care applications are linked to recurrent mothers in care proceedings (Broadhurst, Harwin, Alrouh & Shaw, 2014). The study also identified that 50% of these mothers were aged 24 or younger. Furthermore, 58% of all recurrent applications concerned infants under the age of 12 months with 42% of all applications made within one month of birth (Broadhurst et al., 2014). These statistics illuminate a need to explore the reasons behind the repeat pregnancies and removals and how practitioners could assist and support in avoiding further losses to care. Child or pregnancy safeguarding issues often involve multiple agencies, therefore it is not possible to look at every practitioner's role. However, it is important to acknowledge the impact and input of health, police and other specialist agencies for both children and adults in this complex cycle of repeat removals. This paper will specifically focus on the role of the social worker as the lead professional whilst also briefly exploring the interventions offered by post removal services, with a view to consider how the two services could align.

This paper does not seek to address whether social workers should or should not recommend the removal of a child but rather to consider the impact of the social worker's role on the mother when it is deemed necessary for the child to be placed into care. It is essential to recognise the crucial role of birthfathers in their own right in this process (Clapton, 2007). However, there is not the scope to do justice to the depth required to

address both parents' needs together and individually (Baum, 2013) in this paper. The focus will largely remain on how we specifically work with the mother, who automatically has parental rights within legal proceedings (UK Department of Health, 1989).

Two separate strands will be explored: how policies and the law affect the way child protection practitioners work with families, and the mother's experience of losing her child to care and the meaning this can have on subsequent pregnancies. From these key yet distinct strands, two main arguments emerge. First, this paper echoes recent literature advocating the need for a post removal service for the mother, which is independent from children and families statutory services (Broadhurst & Mason, 2013; Neil, Cossar, Lorgelly & Young, 2010). Secondly, there is a lack of attention paid to the impact of child protection workers on successive removals, the exploration of which will be the main focus of discussion. In considering the policies which impact the social worker, and then examining the impact the practitioner has on the mother, this paper seeks to explore how we can viably work with mothers to avoid further removals of children.

Case Study

A brief outline of the case study is given here, with further details presented throughout the paper. All names and identifiable information have been anonymised to ensure data protection and confidentiality.

Amy, a white, British woman aged 21, was receiving support from the leaving care team. She was taken into care when she was 14 and is currently living in supported accommodation. Her first child, Adam, had been removed by another local authority 18 months previously due to neglect. He was taken from her care shortly after he was born. She had been subject to domestic abuse from her partner who was unknown to both local

authorities but well-known to the police for criminal activity and the high number of callouts regarding domestic violence towards Amy. The police reported that she and her partner smoked and drank heavily, and used cannabis regularly. There were concerns for her mental health and reports that she was admitted to hospital three times after attempting to take an overdose, following the removal of her son. However, no formal diagnosis was made. She became pregnant 6 months after losing Adam to care, which resulted in a miscarriage. When Adam was going through the adoption process she fell pregnant again and was referred to our assessment team when she was 20 weeks pregnant. 8 weeks prior to her giving birth, a final hearing took place for Adam's adoption which went through successfully.

The recommendations from the previous child and family assessment concerning Adam, were for Amy to undergo counselling, anger management classes, parenting classes and access a domestic violence worker. However, when she came to our attention pregnant again, she had not accessed any of these services. She remained under the leaving care team and despite her sporadic engagement, this appeared to be the only consistent support network in Amy's life. However, due to Amy's age, the leaving care team were shortly due to stop working with her.

The outcome of our pre-birth assessment was that there had not been significant change in her parenting capacity since the previous removal 18 months prior. One month before she was due to give birth, the case was transferred to another team in the borough due to local procedures. At the time of writing, the case went to court seeking a removal at birth. Kinship assessments were unsuccessful as family members willing to undergo assessments had children themselves on child protection plans.

Implications of policies and the law on social work practice

Currently there is no UK government policy to specifically address multiple removals of children from the same birthmother (Broadhurst & Mason, 2013). The national framework, Working Together to Safeguard Children 2015 uses a continuous flow chart outlining clear protocols for each step and stage of the assessment process to ensure effective intervention and child protection (UK Department for Education, 2015). These carefully structured procedures are the backbone to successfully safeguarding children and focus on a "now or never" approach (Munro, 2011, p. 69). However, this crisis-oriented response leaves little room for workers to take into account the long term implications of their actions on the birthmother.

Parental needs must be secondary to the child's needs

Children and family social workers have a duty to put the best interests of the child first (UK Department for Education, 2015) under the Children Act 1989, with specific duties toward children in need and children suffering, or likely to suffer, significant harm (UK Department of Health, 1989). These laws initiated the foundation of the child centred approach (Munro, 2011) which social workers adopt to effectively meet the needs of the child. Although the philosophy of the Children Act 1989 is that the best place for a child is in the family home (Gardner & Manby, 1993), the safety and well-being of the child overrides the need to keep the family together (Munro, 2011). Therefore, the parents' needs, while still an important element in working with families (UK Department for Children, Schools and Families, 2009; UK Department for Communities and Local Government, 2012), remain secondary to the well-being of the child. Yet when repeated removals occur for the same birthmother, it raises a question we cannot afford to ignore: how does our approach to working with the mother influence this repeated cycle in which the family and workers remain perpetually stuck?

The child's timeline comes first

Social care dropped in and out of Amy's life after her first child was taken into care. Her attendance at contact was poor and she shortly fell pregnant during the time Adam was being placed for adoption where the pre-birth assessment along with local authority input ceased when she had a miscarriage. During this assessment, we worked with Amy to consider accessing services and her leaving care worker referred her to a domestic violence advocate, all of which she initially agreed to but never sought to engage with. The lack of change in her parenting capacity was not unexpected since she had not obtained any of the support services recommended and perhaps did not have the chance to with the discrete and intermittent periods of interaction with social services. The Children and Families Act 2014 now requires that all care, supervision and other proceedings must be completed within 26 weeks (UK Department for Education, 2014a)**.** An extension can be considered, although social workers must have strong justification for applying for one (Barlow, Dawe, Coe & Harnett, 2015). This, however, cannot be at the expense of the child's developmental timeframe (Munro, 2011). Speculatively, even if Amy had taken up these services there are doubts that she would have made enough significant change in the timeframe required due to the complexity of her needs.

While pre-birth assessments should start by 20 weeks of the pregnancy, if not earlier (London Safeguarding Children Board, 2015), social work professionals may delay the start of a pre-birth assessment due to prioritising other high risk cases and emergency situations (Hodson, 2012). This can lead to inadequate, incomplete assessments (Calder, 2013). Yet there is a strong argument for assessments and court proceedings to be carried out faster and for adoption placements to happen more quickly to ensure the adequate development and continued well-being of the child (Narey, 2011). The recent 1001 Critical Days Manifesto highlights the importance of a child's life from the moment it is conceived, and is currently

championing services for the pregnant mother from conception (All Party Parliamentary Group, 2015). However, for mothers with a history of losses to care, there is a question as to whether support needs to be put in place even before the mother conceives again and perhaps even as early as the point of removal if we are to give mothers the opportunity to make significant parental change for the benefit of future children and indeed for the mother herself.

Parent's rights in the process

While there is an argument for parental rights under the Human Rights Act 1998 (UK Home Office, 1998) to be considered when a child is being removed, particularly with regard to their views around contact (Sellick, 2007; Young & Neil, 2004), the European Court of Human Rights has never challenged the paramountcy principle over parental rights (Narey, 2011). However, Section 1 of the Adoption Act 1976 requires local authorities to provide services to the parents and guardians of such children who may have been or may be adopted (Charlton, Crank, Kansara & Oliver, 1998). The implementation of the Adoption and Children Act 2002 has increased birth relatives' rights to support services when a child is adopted, yet this has not always been followed through (Cossar & Neil, 2010; Triseliotis, Feast & Kyle, 2005). This highlights the lack of support for birthparents stuck in this cycle, despite being lawfully entitled to it. Furthermore, Broadhurst et al. (2015) stress that there is no requirement for adoption agencies to address the complex needs of mothers whose children are in care.

Policies and procedures are required to be prescriptive and pragmatic to avoid misinterpretation, confusion and chaos, especially when dealing with the upmost importance of children's wellbeing and safety. It is the challenging task of the social worker to somehow keep to the fore procedures and their duties simultaneous to connecting with families on a personal, human level. The unnatural shift from discussing the prescriptive nature of policies

to exploring the needs of the mother on a psychosocial level, which follows next, perhaps reflects the dichotomy of the real life dilemma social workers are faced with on a daily basis.

Post removal: The meaning of the next pregnancy and the impact on future children

With both workers and families remaining stuck in the successive removal cycle, it is important to explore the meaning of the pregnancy and the extent to which the birthmother's experience of losing her child to care impacts the next pregnancy and future children. Understanding the experience of the bereft mother could help inform the assessment of the next child and prompt social workers to consider how they impact this repeated cycle.

Motherhood and pregnancy

There are many and varied reasons why a woman desires to become pregnant, from cultural, social to personal and psychological reasons to name a few, and this can be very individualised for each woman (Feeney, Hohaus, Noller, & Alexander, 2001; Raphael-Leff, 2001a). However, there are also unintended and unwanted pregnancies resulting from women subjected to domestic violence, sexual abuse and rape (Keeling, Birch & Green, 2004; Welch & Mason, 2007). A biological, evolutionary perspective would state that we are programmed to procreate as "survival machines" (Dawkins 2006, p. 21). Historically, from a feminist, gendered perspective, motherhood is a principal social role women must fulfil in a patriarchal society (Gillespie, 2000). Although this landscape has gradually changed over time, with social and technological advances such as the availability and use of contraception, which has given women the option to remain childless (Raphael-Leff, 2001a), the ideology of femininity is still strongly linked to motherhood (Gillespie, 2000; Malacrida & Boulton, 2012). There is, however, an argument for a more internal, personal drive to have a child. Brazelton and Cramer (1991) suggest that unmet needs from childhood and

adolescence are part of the desire to become pregnant. A number of studies on teen pregnancies reinforce this view: research showed that having a child was filling an emotional void due to lack of attachments throughout their lives (Connolly, Heifetz & Bohr, 2012). In one study the meaning of the pregnancy was also linked to young mothers' experience of childhood: these women viewed becoming a mother as a form of healing from the lack of connection they desired from their own mothers (Middleton, 2011). Therefore having a baby for some women was seen as a way of gaining a meaningful relationship (Connolly et al., 2012) and gave young women a sense of achievement, identity and intimacy (Musick, 1993). On reflection, if I had asked Amy what the meaning of her child was to her, it could have given me a greater understanding of her needs and expectations, and how this might impact her child. This knowledge could enable the worker to explore any fantastical expectations (Raphael-Leff, 2001b), and to prepare the mother for the reality of having a new born child. Perhaps in addition to the extensive, albeit vital list of questions recommended for pre-birth assessments (Calder, 2013), the meaning of the child to the mother is a fundamental question we should consider as core to understanding the mother-child relationship.

When a mother undergoes the removal of her child, a number of losses ensue from the separation. Three areas of loss will be explored: trauma and loss, ambiguous loss and loss of identity. All appeared to be present in Amy's experience. Following this, the meaning of subsequent pregnancies after losing a child to care or adoption will be examined.

Trauma and loss

After Adam was taken into care, there were reports of three hospital admissions where Amy had ingested a high number of tablets, highlighting the trauma she experienced due to losing her child. She continued to drink, smoke heavily and use cannabis.

Trauma is defined as a type of unusual loss; however, there are also losses that do not constitute as trauma (Harvey & Miller, 2000). There are a number of studies that evidence

the detriment to the psychological wellbeing of birthmothers due to the loss of a child to adoption (Charlton et al.,1998; Fravel, McRoy & Grotevant, 2000; Neil, 2013), and that trauma arises in parents from compulsory removals (Battle, Bendit & Gray, 2014). Winkler and van Keppel's (1984) study also demonstrates that the biological mother's mental health may deteriorate further over time after giving up a child for adoption. While some of these studies generally focus on mothers relinquishing their children for adoption, parallels have been drawn from the studies carried out on the impact of the traumatic experience of the birthmother who is forcibly separated from her child (Charlton et al., 1998; Jenkins & Norman, 1972; Schofield et al., 2011).

The combination of the trauma of separation and loss with an often traumatic court process (Buchannan, Hunt, Bretherton & Bream, 2001; Charlton et al., 1998; Schofield et al., 2011) can further impact the mother's mental health and her emotional wellbeing. When we consider Amy and other mothers who fell pregnant before the court process concerning her first child concluded, it raises additional concerns for the development of the foetus due to evidenced links between the wellbeing of the mother and the unborn child (Cairns, 2002). Research shows that the stress hormone cortisol is able to traverse the placenta, overwhelming the foetus' capacity to regulate its own stress response, impacting its development (All Party Parliamentary Group, 2015).

It is important to note that some parents' resilience is stronger than others (Broadhurst & Mason, 2014) and some are more determined to prove to social services that they are able to look after their children, for example, by fighting their addictions to drugs and alcohol (Schofield et al., 2011). These parents may experience reunification with their child or are able to care for their other children or future children. Yet, for those who remain in the cycle of removal and repeat care proceedings is it likely that the impact of the traumatic experience will influence parents' use of drugs and alcohol to cope (Neil et al., 2010, Schofield et al., 2011). Here the foetus is not only exposed to the mother's emotional turmoil

but also the increase in harmful substances (Cairns, 2002). This results in social workers focusing on a removal at birth rather than trying to keep families together, as the development of the unborn is now potentially at even greater risk (Grant, Graham, Ernst, Peavy & Brown, 2014) than the previous child who was removed. Burgheim (2005) stresses that if practitioners expect mothers to put the needs of their children first, then they need greater support for their grief and trauma. However, the complexity of the loss of the child who remains alive is ambiguous and this freezes the grief process (Boss, 1999).

Ambiguous loss

Boss (2007) describes ambiguous loss as one that remains unclear, leaving the parent traumatised due to the uncertainty or lack of information about the whereabouts or status of their child as absent or present. In addition, Boss (2006) coined the phrase “boundary ambiguity” (p. 12), where there is a lack of clarity as to who is in and who is out of the family system, which causes further distress to the mother. This was very much the case for Amy, who flitted between feeling sad and angry that she had forever lost her son, and being hopeful she could get him back at the final adoption hearing. The stress and anxiety of this ambiguity may encourage denial of loss, leading to more crises (Boss, 2006) and blocking the ability to cope (Boss, 2010).

Amy’s engagement with both health and social care practitioners was sporadic. It is possible that these inconsistent professional relationships re-enacted this boundary ambiguity whereby workers came in and out of Amy’s life without any formalised closure to the work. When the case was transferred from us to another team, there was no means of contacting Amy at the time as she had turned off her mobile phone and temporarily switched to using another number unknown to us, and had not told anyone where she was residing. However, no preparatory work had been undertaken with her to acknowledge ending the working relationship with one team and transitioning to another. We see here repeated patterns of

unclear relationships between Amy and different workers, which can distress or traumatise families further due to the “human need for finality” (Boss, 2006, p. 106).

Howe, Sawbridge and Hinings (1992) highlight that when a child is adopted, support offered is often mistimed when a mother is in shock, yet by the time the “numbness” (p. 119) had worn off and she was ready to accept support, the agency had ceased contact. Perhaps we can also draw parallels between Amy’s futile hope of Adam returning to her care and Bowlby’s (1998) representation of parents who are in the stage of disbelief when their child has a terminal illness. He suggests that when the disbelief is strongly asserted, the mother may not be ready to undergo therapy, suggesting a reason why Amy may have chosen not to engage in counselling.

Social workers are faced with the dilemma that a mother may fall pregnant again before accepting her child was taken from her care, and thereby refuting that she could not adequately care for the child. In order that mothers can utilise therapy and other services to aid their recovery, Burgheim (2005) stresses that “parents need to know the full reality of what has happened, not meaningless hope which they cling to and therefore do not accept reality of the grief” (p. 59). Consequently, a worker’s avoidance of honesty regarding the loss of the previous child for the mother and the exacerbation of ambiguous relationships may lengthen the mother’s recovery process; thus widening the gap between the next child’s developmental timeframe and the timeframe of the mother’s rehabilitative needs.

Loss of identity and stigma

In addition to the mother’s own internal struggle to grieve, she is further blighted by public blame and shame from society who view her grief as unacceptable, deeming her at fault for losing her child (Robinson, 2002; Schofield et al., 2011; Wells, 2011). The concept “disenfranchised grief” (Doka, 2002, p. 5) where grief is not socially supported or culturally acknowledged has been widely used to describe the stigma attached to the failed birthparent

(Broadhurst et al., 2015; Neil et al., 2010; Robinson, 2002; Schofield et al., 2011). Studies show that the stigma and disenfranchised grief the birthmother experiences results in shame, secrecy, low self-esteem and self-worth (Winkler & Van Keppel, 1984) and long term psychological damage (Broadhurst & Mason, 2013; Logan, 1996).

From a social constructionist perspective, the mother's disenfranchised grief is coupled with the loss of her parent identity: a construct formed from society's moral judgements (Schofield et al., 2011). For many women, being a good mother can form the moral presentation of self (May, 2008). Gustafson (2005) uses the term "unbecoming mothers" (p. 1) to describe the binary polarisation of women who have fallen from being a typically good mother to the socially shameful position of a bad mother or even a non-mother. The public nature of losing the status of being a good mother results in what Goffman (1963) calls a "spoiled identity" (Sykes, 2011, p. 448). Conversely, Winnicott's (1953) concept of the "good enough" (p. 93) mother challenges the idealisation of the good mother. However, these mothers are assessed by social workers and the courts as not even 'good enough' as they have failed to adequately care for their children. Therefore it is vital that support and rehabilitation required to overcome the stigma and guilt the mother experiences from the social worker comes from an agency not associated with children's services.

Humans are social beings and have an inherent need to belong to a social group or society (Howe, 2011). Yet acceptance in a group is based on how well we can present ourselves as moral actors (Goffman 1959; May 2008). Thus with the stigma of deserving to lose her child and the threat to her identity (Breakwell, 1986) as a parent, comes the social isolation (Burgheim, 2005; Kielty, 2008). The only person left in Amy's life was her abusive partner who held power and control over her, adding to her isolation. I suspect Amy felt social workers threatened her identity and caused her segregation from others: Amy was a mother who was paradoxically without a child, and when she was taken into care herself, she was a child without parents and siblings. She was often very angry and blamed social services for

losing her family as a child, and for taking her first child away. She was also now angry that we were repeating the process with her unborn child as well as trying to encourage her to leave her partner. Breakwell (1986) posits a number of strategies individuals employ for coping with a threatened identity, and one that appeared to resonate with Amy's behaviour, was signs of negativism which can lead to conflict in order to defend one's identity or self-esteem. Furthermore, Wells (2011) notes that aggression and self-defeating behaviour can result from a lack of resources to cope with the demands of the stigma, which can reduce socially acceptable behaviour. Thus with each loss the relationship between mother and children's services can deteriorate. The mother's psychological wellbeing and behaviour may worsen and the further the mother's identity is threatened, the more resistant or confrontational she becomes towards intervening social workers (Sykes, 2011), increasing further concerns for the next child (Holland, 2000). When practitioners begin to feel hopeless about a case (Wiltse, 1958) they must be mindful not to blame and pathologise the mother when interactions are adversarial (Daniel, 2005). This can further stigmatise mothers, and workers may lose sight of strength-based practice due to our own sense of hopelessness or failure (Daniel, 2005).

The meaning of subsequent pregnancies

For some women there is an ambivalence to their child once he or she is born (Hoffman, 2003; Raphael-Leff, 2001b) and the reality of caring for an infant may not live up to the fantasy of the pregnancy (Brazelton & Cramer, 1991; Raphael-Leff, 2001a). Reports regarding Amy's care of Adam stated that she would prefer someone else to hold him and play with him. His clothes were dirty and she would shout at Adam when she thought she was unobserved, contradicting the moments when she was seen to be caring and loving towards him. Burgheim (2005) suggests that this ambivalence is not based on whether a mother loves her child but on the child not fulfilling her dream of family love. While this may be the case, it does not explain why Amy continued to try for another baby if Adam had not given her the family love she desired.

The birthmother who has experienced loss through the removal of her child needs to find a way to rebuild her life. With such low resilience (Boss, 2006), reclaiming the loss of her child, regaining her identity, re-establishing a family and community, and rebuilding her self-esteem may seem an overwhelmingly impossible task. In the past, women who suffered a perinatal loss were told to have another baby, which led Cain and Cain (1964) to develop the concept of “the replacement child” (p. 443) as a direct substitute for the previous child. Grout, Bronna and Romanoff (2000) refute the notion of the replacement child, proposing that the next child is way to cope with the feelings of emptiness, and that the child is still deemed a person in his or her own right. Either way we can surmise that one way the birthmother might cope with the loss of her child, her own identity and community, is to have another baby (Broadhurst et al., 2015; Grant et al., 2011; Memarnia, 2014).

Considering the notion of loss and trauma, Van der Kolk (1989) proposes that some people unconsciously experience a compulsion to repeat trauma to gain a mastery over the initial trauma yet when this does not happen, it results in prolonged feelings of helplessness and experiencing themselves as bad and uncontrollable. He also notes that traumatised individuals repeat familiar behaviours and patterns in times of distress, regardless of painful consequences. In a similar vein, becoming pregnant again to gain attention from various professionals and services may serve as an temporary way to cope with the isolation and vulnerability (Gordon, 2014) even though the mother knows that these professionals may remove the next child and that she will ultimately become isolated again. While these notions may or may not form part of the reason for Amy’s pregnancy, she stated that with this child she wanted ‘to get it right this time’. This motive resonates with previously documented views from a mother whose reason to have another child was “to get it just right this time” (Raphael-Leff, 2001b, p. 12). It is interesting to highlight the parallels this has with what social workers may experience in their work. For example, workers can be hopeful and passionate about a new case but become more hopeless and give up as crises, concerns

and blocks to keeping the family together arises (Daniel, 2005). Yet practitioners resume motivation for the next new case, hoping to make a difference this time. Similar is the mother, who is excited about the next pregnancy and getting it right this time, but as things continue to go wrong during pregnancy or postnatally, she too may give up. It seems important for the worker to understand their own and the mother's experience and for both to remain hopeful, which was seen as a key factor in a study where mothers had turned their lives around (Broadhurst & Mason, 2014). Yet the balance between hope for the family unit and fear of risk to the child is difficult for child protection workers to maintain when their focus is the safety and wellbeing of the child.

Impact on the next child

When a mother falls pregnant again after losing her child to care, the traumatic experience of loss, the impact on her psychological wellbeing, her isolation and negative behaviours cumulatively result in concerns for the development and wellbeing of the foetus (Cairns, 2002; Rothman, 1990). Brazelton and Cramer (1999) suggest that even after birth, the mother-infant pair must initially be cared for as one unit due to the interdependence on each other. Thus while we save the existing child from harm, the prospects for the next child are even bleaker since we are not addressing the needs of the mother. With each removal there is an added layer of trauma to the mother and further loss of identity, relationships and self-esteem: a downward cycle that becomes harder to break. Social workers may also feel trapped in this vicious circle of repeatedly removing the next child, knowing this might cause further decline in the mother's well-being and aware that this may not be the last child they will have to remove from her (Blazey & Persson, 2010). The time limits on assessments and court proceedings are there to meet the timeframes of the child, but this is often not enough time to rehabilitate the mother once she is pregnant again. This highlights the need to address the mother's rehabilitative need before the next child is conceived.

Addressing the needs of the mother

No money, no time, no resources: whose role is it anyway?

Historically and still prevalent today, the rehabilitative needs of birthmothers fall outside the remit of statutory services (Broadhurst & Mason, 2013). With funding an issue in today's economic climate (Munro, 2015; Puffet, 2015; Stevenson, 2015), high caseloads and extreme pressures from rising referrals (Donovan, 2014; Munro, 2015), social workers' priorities and duties lie with other children at risk on their caseload ahead of tending to a bereft mother's needs. Contentiously, Narey (2009) goes one step further stating that social workers should focus on putting more children in care and less on "fixing families" (p. 181). However, when the same birthmother becomes pregnant again, money, time and resources are repeatedly consumed and caseloads increase, suggesting that workers need to address the needs of the mother as well as the needs of the child. Yet when parents blame and take out their anger on social workers (Charlton et al., 1998; Schofield et al., 2011), and mothers feel relief when contact with the adoption team has ended (Howe et al., 1992), it appears that the mother is reluctant to engage with the child's case worker. Contrary to this, Schofield et al. (2011) argue that the mother's anger is only part of the complex emotional picture and it does not mean she wishes contact to stop with social workers. However, Amy's choice to switch off her phone or not inform us of her living arrangements implies that it is unlikely that the mother will trust or engage with the social worker who proposes the removal of her child. Adoption teams are often seen as extensions of child protection teams and therefore parents do not feel they can trust them either (Neil, 2013; Sellick, 2007). Studies show that mothers felt their needs were never looked at and that they were seen as the poor relation of the adoption triangle, with workers focusing solely on the child and their new adoptive parents (Logan, 1996; Triseliotis et al., 2005). These tensions in the relationship between practitioner and mother suggest that the child's case worker may not be the best person to aid her rehabilitation.

Long withstanding is the notion that there is a need for an independent post removal service for parents (Broadhurst & Mason, 2013; Charlton et al., 1998; Neil et al., 2010). Encouragingly, in recent years a number of pilot schemes for independent teams have received funding to carry out work with mothers who have had their children removed from their care. Most prominent in the media and fast growing is 'Pause', with the flagship service piloted in Hackney and funding secured for 6 other sites nationwide (Pause, 2015). Other pockets of innovation and pilot schemes have been emerging such as 'Support For Change' (Tri-borough, 2015) and Suffolk County Council's 'Positive Choices' (Cox, 2012). Similar schemes have been carried out in Australia (Battle et al., 2014) and the United States (Grant et al., 2014). These independent teams are able to focus on the needs of the parent, from a seemingly non-threatening or biased position since they are unconnected with children's services. However, many of these projects are in their infancy with results and evidence yet to be fully formed to conclude whether they will have a sustainable impact on avoiding future, successive removals.

Currently, few local authorities offer an independent post removal agency. It is statutory services who will always remain and hold much influence, being the lead agency from the point of the referral to adoption. Therefore it is necessary to consider the role and impact of statutory services in this cycle of repeat losses to care. Before focusing on a deeper exploration of the role of the social worker across the whole cycle, the interventions from these innovative post removal agencies will be briefly considered to determine their compatibility with social work practice.

Interventions post removal

Support For Change (Tri-Borough, 2015) and Pause (2015) both stress that engagement is crucial to the success of their projects. A recent study found that a key aspect for women who were able to make significant change in their lives after losing their child to care was the

quality of the worker-mother relationship (Broadhurst & Mason, 2014). While this was a relatively small scale study in which change occurred for 11 out of 26 participants, similar successful social work practice has been evidenced (Gladstone et al., 2012; Turney, 2012). Yet more specifically in child protection practice, it is typical for workers to be faced with resistant, hostile, non-compliant parents and have to deal with manipulation and deception (Tuck, 2013), making it extremely difficult to engage and build positive working relationships with parents. The stark difference between these independent agencies and children's statutory services is that the mother-worker relationship can flourish more easily when decisions about a child's welfare is not at stake.

The necessity of grief counselling for parents post adoption has longstanding been recognised in the UK and internationally (Betz & Thorngren, 2006; Boss, 2006; Broadhurst et al., 2015; Charlton et al., 1998; Jenkins and Norman, 1972). The 2014 adoption statutory guidance (UK Department for Education, 2014b) acknowledges that mothers may not wish to engage with counselling initially and that statutory adoption teams must ensure this service is offered at a later date. To work with stigma and shame, the therapeutic relationship requires a non-judgemental approach (Robinson, 2002) and a "stance of respectful neutrality" (Battle et al., 2014, p. 331). The statutory guidance stresses that counselling services offered to parents need to be delivered by someone independent from the child's case (UK Department for Education, 2014b), which would serve to alleviate barriers from the stigma and shame formed from the person who they deemed to have judged them, and with whom they associate the traumatic experience.

Boss (2006) highlights the need for group and community based interventions to decrease the sense of isolation from ambiguous loss, stating that "human connections are severed so it follows that treatment must also centre on human connections" (p. 37). Health and social care professionals refer mothers to antenatal classes, parenting classes and children centres. After losing her child to care, the mother is excluded from these support networks

and groups. Therefore, mothers might be reluctant to participate in group activities for women without children: these groups may increase a mother's threat to her identity and shame of the stigma (Sykes, 2011), serving as a reminder that she no longer belongs to the parent group (Charon, 2010). However, research shows that group work for birthmothers without children is vital to developing support networks and practising new behaviours in safety (Battle et al., 2014). Pause (2015) stress that they do not offer parenting classes but offer group activities to rebuild women's personal narrative to see themselves as a person and not just as a mother. It seems here that both social workers and post removal teams are offering necessary, timely groups that may appear conflictual to the parent.

Working through grief and loss is a key element of rehabilitation but it is also essential to address the complex needs of these women (Broadhurst & Mason, 2013), for example, mental illness (Coombe, 2012), learning disabilities (Gould & Dodd, 2014), or as in Amy's case, substance misuse and domestic abuse (Cleaver, Unell & Aldgate, 2011). Domestic violence has been an issue in 71% of the cases for repeat removals in Hackney (Pause, 2015). A new pilot called 'Action For Change' focusing on women who have lost their children to care, who remain in domestic abusive relationships, is being launched this year by the team who set up Support for Change (Tri-Borough, 2015). These mothers also often present with co-occurring psychological disorders with substance misuse (Grant et al., 2014). A fundamental part of the social worker's role is to assess for such psychological and physiological needs and to make referrals to specialist teams. However, parents do not always engage with these services, which may go against them in the child and family assessment due to lack of compliance (Holland, 2000). Yet it is understandable that Amy, under the power and control of her partner, disengaged with the domestic violence advocate (Coy & Kelly, 2011). Practitioners need to work collaboratively both with other agencies and parents over time to access services (Cleaver et al. 2011).

Aside from rehabilitation, preventative interventions regarding sexual education and contraception have been the focus of discussion (Broadhurst et al., 2015; Cox, 2012), since a key issue is that women fall pregnant again before they have had the chance for rehabilitation, as was the case for Amy. Studies in the United States, with a focus on substance-abusing mothers, showed that these mothers were more likely to have a subsequent birth shortly after losing their child to care (Grant et al., 2011). For young mothers there appears to be a sense of urgency to become a mother with an unusual acceleration of timeframes (Middleton 2011) which may skew their judgement to take time out to work on their own needs before having another child. Sex and contraception education has been recommended to reduce pregnancies especially among young women (UNICEF, 2003) and therefore this method of intervention has been proposed to assist in avoiding repeat pregnancies for women who have had their children forcibly removed (Cox, 2012). However, research shows that this form of education has not effectively reduced teenage pregnancies (Schunmann & Glasier, 2006). Similarly, if we recall the possible reasons a mother desires to have a subsequent pregnancy after the removal of her child, this may render sex education somewhat redundant. Some post removal pilot schemes are inviting women to opt to take long term acting contraception (LARC) as a temporary measure to prevent pregnancies so these women can focus on their own needs and rebuild their lives to avoid another removal at birth (Pause, 2015). Part of the work around this is to educate women on sex and birth control so they can make an informed decision whether to use this form of temporary sterilisation. But of equal importance is careful consideration of women in abusive relationships where pregnancy coercion and birth control sabotage are key factors (Miller et al., 2010), or where women actively refrain from using contraception, for example, for religious reasons (Srikanthan & Reid, 2008). Interestingly, since the pilot began 18 months ago, none of the mothers supported by Pause have had a repeat pregnancy as those who choose to partake in the scheme must agree to using LARC (Pause, 2015). While Pause is a far cry from Project Prevention (2015) who pay female drug addicts to be sterilised, there are questions regarding the ethicality of targeting specific social groups to

prevent pregnancy and the autonomy and choice of these women (Broadhurst et al., 2015; Cox, 2012). Broadhurst et al. (2015) note the need for all health and social care practitioners to be careful not to be tempted to pressure these mothers into delaying or preventing another pregnancy due to the cost to the public purse of another child being taken into care.

While there is hope that these post removal support agencies will prove effective and be funded nationally, previous, successful pilot projects in the nineties were unable to maintain further funding such as 'Parents Without Children' and 'Before Adoption' based in Durham and Manchester respectively (Charlton et al., 1998). Furthermore, funding activities for these women such as horse riding and go-karting (Pause, 2015) may cause controversy, especially when there are cuts to public spending such as the NHS's sexual health advice and provision; with fears that the number of unplanned pregnancies is likely to rise (Mason, 2015). Sophie Humphreys, the co-founder of Pause, unapologetically advocates the need for such activities as part of building mothers' personal narratives and rehabilitation (BBC, 2014). The end goal is not to assist mothers to get their child back (Pause, 2015), but to help these women see themselves as individuals and not dependent upon having another child to give meaning to their lives (Hill, 2014; Tri-Borough, 2015). As a result, Pause (2015) give projected estimates of saving approximately half the cost of removing children into care over a 5 year period from their current 5 sites, with potential savings of around £10 million. The project is backed by former Judge Nick Crichton, the founder of the Family Drug and Alcohol Court (FDAC) (Pause, 2015), a therapeutic court whose intentions are to reunite parent and child where possible (Bambrough, Shaw & Kershaw, 2014). While the outcomes of these two services may seem at odds, they can be seen as complementary services to each other, both relevant to the needs of the family at different points in the cycle. There is, however, a vast gap in this unity of services, namely the role of statutory services, who play a key role in working with parents whose children are subject to care proceedings. Therefore, there is a need to look at how statutory services might complement FDAC and independent post

removal teams and vice versa, if we are to collectively avoid multiple, successive removals at birth.

Implications for social work practice

> Prevention…does not occur only at a single point in time but rather can be conceptualised as applicable along a continuum.
>
> Jenkins and Norman, 1972, p. 259

With the possibility of an independent post removal service coming to the fore and the development of FDAC nationwide (Harwin, Alrouh, Ryan & Tunnard, 2014), the already overstretched children's social worker (Action for Children, 2015) may breathe a sigh of relief that the rehabilitation of the parent is not just another role required of them. While both Cox (2012) and Broadhurst and Mason (2013) highlight the need for a national conversation and national change in policies to address this cycle of successive removals, there remains a key area underexplored in the literature: the impact and role statutory children's services have on the cycle. It would be beneficial to offer consistency and support throughout the assessment process, right through to adoption for parents to assist in breaking the cycle. While not discounting Narey's (2009) view of child protection services needing to focus more on children being placed in care, Triseliotis et al. (1993) rationalise that supporting parents while protecting children are "neither incompatible objectives to pursue nor conflict free approaches" (p. 216). In addition to this argument, re-evaluating how social workers assess and remove an existing child from the mother may assist the reduction of unnecessary damage to any future children. By considering the impact social workers have on each of the three areas of loss the birthmother experiences, implications and recommendations for social work practice will be discussed.

Worker-parent relationship: are we adding to the trauma of the loss?

Triseliotis et al. (1993) highlight the importance of lessening the separation distress and therefore the subsequent trauma of both parent and child. They discuss the paradox faced by social workers of the pressure to hasten their pace in ensuring an abuser is convicted, but conversely, the process of separation and provisions for this must not be hurried. Burgheim (2005) highlights the need for the birthparent to be made fully aware of permanency planning. While the shock and disbelief of losing their child would still be present, assisting parents in the preparation for removals and permanency may soften the impact of the trauma, or at the very least, provide time and space for families to process the likelihood of separation. Even before a child protection case reaches high levels of concern or court proceedings, Ghaffar, Manby and Race (2012) found that families were not routinely given written information about child protection procedures: parents described their lack of understanding of the process and how their stress and anxiety in the early stages, affected their ability to take in and retain information. Furthermore, birthmothers felt betrayed by workers who were encouraging about their chances to keep their child and then were shocked and ill-equipped when they were suddenly told the opposite (Neil et al., 2010). At such a highly stressful and emotional time for mothers, transparency from the practitioner is vital to the mother's psychological wellbeing and the relationship between worker and mother (Healy & Darlington, 2009).

Research suggests that most social workers recognise that the loss of a child to care is traumatic for parents and that they specifically understand how difficult court and contact experiences can be for parents (Schofield et al., 2011). Yet the same study revealed that many of these parents did not feel understood by social workers, who were seen as "representing the 'authorities', being too distant, too young, too educated or as talking from a textbook" (Schofield et al., 2011, p. 16). Perhaps it would be prudent to consider the importance of not just having the capacity to empathise (Forrester, Kershaw, Moss & Hughes, 2008), but whether the client *perceives* empathy (Rogers, 1957) in order to facilitate

engagement and develop good working relationships. Parents need to feel understood before we can invite them to re-evaluate their social constructs of workers (Davis & Day, 2010). However, Lawrence (2004) points out that social workers' roles have been shaped through a judicial lens since the uncovering of misdiagnoses of abuse in the Cleveland report and failure of workers highlighted in Serious Case Reviews. Accordingly, the role of the social worker appeared to have shifted from a therapeutic one to "a 'soft' police role" (Lawrence, 2004 p. 71) in order to make defensible decisions and ensure forensic evidence is present for court. Yet this creates a stark misalignment with the therapeutic interventions of services post removal and ironically the therapeutic family courts. Therefore, parents may receive inconsistent interactions with professionals at a time when they are arguably most vulnerable, further fuelling the anxiety and stress of such a traumatic experience. Forrester et al. (2008) rightly point out that the role of the social worker is not that of a counsellor. Despite this, they postulate that social workers should be trained in counselling skills such as empathic listening and responding, in order to strengthen the level of trust and understanding in the mother-worker relationship. However, acquiring these therapeutic skills can be problematic. My training in both social work and humanistic counselling conflicted at times and it proved difficult for me to be both empathic towards Amy whilst focusing on the needs of her unborn child. Likewise, Schofield et al. (2011) note that children's services have struggled to establish a balance between recognising the parent's own support needs and remaining child-centred. Workers' fear of risk of failure (Fook & Gardner, 2007) may force practitioners to take a reductionist stance using technical rationality and procedurally dominated practice in the way they assess families and intervene (Ruch, 2005). Yet Gilligan (2004) stresses that without a "therapeutic alliance" (pg.97) nothing very productive will come from the helping relationship, thus locking us all back into the cycle of successive removals.

Endings and Transitions: how we impact ambiguous losses

Simultaneous to losing her child, the mother will lose support from health, social care and other children's services, yet she will attract attention when she is pregnant again. In Amy's case, her contradictory behaviours and actions towards professionals appeared to highlight the lack of trust or disillusionment she has experienced through her interactions with social workers since she was a child. Analysis of her insecure attachment behaviours (Ainsworth, 1978) may suggest she might have wished for contact even though she became angry and withdrew from us. Her only source of support was her abusive partner and a sudden rush of professionals swooping in when she became pregnant again. Furthermore the lack of consistency and stop-start nature of services adds to the boundary ambiguity (Boss, 2006), all of which feed into her insecure attachments.

Gilligan (2004) effectively explains Harris' (1993) metaphor that "help may be more valuable coming in the form of a 'milk van' (low key, discreet, inobtrusive, nurturing, regular, reliable, long term) rather than a 'fire brigade' (sudden, one off, invasive, crisis driven, hyped)" (p. 97), and this constant, reliable form of support enables a trusting therapeutic alliance to develop over time. In taking this metaphorical approach, it intimates that there is some validity in social workers retaining some form of contact with the birthmother even after her child has been taken into care. But through a rights-based lens, this raises the dilemma that at what point does continuous support become intrusive of family life (Brammer, 2010), especially when the parent appears to not want to engage? In practice, lack of funding has prevented workers maintaining a long-term therapeutic alliance with families (Triseliotis et al., 1993). Furthermore, with the requirement for the parent to be supported by an independent worker separate from the child protection team, the social worker's role would become redundant at this point. Perhaps what is just as important to consider is greater emphasis on endings and transitions and how these are managed between worker and mother.

Endings within social work practice have not been widely addressed (Coulshed & Orme, 2006), particularly in comparison with other therapeutic practices (Huntley, 2002). When considering the complex feelings of loss Amy encountered throughout her life, positive endings have not been a feature for her. The traumatic experience of ending for clients can reactivate past trauma, and individuals with anxious attachments are affected even more so by poorly managed endings (Huntley, 2002). Amy stopped attending contact a significant length of time before adoption proceedings took place and she did not say goodbye to Adam. While research shows that continuing access between the biological mother and child positively impacts the child's mental health (McWey, Acock & Porter, 2010) and sense of identity (Triseliotis et al., 1993), and helps to reduce separation distress in both parent and child (Neil, 2013), it is most commonly the birthparent who ceases contact, perhaps partly due to the difficult feelings associated with it (Cossar & Neil, 2010). It is important for workers to acknowledge and prepare for endings in advance with parents especially if they are to be separated from their child. This is so that the family can replicate managing endings as best as they can for both the child and parent's sake. However, in reality this is much more difficult to achieve, particularly when working with hostile or hard to reach families. It may be easier and a relief to avoid further contact (Ferguson, 2011; Ward, 1984), especially if workers themselves have not experienced positive endings in their own lives. Furthermore, as with Amy, who denied herself and us an ending by being uncontactable, leaving messages to acknowledge the end of our working together and to say goodbye, even if is not face to face, maybe the best we can hope for. However, in light of the reviewed literature, advanced thought in preparation for managing the ending could have elicited a different response from Amy.

Preparation for endings could also factor in the transition from one agency or worker to the next to prevent the shock of isolation or abandonment the parent feels when services are terminated. Howe et al. (1992) note that the mother may struggle to form a working relationship with a new agency. Joint visits between other services and statutory services

prior to the ending could allow for smoother transitions and parents feeling contained (Bion, 1962). It has been argued that when too many professionals are involved, it can enhance the parent's sense of failure in their own ability to parent (Asen & Schuff, 2004). Conversely, independent teams may not want to be associated with the negatively viewed social worker and prefer to meet the parent alone. Perhaps this is where partnership working with mothers is key to exploring how they would wish to manage the ending and transition to another service (Davis & Day, 2010). Agencies must also work in partnership with each other to judge what services are required (Cleaver et. al., 2011) and the appropriateness of the timing of support across the cycle, even beyond adoption (Sellick, 2007). This could help reduce ambiguous loss and ensure parents are supported on a continuum.

The next assessment: stigma and loss of identity causing non-compliance

Prior to meeting Amy, I had already formed preconceptions regarding her parental capacity based on the information I received about the case regarding her loss of Adam. While family history and functioning has a central role in an assessment (Horwath, 2010) the pregnant mother automatically faces further stigmatisation as a result. Furthermore, workers' constructs appear to be validated when the mother appears to be neglectful of her child due to her disengagement with services and non-compliance with child protection plans, thus leading to repeat care proceedings (Harris, 2012). Sykes (2011) interviewed neglectful mothers who highly praised their own parenting skills and suggests that "identity maintenance" (p. 451) pushes mothers to disassociate themselves from a neglectful parent image. This threat to identity causes psychological stress, anxiety and lowers self-esteem (Schofield et al., 2011). To alleviate these feelings, thoughts or behaviours are distorted or denied to experience the world more consistently and to protect the self-concept (Rogers, 1951), resulting in cognitive dissonance (Schofield et al., 2011).

Wells (2011) suggests that maternal-identity construction presents an enormous, and often underestimated task for practitioners to work with. Workers may not fully recognise the deep trauma of the experience for birthmothers (Logan, 1996) thus fuelling their disenfranchised grief. Additionally, practitioners need to recognise how mothers experience being labelled negatively. Sykes (2011) calls for a move away from workers wanting mothers to accept stigmatising labels of being neglectful parents and abandoning their positive parental identity to show their capacity for change in an assessment. In practice, it is difficult to separate the mother's experience of stigma from her lack of responsibility and repeated negative behaviours which are detrimental to the child. Strength-based practice, combined with breaking down social constructs is a possible way to address this issue (Davis & Day, 2010).

Recommendations for Practice

Building positive working relationships and engagement are seen as central to working with the birthmother who loses her child to care (Blazely and Persson, 2006; Broadhurst and Mason, 2013; Schofield et al., 2011). This relationship-based practice is congruent with the ethos of independent post removal services (Broadhurst & Mason, 2014). Scott and Honner (2003) highlight substantial evidence for the value of engaging birthparents with children in care. However, there is a difficult complexity to this relationship where workers need to acknowledge and respect the mother's issues of grief and loss (Scott & Honner, 2003) and respond empathically, yet balance this with transparency of the outcome of care proceedings and permanency planning (Burgheim, 2005). It is extremely difficult for social workers to hold in mind the duties and procedures they are required to follow whilst working in partnership with parents of children at risk of harm (Lawrence, 2004). Despite this difficulty, parents of looked after children have voiced how positive the experience was when they felt the worker had succeeded in balancing these contradictory tasks (McCann, 2006).

Just as important as engagement is in a relationship, so is managing endings; and this is even more crucial with a mother who is to lose her child. Rather than responding just to the immediate situation by intervening and exiting, practitioners should take a longitudinal approach by preparing for endings and transitions in collaboration with parents and other support services, and regularly reflecting on how their input may impact the lives of the mother and her future children. Yet workers are bound by procedural policies, which highlights a wider need to shift policies and procedures from just creating task-centred and compartmentalised practice (Ruch, 2007a), to including a longitudinal approach which considers the impact to future children.

Key to managing this difficult balance of removing a child while being sensitive to the parents needs is for social workers to engage in reflective practice (Ruch, 2007b). It is important to reflect on a number of elements: our own social constructs, which impacts the stigmatisation the parent feels; how we manage risk and create ambiguity by jumping in and out of a family's life to intervene successfully, but with no thought of the aftermath; and how comfortable we feel about endings as there is a strong human tendency to avoid issues of loss and endings (Ward, 1984). For workers to feel safe to reflect openly, supportive supervision where the relationship between supervisor and supervisee models the relationship between worker and parent is crucial to the containment of the worker and consequently, the containment of the mother (Lanman, 1998). While this may not prevent the trauma of losing one's child, containing and easing the process is crucial to the overall approach that may help avoid repeat losses to care.

One way of working which could address a number of these complex issues is the Family Partnership Model (Davis & Day, 2010). This adaptable, evidence-based model has been successfully implemented in various setting in health and social care in the UK and Australia, including families with complex psychosocial circumstances and adversity (Day, Ellis & Harris, 2015). Drawing on a combination of Carl Roger's person centred approach to therapy

and Egan's skilled helper model, the aim is to work empathically yet purposefully with parents for the benefit of the child (Davis & Day, 2010). The helping process is structured yet flexible, focusing on engagement and understanding parents before breaking down social constructs on both the mother's and practitioner's part; whilst maintaining just as much emphasis on reviewing and endings with families (Day, Ellis & Harris, 2015). However, an evaluation of the approach showed that the sustainability of the model relies on adequate support for practitioners (Keatinge, Fowler & Briggs, 2007). Since then, this approach has been modified for supervision of workers (CPCS, 2011) ensuring that managers and supervisors model the positive partnership working with supervisees. Using this partnership approach across all levels could potentially lead to a collective way of taking a longitudinal approach to working with mothers who lose their children to care; an approach which is sensitive to the parents needs that avoids the fire brigade syndrome (Harris, 1993), while still ensuring the protection of their children as well as future children.

Future research

While exploring the role of the social worker in these successive removals through a case study has meant there has been a depth of analysis of one particular experience for one birthmother and practitioner, there are many limitations to this framework. There is much scope to carry out a wider scale, qualitative study incorporating both the views of the parent and the social worker, and accounting for a fair representation of ethnicity and culture within the UK. Although this paper has focused on the needs of the birthmother to avoid successive removals, there is just as much need to address the role of the birthfather.

There are a multitude of services involved in the cycle of successive removals which this paper has not been able to address in detail. The role of healthcare professionals which is a key service for mothers during pregnancy and birth, is being addressed by The 1001 Critical

Days Manifesto (All Party Parliamentary Group, 2015). While there have been more studies carried out on the role of the adoption team (Cossar & Neil, 2010), further work could be explored regarding the impact of contact between child and parent, reunification, and kinship placements on successive removals. There is also the possibility of examining the role of leaving care workers and the responsibilities of the state as a corporate parent in this cycle as a vast number of these women who fall pregnant are still under our care as young people themselves (Broadhurst et al., 2014), which further amplifies the need for a longitudinal approach.

Conclusion

A number of factors play an important role in the cycle of successive removals of children. There is an evident gap in services for parents after their child has been taken from their care, which is hopefully being addressed by the emergence of independent, post removal services. However, this needs to be disseminated nationally with the impact of repeat losses to care affecting time, workload and funding, and most importantly the lives of many children being separated from families at birth. Alongside the hope for a new agency nationwide is the need for child protection workers to reflect and consider the way in which they work with mothers. While changing our practice will not solve all problems or solely prevent successive births, our role as the lead agency contributes hugely to this cycle. Indeed, practitioners must remain child-centred but understand the various losses the birthmother suffers and to work sensitively with mothers throughout the removal process. Workers are also able to aid and facilitate gateways to other services and should strive to manage endings with families as much as engage with them, if we are to expect mothers to do the same with their children. Yet intervening with families to place children in care with an eye on both the immediate and long term impact will prove hard at grassroots level if managers and policies do not also adopt a longitudinal approach. There is a need for all professionals to work in partnership

with families on a continuum, taking into account the past, present and future of the family if we are to assist in avoiding future successive removals at birth for families like Amy and her children.

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