Centre for Child & Family Justice Research

Lancaster University

Vulnerable Birth Mothers and Recurrent Care Proceedings

Final Main Report

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1 Introduction - a problem with no name

1.1 Background and context

Social workers, family lawyers and judges have long recognised that some women to return court as respondents in care proceedings, having experienced the removal of a child in a previous set of care proceedings. A proportion of women are repeat clients of the family justice system and lose multiple children to public care and adoption. This causes untold distress to women, their partners, children and extended networks and in addition, places exceptional demands on services. Yet, prior to the study reported here, the scale of this problem was unknown and there was an absence of systematic analysis of the reasons behind women's return to court. Professor Pamela Cox has captured research and policy silence on this topic in her fitting description of repeat losses to care as "a problem with no name" (Cox, 2012).

In the same year, a network of concerned academics and practitioners brought together by Dr. Mike Shaw and Ms. Sophie Kershaw sparked something of a revolution in thinking about family court proceedings. A community of interest was first hosted by the Family Drug and Alcohol Court team, at the Tavistock and Portman NHS Foundation Trust, leading to the publication of a series of papers in Family Law in 2014 (Shaw et al., 2014; Harwin et al., 2014; Broadhurst and Mason, 2014). The subject of 'repeat removals' was firmly placed on policy and practitioner agendas, with searching questions raised about what more could be done to prevent this negative cycle.

In this report we document the findings from the first comprehensive study of recurrent care proceedings in England focused on birth mothers. Following a successful feasibility study that demonstrated the research value of national electronic records held centrally by the Children and Family Court Advisory and Support Service (Cafcass), the Nuffield Foundation granted further funding for a substantive 2-year study (2014-2016). Aiming to establish the first estimate of the scale of women's return to court and to understand the factors behind this, the study combined analyses of population-wide court records and in-depth interviews with birth mothers, with intensive reading of a large sub-set of court files. Further funding was provided by the Foundation (2016-2017) to support dissemination of the findings and to engage in further work with agencies to ensure maximum translation of key messages.

Some of the findings we present in this report will no doubt be difficult to hear, not least, that a sizeable proportion of the women identified as repeat clients have been in the care of the state as children themselves. From women's first person accounts, we report on the sensitive topics of reproductive decision-making and women's experiences of removal at birth. We also consider barriers to mental health services that foil women's self-help efforts after child removal. The study raises searching questions about the accountability of social work services and the courts to this marginal group of women, particularly in relation to treatment recommendations made during the course of care proceedings. Readers may find it useful to consult articles published by the team during the course of this study, which include a discussion of what we have termed the 'collateral consequences' of child removal (Broadhurst and Mason, 2017). A consideration of the negative consequences of child removal, helps explain why women are at risk of appearing in repeat care proceedings.

In Section 4, we consider the implications for children born into a cycle of recurrent care proceedings, again presenting the preliminary picture of health, welfare and legal outcomes for England. Based on the limited data available in case files, infants born into a cycle of recurrent care proceedings are more likely to be 'born into care' and to be placed separately from siblings who enter care at the same time.

They are less likely to have direct contact with their birth parents and have poorer health outcomes than the general population of children. Recurrent care proceedings affect adults but also children, and as we write, we know little of the life chances of these infants and children.

This is the first study of recurrent care proceedings and as such, the study aimed to generate research questions to guide further work. A series of linked studies, funded by the Nuffield Foundation, are now under way that build on the initial work of the team and which promise new and equally important insights. Professor Ruth Gilbert and Dr. Linda Wijlaars at University College London (UCL) are now working with members of the research team to link family court and health records, with the aim of gaining a far clearer view of women's health needs and interaction with health services. The team is also working with Professor Marian Brandon at the University of East Anglia to examine the position of fathers in repeat care proceedings. Further afield, Australian colleagues have commenced a new study looking at infant removals and pre-natal reporting, also with an interest in repeat cases. This project is led by Dr. Stephanie Taplin at the Australian Catholic University, funded by the Australian Research Council. However, many more questions remain unanswered particularly in relation to the potential of emerging preventative initiatives, including alternative court models, to intercept a pattern of recurrent care proceedings through tailored support for women's rehabilitation.

As we write, a vocabulary of recurrent proceedings has found its way into mainstream policy, practice and research literatures, and sparked major investment in preventative services, such as Pause (McCracken et al., 2017), Positive Choices (Cox et al., 2017), and Gwent Reflect in Wales[1]. However, far more needs to be done to mainstream new preventative initiatives and to examine their impact in the longer term.

New initiatives, led by pioneering practitioners who bring first-hand experience to the design of preventative solutions, need more than skeletal funding if they are to deliver durable solutions for children, families and communities. It will be important to make very good use of the data routinely generated by the Pause initiative, now established in multiple sites in England, to ascertain the longer-term impact of this programme. Working alongside the research intermediary, Research in Practice, we are now developing tools for frontline practitioners. A clearer understanding of the complex grief responses that arise from child removal is urgent, as well as a more humane approach to the removal of infants at birth.

In April 2016, a "looming crisis" of care proceedings was described by the President of the Family Division (Munby, 2016). In response to this, the research team produced an updated picture of the contribution of 'repeat mother' cases to rising care demand. Although we did not find a significant increase in the rate of repeat cases, neither did we find any decrease. Additionally, as more mothers, in general, come before the courts in care proceedings, this increases the number at risk of entering repeat cases in the future. Over time, the impact of new initiatives will most likely be more evident, but there is further work to be done to reduce recidivism in the family justice system.

We would encourage readers to consult our published papers to-date, which are signposted in the body of this report. Further publications will be published on the website of the Centre for Child and Family Justice Research at Lancaster University as they come to fruition.

1.2 Report structure

We have written and structured this report for the purposes of a broad audience. Depending on the interests of the reader, some sections can be omitted with only a minor loss in understanding of the study as a whole.

In Chapter 2 we present a summary of the study: research questions, definitions, and an overview

[1] http://sites.cardiff.ac.uk/cascade/2017/03/23/launch-of-the-gwent-reflect-project/

of our methodology. A more detailed account of methodology is located in Appendix A, given that technical information may be of more relevance to academics rather than our general readership.

Findings start at Chapter 3 and 4 reporting on the number of recurrent care proceedings cases visible within our observational window (2007/08 to 2015/16), as well as their profile. This is followed by a descriptive profile of mothers in recurrent proceedings and their children. These sections present descriptive statistics based on population-level data (Element A) and our court case file review (Element C).

Chapter 5 presents findings from statistical analyses concerning the scale and pattern of mothers in recurrent proceedings using data from Elements A and C. Analyses are reported about the risk of a mother returning to court over time; the probability of a child being adopted; sub-groups of women, according to presenting issues at proceedings and duration of proceedings.

In Chapter 6, we present detailed findings from the birth mother interviews, which take readers into the experiences of the women who have all experienced repeat removals of children.

Finally, in Chapter 7, we present a discussion of the main findings and conclude with a consideration of the policy and practice implications of this study.

2 Study summary

2.1 Overview and research questions

A mixed methods study was carried out between 2014 and 2017, focused on birth mothers and their children in care proceedings under s.31 of the Children Act 1989. Building on a feasibility study completed in 2013-2014, This study was designed to: (a) provide the first national (England) picture of the scale and pattern of recurrent care proceedings, (b) identify and explain the factors or processes associated with a woman returning to court and the implications for her children, and (c) identify opportunities where policy and practice might make a difference. The following research questions framed the study:

1. What is the scale and pattern of recurrent care proceedings nationally and what is the profile of birth mothers involved in this cycle?
2. Is it possible to differentiate the population of birth mothers caught in a cycle of recurrent care proceedings and what are the implications for intervention?
3. How can a dynamic understanding of risk and protective factors and processes over time, inform the development of preventative services?
4. Where mothers exhibit recovery of parenting capacity, how is this achieved?
5. How might reproductive health services be delivered differently to intercept a cycle of repeat pregnancy and recurrent care proceedings?
6. What are the implications for children, fathers and kin networks of recurrent care proceedings?

2.2 Definitions

For the purposes of this study we consider a woman to be *recurrent*, if we were able to identify more than one set of s.31 care proceedings in which she was the respondent. She also had to be the birth mother to at least one of the children who was a subject within the proceedings. Under this definition, we refer to the first recorded set of s.31 proceedings for a mother as the mother's *index* set of proceedings. This is because it is possible that the mother may have had earlier proceedings but we are unable to identify these due to limitations with each of the data sources and methods. Subsequent proceedings are described as the mother's *first repeat*, *second repeat*, and so forth.

Based on whether or not the child or children in this second set of proceedings have previously been seen by the family court, a mother's recurrence can be further described as either recurrent *with at least one new child*, or recurrent *with previous child or children only*.

2.3 Methodology summary

The study comprised three main elements:

- Element A (population-level): comprised statistical descriptive analysis and reporting of data extracted from routine administrative records held by the Children and Family Court Advisory

and Support Service (Cafcass). Records concerned approximately 65,000 birth mothers appearing as respondents in s.31 proceedings under the Children Act 1989, between 2007/08 and 2015/16. The Cafcass data required considerable manipulation to be suitable for analysis and variables were restricted.

- Element B (interviews): comprised qualitative analysis of 72 semi-structured interviews with women who had experienced repeat removal of children, followed by a questionnaire. Women were accessed via 7 local authorities, participation was voluntary. The sampling strategy had tended to attract women who had made marked improvements in their lives and who, at the time of interview, were positively engaged with services. Data was subject to standard thematic analysis, using the software package NVivo for data storage and coding.
- Element C (manual review of court case files): comprised statistical descriptive analysis and reporting of systematic manual reading of court case files concerning a sample of 354 women in recurrent care proceedings. The case files were accessed via the court archives at 5 DFJ areas and concerned women appearing in a total of 851 care proceedings issued by 52 local authorities. Detailed reading of court files aimed to compensate for the restricted detail on cases in Element A.

While each element has its strengths and limitations, combined together we were able to build a comprehensive picture of birth mothers in recurrent proceedings. Appendix A provides an account of the methodology in full.

3 Profile of mothers in recurrent proceedings

In this chapter we describe recurrent care proceedings in England, indicating the number of repeat cases visible within our observational window (2007/08 to 2015/16), as well as their duration and pattern. We also provide a descriptive profile of mothers and children in recurrent proceedings, drawing on data from Element A (population-level administrative data) and from Element C (court case file review). This first section is scene setting in terms of providing an initial picture of recurrent proceedings, however, we present multiple new observations that are vital to understanding why women are vulnerable to repeat appearances before the family court and the implications for their children. Where appropriate, we have benchmarked our findings against a small number of relevant published studies.

3.1 Recurrent care proceedings in England

Key findings

Between 2007/08 and 2015/16, mothers' recurrent care proceedings:

- Typically involved a single child (85%).
- Typically concerned a child aged less than 12 months (73%). With the percentage concerning a child aged under 4 weeks found to be 60%.
- Approximately 25% were issued prior to the final hearing of an earlier set of proceedings, and an additional 35% were issued within one year (i.e. 60% of repeat proceedings were issued in short succession).

Between 2007/8 and 2015/16, at a population level, we were able to capture a birth mother's appearance in an index, first repeat and second repeat set of s.31 proceedings. Table 3.1 presents summaries of these s.31 proceedings: type of application, whether or not the mother is the sole-respondent or if the father is also present, number of children, age of youngest child, duration and intervals between proceedings.

It is important to note that, the numbers and percentages in Table 3.1 do not take in to account the varying amount of time that we have been able to observe mothers within our population-level data (Element A). For example, mothers who recorded an index set of proceedings in year 2007/08 can be followed up for a further period of eight years to establish whether they return. While for a mother who enters in 2014/15, she can only be followed up for two years. Moreover, the period of a woman's life in which this follow-up period spans depends on the age at which she first appears in the data (i.e. her index set of proceedings). To accurately calculate a mother's risk of returning to the family court over time based on available data, we use method of survival analysis, and we report the results of this sophisticated statistical analysis in Section 5.1.

Table 3.1: Descriptive statistics of all birth mothers' index, and where appropriate, first repeat and second repeat s.31 proceedings between 2007/08 and 2015/16 (Element A). Note counts are rounded to nearest 10, and, due to rounding, column percentages may not add up to 100.

	Index		First repeat		Second repeat	
Number of mothers	64,980	(100.0%)	11,190	(100.0%)	2,120	(100.0%)
Type of application						
Care Order	61,510	(94.7%)	10,530	(94.1%)	2,000	(94.5%)
Supervision Order	3,470	(5.3%)	670	(5.9%)	120	(5.5%)
Respondents						
Mother only	12,220	(18.8%)	2,580	(23.0%)	490	(23.1%)
Mother with father(s)	52,760	(81.2%)	8,620	(77.0%)	1,630	(76.9%)
Child count						
One	37,170	(57.2%)	9,470	(84.6%)	1,840	(86.8%)
Two	14,510	(22.3%)	1,050	(9.4%)	200	(9.6%)
Three	7,460	(11.5%)	420	(3.7%)	50	(2.5%)
Four	3,580	(5.5%)	160	(1.5%)	20	(0.9%)
Five or more	2,270	(3.5%)	90	(0.8%)	–	–
Age of youngest child						
Under 4 weeks	12,170	(18.7%)	6,420	(57.3%)	1,310	(61.9%)
4 weeks to 1 year	15,010	(23.1%)	1,760	(15.7%)	320	(15.1%)
1 to 4	20,630	(31.7%)	1,630	(14.6%)	290	(13.9%)
5 to 9	10,090	(15.5%)	770	(6.9%)	120	(5.4%)
10 to 15	6,780	(10.4%)	590	(5.2%)	80	(3.5%)
16 and above	300	(0.5%)	30	(0.3%)	–	–
Missing	10	(0.0%)	–	–	–	–
Duration						
Under 26 weeks	18,110	(27.9%)	5,410	(48.4%)	1,230	(58.1%)
26 to 38 weeks	16,140	(24.8%)	2,820	(25.2%)	520	(24.3%)
39 to 51 weeks	11,670	(18.0%)	1,460	(13.1%)	200	(9.4%)
1 year or over	19,050	(29.3%)	1,500	(13.4%)	170	(8.1%)
Time since previous proceedings						
Overlapping/Consolidated			2,790	(25.0%)	280	(13.0%)
0 to under 1 year			3,950	(35.3%)	790	(37.3%)
1 to under 2 years			2,070	(18.5%)	610	(28.8%)
2 to under 3 years			1,140	(10.2%)	260	(12.5%)
3 years or more			1,240	(11.1%)	180	(8.4%)

Number of mothers

We identified 64,980 mothers in s.31 proceedings in England between 2007/08 and 2015/16. Of these, a raw count of repeat cases, identified 11,190 mothers at first repeat proceedings, and 2,120 at second repeat proceedings. As we have stated in Broadhurst et al. (2015a), over time, as the national administrative data sets mature, it will be important to further calculate women's repeat appearances, based on a longer observational window and for specific cohorts of women. It is not known how fully we have been able to capture mothers' history of care proceedings, given this limited observational window (2007/8 to 2015/16).

Type of s.31 proceedings

The vast majority of s.31 proceedings (94.7%) captured in our observational window involved a single application for a Care Order, with only 5.3% for a Supervision Order.

Mother as sole- or co-respondent

We found that in 81.2% of index proceedings the father was also named on the application. Fewer fathers were listed on repeat cases than at the index (a decrease in 4 percentage points). However, it is not known what proportion of mothers or fathers actually attended hearings. These figures are substantially higher than those reported by Masson et al. (2008), who reported that in only 63.0% of proceedings involving a mother was the father also listed. It is possible that the further embedding of a formal pre-proceedings process within local authorities in England has led to earlier and greater identification of fathers. Moreover, a more comprehensive picture of men's participation is gained when we look across sets of care proceedings, rather than simply focus on an index episode.

Number of children per proceedings and age of youngest child

The majority of proceedings only have a single child as the subject; 57.2% at mother's index proceedings, 84.6% and 86.8% at mother's first repeat and second repeat, respectively. This increase reflects that fact that the majority of repeat proceedings concern infants aged less than 12 months (41.8% at mother's index, 73.1% and 77.0% at first repeat and second repeat). The percentage change in the proportion of newborns is also striking (18.7% at index; 57.3% and 61.9% at first and second repeat). These findings are comparable with Masson et al. (2008) in terms of the number of children appearing at our index. However, we gain a more nuanced picture of both the number and age profile of children in care proceedings when we separate out index, from first and second repeat. The change in the percentage of infants from index to repeat, provides important insights into how local authorities and the courts respond to repeat cases.

Duration and intervals between proceedings

A mother's first repeat proceedings is likely to be shorter; 48.4% complete within 26 weeks, compared to 27.9% of index proceedings. Additionally, 25.0% of first repeat proceedings overlap with the mother's index. An important factor to consider regarding duration, is that because the sampling window for the extract is from 2007/08 through to 2015/16, this includes the introduction of the legislation (Children and Families Act 2014) that stipulated a 26 weeks performance target for care proceedings. In Section 5.4 an analysis of the duration of proceedings is presented, which, in part, controls for the year in which the proceedings commenced, thus taking into account this change in practice.

3.2 Maternal profile

Key findings

Mothers who have appeared in recurrent care proceedings:

- Often became mothers at a far younger age compared to women in the general population, as well as those who appear in a single set of proceedings. With 64% of recurrent mothers having their first child before the age of 20.
- Were more likely to have 4 or more children (42%) compared to the general population, where 2-child families are the most common.
- Majority of recurrent mothers were white/white British (82%), and were UK nationals (95%).
- Had a range of issues as reported by the local authority. Service non-engagement featured as the most common key professional concern (72% at recurrent mothers' index proceedings). This was followed by being a victim of domestic abuse (65%), engaging in substance misuse (56%), and experiencing mental health issues (51%).

In order to understand the characteristics of birth mothers involved in recurrent care proceedings, we have drawn on data from both Element A (population-level) and Element C (case file sample). Helping agencies develop preventative solutions for this population requires detailed analysis of both the issues that women present within care proceedings, but also their histories. Detailed histories help explain why women may be hard to help and why difficulties persist.

Table 3.2 provides information on the 64,980 mothers who were party to care proceedings between 2007/08 and 2015/16, grouped according to whether women appeared in only an index set of proceedings (53,780), or two or more sets of proceedings (11,190). Based on available population-level biographical information within the ECMS, we have profiled the mothers in terms of their age at entry to motherhood, number of children, her age at her index set of proceedings, and number of proceedings.

As explained in Appendix A, source data for Element A contained only limited information regarding women's profiles. Therefore, further profiling data was extracted through systematic review of a representative sample of court case files (Element C). This second source of data allowed us to gain a far more detailed picture of mothers within recurrent care proceedings, by capturing demographic information, as well as information about mothers' own childhoods, care experiences, and the issues presented at each set of proceedings.

Table 3.3 presents demographic and maternal profiles from the court case file study. When we compare Table 3.3 with the appropriate population-level numbers in Table 3.2 (i.e. the column for mothers who have had 'two or more proceedings'), we see differences in terms of age at first child and number of children. This reflects the differences in the depth of the information from each of the sources, and is discussed further below. In the example of age at entry to motherhood, the case file data gives a more accurate picture over the population-level data.

Table 3.4 summarises the prevalence of mother-related issues at her index and first repeat set of proceedings. These are the concerns that are central to the issuing of the case, such as domestic violence or substance misuse. In order to understand the possible antecedents of the issues that the local authority presents to the court concerning the women, we have also captured from the file study, where possible, information regarding women's childhood experiences which are presented separately in Section 3.3.

Tables 3.2, 3.3 and 3.4 are presented together for ease of reference, and need to be read in conjunction with the summary of findings that follow.

Table 3.2: Descriptive statistics of all birth mothers who have had one set of s.31 proceedings compared to two or more between 2007/08 to 2015/16 (Element A). Note counts are rounded to nearest 10, and, due to rounding, column percentages may not add up to 100.

	Number of proceedings			
	Only one		Two or more	
Total	53,780	(100.0%)	11,190	(100.0%)
Age at first child				
Under 16	1,410	(2.6%)	370	(3.3%)
17 to 19	15,220	(28.3%)	4,630	(41.3%)
20 to 24	13,870	(25.8%)	3,270	(29.2%)
25 to 29	8,690	(16.2%)	1,510	(13.5%)
30 and above	10,260	(19.1%)	1,180	(10.5%)
Missing	4,330	(8.1%)	240	(2.2%)
Number of children				
One	28,750	(53.4%)	780	(7.0%)
Two	12,850	(23.9%)	4,370	(39.0%)
Three	6,680	(12.4%)	2,940	(26.3%)
Four	3,270	(6.1%)	1,620	(14.5%)
Five	1,370	(2.5%)	840	(7.5%)
Six or more	870	(1.6%)	640	(5.7%)
Age at s.31 index proceedings				
Under 16	370	(0.7%)	70	(0.6%)
16 to 19	5,190	(9.6%)	1,850	(16.6%)
20 to 24	10,280	(19.1%)	3,310	(29.6%)
25 to 29	10,010	(18.6%)	2,550	(22.8%)
30 and above	23,610	(43.9%)	3,170	(28.3%)
Missing	4,330	(8.0%)	240	(2.2%)
Number of s.31 proceedings				
One	53,780	(100.0%)	0	(0.0%)
Two	0	(0.0%)	9,080	(81.1%)
Three	0	(0.0%)	1,740	(15.5%)
Four or more	0	(0.0%)	380	(3.4%)

Table 3.3: Summary description of demographics and motherhood characteristics in recurrent mothers (Element C).

(a) Demographics and experiences.

	Count	Percent
Total	354	100.0
Ethnicity		
White	289	81.6
Black/Black British	32	9.0
Other	33	9.3
Immigration status		
UK National	336	94.9
Other	10	2.8
Missing	8	2.3
Age at first application		
Under 20	82	23.2
20 to 24	115	32.5
25 to 29	75	21.2
30 and above	82	23.2

(b) Motherhood.

	Count	Percent
Total	354	100.0
Age at first child		
Under 20	225	63.6
20 to 24	91	25.7
25 to 29	20	5.6
30 and above	14	4.0
Missing	4	1.1
Number of children		
Two	110	31.1
Three	95	26.8
Four	68	19.2
Five or more	81	22.9

Age at first child and number of children

Based on our population-level data, from Table 3.2, we found that recurrent mothers, on average, had their first child at a younger age than those appearing in the index only: 44.6% were aged less than 20 years at the birth of their first child, compared to 30.9% for those who only appeared in a single set of proceedings. As stated in the Methodological Appendix (Appendix A), reliable population-level data from Cafcass is only available from 2007/8, we are potentially under-estimating how young women were at the birth of their first child.

From Element C, we found that 63.6% of recurrent mothers were aged less than 20 years when they had their first child. This is significantly different from the earlier finding from Element A ($\chi^2 = 62, df = 4, p < 0.001$). Benchmarking this data using an ONS statistical bulletin regarding births by parents characteristics in England and Wales (ONS, 2016b), women in Element A are on average entering motherhood much earlier than the general population. The bulletin reports that, over the same time frame as our extract, the median age of a mother at the birth of her first child is between 27 and 29 years, while for mothers from Element C, the equivalent median age is 19 years.

Regarding birth rate, we can only calculate this on the number of children we can see linked to mothers at the time of our study (i.e. women will likely have had more children, after the point at which we have measured this variable). However, we can conclude from both the population-level data and from case file review, that women's birth rate is higher than in the general population, because 2-child families remain the norm for England and Wales (ONS, 2016c). Drawing on data from Element A, for women who record two or more sets of proceedings, 93.0% have had two or more children subject to proceedings, with their median number of children being 3. From case files, and because we have been able to gain a more complete picture of motherhood trajectories, we see that 42.1% of the women had four or more children, compared to approximately 28% in Element A ($\chi^2 = 316, df = 3, p < 0.001$). To conclude, women's birth rates are higher than in the national population, and through the case file review, 'large' families (3 or more children) are not uncommon for this group of women. This is out of sync with national demographic trends towards later motherhood and smaller family sizes.

Mother's age at first s.31 proceedings

A second and related question concerns the age at which women first appear in the family court, as a respondent in care proceedings. Again, based on Element A, we see that recurrent mothers tend to become first time respondents at a younger age than women appearing in an index episode only.

Again, our case file data is more reliable regarding age, for the reasons stated above. From case file review, we found that 23.2% of recurrent women in the sample were are aged less than 20 years, at their first set of proceedings. This is a concerning finding and we return to this when we discuss women's experiences of the family court in Section 6.4. Teenagers clearly grappling with their own developmental needs may struggle with parenting, but in addition, without very effective legal representation, will no doubt have major problems in engaging meaningfully with the court process. Regarding age, we can also report from case file review that the majority of women were aged less than 25 years at a first set of proceedings, and this is consistent with our observations from our analysis of our population-level data.

Recurrent mother demographics

Details regarding ethnicity were not consistently recorded over time by Cafcass. From the case file study of recurrent mothers (Element C), we found that 81.6% were white/white British, 9.0% were black/black British and 9.0% were 'other'. Regarding immigration status, 94.9% of recurrent mothers were UK nationals, 2.8% had some other status, and for 2.3% of mothers we were unable to determine their status. These results are in line with Masson et al. (2008).

Maternal issues at index and first repeat proceedings

From the case file review we were able to identify maternal issues at proceedings as described by local authorities in their statements to court. Table 3.4 summarises the percentage of recurrent mothers with each issue at both index and first repeat proceedings. Service non-engagement was the most prevalent concern, with this being reported for 72.9% of recurrent mothers at their index proceedings, and 65.5% at first repeat. Other prevalent issues at index proceedings are: the mother being a victim of domestic abuse (65.0%), engaged in substance misuse (55.9%), and experiencing mental health issues (50.6%). One consistent trend, is for the number of issues to be decrease slightly between the index and first repeat set of proceedings. For example, service non-engagement was mentioned in 72.9% of index proceedings, but only 65.5% of first repeat proceedings. Despite reporting of each concern decreasing from 2 to 7 percentage points, the ranking of issues remains largely the same. Where proceedings follow in short intervals, it is likely that the local authority is more economic in the description of risks, given that this evidence has very recently been put before the family court.

While these percentages show the reported prevalence of the issues for the sample as a whole, they do not show how likely issues are to be co-occurring. An identification and analysis of subgroups of issues within the sample is presented in Section 5.3.

Table 3.4: Prevalence of the types of mother-related issues mentioned by professionals at recurrent mothers' index and first repeat proceedings (Element C, n = 354).

	Count		Percent	
	Index	First Repeat	Index	First Repeat
Total	354	354	100.0	100.0
Mother-related issue				
Service non-engagement	258	232	72.9	65.5
Victim of domestic abuse	230	201	65.0	56.8
Substance misuse	198	176	55.9	49.7
Mental health	179	162	50.6	45.8
Housing instability	144	121	40.7	34.2
Pregnancy	116	107	32.8	30.2
No support network	105	88	29.7	24.9
Criminal record	97	78	27.4	22.0
Cognitive functioning	68	63	19.2	17.8
s.20 withdrawal	21	8	5.9	2.3
Sex work	12	14	3.4	4.0
Kinship breakdown	7	9	2.0	2.5
Physical disability	4	6	1.1	1.7

3.3 Maternal childhood profile

Key findings

Mothers who have appeared in recurrent care proceedings:

- Had been exposed to much higher levels of harm and adversity in childhood than what would be expected in the general population. With 56% of recurrent mothers experiencing four or more different types of adverse experience in childhood. From an international evidence base, this is firmly associated with increased risk of poor adult outcomes.
- Prevalence of abuse and neglect in their childhoods was high: neglect 66%, emotional abuse 67%, physical abuse 52%, and sexual abuse 53%.
- In the context of neglect, emotional abuse and physical abuse, mothers' own parents and caregivers were typically the cause of harm. While for sexual abuse we found a more mixed picture of parents, caregivers, and other adults outside the household.
- Approximately 40% of recurrent mothers had been looked after children (formal out of home care), with the largest proportion entering care aged 10 years or older (48%). Half of those looked after had experienced multiple placement moves.
- Approximately 14% had spent a period of time not living with their parents through an informal arrangement.

In this section, we explore maternal childhood experiences as reported in the court case files (Element C). Focusing initially on childhood adversities using our adapted ACE categories (see Section A.5 for details), we report both the type and number of adverse experiences. We were able to capture in more detail, the nature of abuse and neglect experienced by the mothers and the age at which they experienced this, which is often hidden when studies simply refer to 'sexual' or 'physical abuse'. In capturing the perpetrator(s) of abuse, we have been able to quantify the number of mothers in recurrent proceedings who experienced abuse and neglect at the hands of their own parent(s) or caregivers in childhood. This is an issue we return to in our discussion of mothers' own accounts of their childhood in Section 6.

Second, we describe, through the use of our adapted ACE score, the percentage of women in recurrent proceedings that have spent periods in formal and informal out-of-home care. In addition, for those who were looked after, we have also been able to capture age at first entry, a summary of placement moves and types of placement. This is the first analysis of the relationship between childhood care experience and adult appearances in the family court, and establishes a relationship between the two. More work needs to be done to explore and explain this relationship based on the full population of women in care, rather than recurrent mothers only, but this is an important first step. Finally, an analysis is provided of the relationship between ACE scores and whether women were formally looked after as children.

Prevalence of adverse childhood experiences

Mothers' childhoods were clearly marked by adversity. We refer readers to Table 3.5 and 3.6 below. Table 3.5 provides a statistical summary of prevalence and types of harm and maltreatment using our adapted ACE categories, whilst Table 3.6 gives further breakdown of the detail of the particular abuse

Table 3.5: Prevalence of types of childhood experiences by recurrent mothers (Element C). Categories marked with an asterisk were used in the computing the ACE score. Note that column percentage will add up to more than 100% as some mothers will have experienced more than one of the experiences below.

	Count	Percent
Total	354	100.0
Mother's experiences		
Emotional neglect*	207	58.5
Physical neglect*	71	20.1
Emotional abuse*	237	66.9
Sexual abuse*	188	53.1
Physical abuse*	183	51.7
Substance misuse	178	50.3
Mental health	132	37.3
Significant loss*	108	30.5
Looked after	143	40.4
Informal care	88	24.9
Mother's parents' issues		
Domestic abuse*	143	40.4
Substance misuse*	134	37.9
Mental health*	76	21.5

and the perpetrator. When compared to prevalence rates from general population studies the rates of abuse are much higher for our cohort across the range of issues (Radford et al., 2011).

Sexual abuse

The NSPCC prevalence study (Radford et al., 2011) reports that 24.1% of the respondents aged 18 to 24 had experienced sexual abuse (contact or non-contact) in their lifetime. In comparison, our figure is 53.1%, over half of our total sample. Particularly striking is that 18.9% of our total sample had been sexually abused by a parent or caregiver. This is markedly higher than that reported in national prevalence studies (only 1.5% of contact or non-contact sexual abuse in the NSPCC study was perpetrated by the child's parent or guardian). Furthermore the severity of the sexual abuse is greater in our population with 28.5% of women having experienced contact sexual abuse, compared to a reported figure of 11.3% by Radford et al. (2011). These findings are concerning given the particular developmental implications of sexual harm, a point we pick up in detail in Section 7.

Physical abuse

Physical maltreatment in childhood was recorded for 51.9% of women in our study. This is markedly higher than the national prevalence figure, as reported by Radford et al. (2011), in which 12.9% young women aged 18 to 24 reported having been severely physically maltreated in childhood. The rates of harm by a parent or caregiver are also much higher for our sample: 42.3% in our sample compared to only 9.9% nationally. The type of physical harm most frequently reported in the court files was of the mother having been severely hit or beaten. The first incident of physical abuse, happened when women were typically between the ages of 10 and 15. However, in a substantial minority of cases physical (19%), maltreatment began under the age of 10 which once again has developmental implications.

Neglect

The most common type of adversity in childhood, along with emotional abuse, was parental neglect. With incidents of parental neglect recorded in two-thirds of the sample (66.1%). Neglect by comparison was reported as a rate of 16% within national prevalence study (Radford et al 2011). The neglect of the child's basic emotional needs was the most commonly reported type of neglect within our sample.

Emotional abuse

Benchmarking for emotional abuse has proved more challenging due to diverging definitions and the lack of detail available within the case files. However comparison is more reliable if we focus specifically on exposure to domestic violence. Within our sample 48.1% of women had been exposed to domestic violence in their family homes as compared to the national prevalence rate of 23.7% (women aged 18 to 24, over their lifetime).

Summary of abuse and neglect

The women in our study have had high exposure to forms of abuse and neglect in their childhoods when compared to national prevalence statistics. Significantly, this maltreatment is more often perpetrated by a parent or caregiver. This is particularly concerning given that broader prevalence studies point to the fact that children and young people who were maltreated by a parent or caregiver are also at increased risk of or becoming what has been termed as "polyvictims" (Finkelhor et al., 2009; Radford et al., 2011), that is experiencing further forms of abuse by other perpetrators during their childhood and adolescence. Whilst all forms of childhood maltreatment are a concern there is a growing evidence that polyvictims are a particularly vulnerable group. This point is further explored within both our qualitative insights discussed in Section 6 and our analysis of women's ACE scores further in this section.

Given that we have only reviewed files of recurrent mothers, we cannot draw conclusions about differences between women who return to court and those who do not. New preventative initiatives, particularly where they are multi-site provide an opportunity to use local authority data, to draw such comparisons.

Table 3.6: Descriptive details of the nature of childhood abuse and neglect experienced by recurrent mothers, as reported by the local authorities (Element C). Regarding the 'who' and 'what' topics, multiple categories may apply for a single mother.

(a) Neglect.

	Count	Percent
Prevalence		
No	120	33.9
Yes	234	66.1
Age		
Under 1	10	4.3
1 to 4	28	12.0
5 to 9	21	9.0
10 to 15	13	5.6
16+	0	0.0
Missing	162	69.2
Who		
Parent / caregiver	–	–
Friend / family	–	–
Peer	–	–
'Unknown'	–	–
Other	–	–
Missing	–	–
What		
Emotional	181	77.4
Safety	160	68.4
Housing	48	20.5
Nutritional	29	12.4
Hygiene	27	11.5
Clothing	20	8.5
Health	21	9.0
Missing	5	2.1

(b) Emotional abuse.

	Count	Percent
Prevalence		
No	117	33.1
Yes	237	66.9
Age		
Under 1	6	2.5
1 to 4	15	6.3
5 to 9	16	6.8
10 to 15	16	6.8
16+	1	0.4
Missing	183	77.2
Who		
Parent / caregiver	193	81.4
Friend / family	11	4.6
Peer	50	21.1
'Unknown'	4	1.7
Other	6	2.5
Missing	17	7.2
What		
Witness DV	114	48.1
Threat physical	70	29.5
Shouted at	65	27.4
Humiliated	56	23.6
Insulted	54	22.8
Threat removal	22	9.3
Sworn at	21	8.9

(c) Physical abuse.

	Count	Percent
Prevalence		
No	171	48.3
Yes	183	51.7
Age		
Under 1	3	1.6
1 to 4	8	4.4
5 to 9	23	12.6
10 to 15	26	14.2
16+	5	2.7
Missing	118	64.4
Who		
Parent / caregiver	150	82.0
Friend / family	19	10.4
Peer	12	6.6
'Unknown'	6	3.3
Other	14	7.7
Missing	7	3.8
What		
Hit	103	56.3
Beaten	41	22.4
Choked	10	5.5
Burnt	5	2.7
Missing	26	14.2

(d) Sexual abuse.

	Count	Percent
Prevalence		
No	166	46.9
Yes	188	53.1
Age		
Under 1	1	0.5
1 to 4	7	3.7
5 to 9	45	23.9
10 to 15	39	20.7
16+	6	3.2
Missing	90	47.8
Who		
Parent / caregiver	67	35.6
Friend / family	60	31.9
Peer	25	13.3
'Unknown'	43	22.9
Other	38	20.2
Missing	0	0.0
What		
Non-contact	19	10.1
Contact[1]	101	53.7
CSE	69	36.7
Missing	38	20.2

[1] Includes sexual intercourse

Out-of-home care

Table 3.7 presents the prevalence of mothers in recurrent proceedings who had experienced formal or informal out-of-home care, or both. When we combine these different types of out of home experiences, we found that 54.2% of our sample had spent some part of their childhood not living with their parents. With 40.4% specifically being formally looked after.

For those that were formally looked after, they were least likely to enter care as infants (2.8%), and most likely to enter aged 10 years or older (44.1 + 3.5 = 47.6%). Regarding types of placements, 67.1% of the group had been placed with foster carers, a relatively high percentage had also experienced residential and secure unit placements, 39.2% and 11.6%, respectively. Moves within out-of-home care were common, half the women had experienced multiple placements (50.3%). We were able to identify that 20.3% had experienced harm while in care, with harm defined as a specific instance of abuse either by another child or caregiver or informal network.

Table 3.7: Recurrent mothers' experiences of being looked after (Element C).

	Count	Percent
Type of care		
Looked After only	104	29.4
Informal OHC only	49	13.8
Looked After & Informal OHC	39	11.0
Neither	162	45.8
Of the 143 women that were looked after...		
Age at first entry		
Under 1	4	2.8
1 to 4	20	14.0
5 to 9	29	20.3
10 to 15	63	44.1
16+	5	3.5
Missing or unclear	22	15.4
Placement type		
Residential	56	39.2
Foster Care	96	67.1
Adoption	6	4.2
Kinship Care	28	19.6
Secure Unit	17	11.9
Other	21	14.7
Missing	9	6.3
Care experiences		
Stable placement(s)	42	29.4
Multiple short placements	72	50.3
Harm while in care	29	20.3

Volume of adverse childhood experiences

By creating a score for the ACEs (see Appendix A.6.9 for methodology), we were able to measure the number of types of adversity experienced by these mothers. Table 3.8 shows the distribution of ACE scores among the case file sample of recurrent mothers. With the maximum possible score being 10, we found that 55.9% of our sample experienced four or more types of childhood adversity. Based on other population studies, a score of 4 or more is associated with a 12-fold increase in health risks for alcohol misuse, drug misuse, depression, suicide attempts (Felitti et al., 1998). In addition, a 2- to 4-fold increase in poor self-rated health, more than 50 sexual partners over their lifetime, sexually transmitted disease and smoking (Felitti et al., 1998). Furthermore, the number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

As the ACE study suggests, the particular adversities cannot be seen in isolation, but rather there is a graded dose response relationship, which means as the dose of the stressor increases the intensity of the outcome also increases. The high ACE scores indicate the women's heightened vulnerability to poor adult outcomes across a range of adult dimensions. Applying ACE and the work of Felitti et al. (1998) helps to explain why this group of women face the difficulties that bring them before the family court as adults. However, this study provides a first descriptive profile only and is an adapted use of ACE which relies on professional accounts in case files rather than self-report data. Further research is suggested that compares women with recurrent and non-recurrent profiles using the ACE framework.

Table 3.8: Distribution of ACE scores of recurrent mothers (Element C).

	Count	Percent
Total	354	100.0
ACE score		
0	26	7.3
1	38	10.7
2	35	9.9
3	57	16.1
4+	198	55.9

Association between adverse childhood experiences and being looked after

The association between adverse childhood experiences (ACE score) and being a looked after child was examined using a simple logistic regression modelling framework. Results from the model are shown in Figure 3.1. The results show that there is a positive association between being looked after and a mother's ACE score. A unit-increase in the ACE score, increases the relative risk of being looked after by 31%. This means that for a person with a score of 4 (the average in our sample), the probability of them also being looked after is 41%, while for someone with a score of 5, their probability is 47%.

While there is a positive association between being looked after and the ACE score, the estimated percentages show that there is still a large number of mothers in our sample who were not received into any state care. Given what we know from Felitti et al. (1998) about the relationship between a score of 4 or above and heightened vulnerability to poor outcomes, this raises questions about what preventive action is being taken to support these clearly vulnerable women at an earlier point.

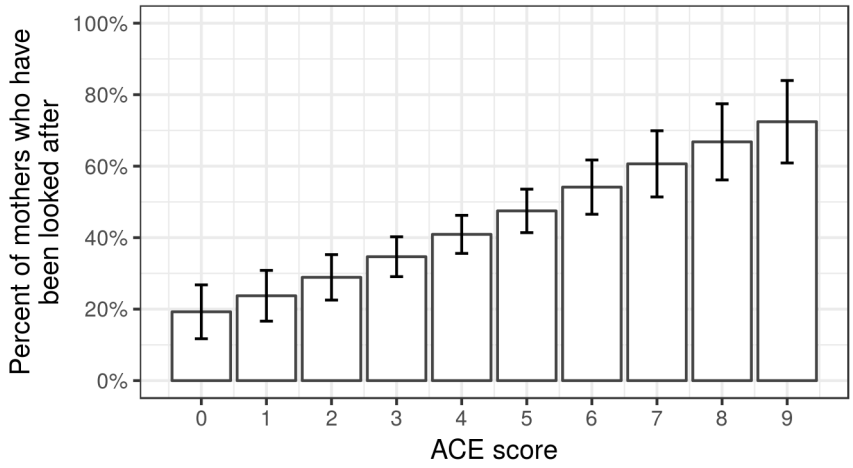


Figure 3.1: Based on Element C, the estimated percentage of recurrent mothers being looked after given their ACE score. Error bars represent the 95% confidence intervals.

4 Profile of children in mothers' recurrent proceedings

Key findings

Regarding the children of recurrent mothers:

- For 72% of those who appear in a mother's first and second repeat proceedings, this is the first time they has been subject to proceedings.
- For 60% of those who appear in a mother's first repeat proceedings, they are typically of a very young age (under 1 year). At second repeat we found that 66% were aged under 1 year.
- For 35% of children at a mother's first repeat, they are subject to either a Placement Order or Adoption Order. This rises to 45% at second repeat proceedings.
- Those appearing in either a mother's first repeat or second repeat proceedings are less likely to placed with siblings than children at a mother's index proceedings.
- Neglect was a concern for approximately 90% of the children. Followed by emotional abuse at 70%, physical abuse at 40%, and sexual abuse at 15%.
- With the exception of sexual abuse, the parent or caregiver was most frequently considered to be the common perpetrator of the harm and maltreatment.
- For those aged under 1 year: 15% were born pre-term, and 18% were affected by mother's substance misuse.

Using information from both Element A and Element C, we are able to provide a profile of children who appear as subjects in the proceedings of recurrent mothers. From Element A, we are able to explore the population-level changes in the age profile of the children who appear in mothers' index proceedings compared to first repeat and second repeat proceedings. From Element C, we are able to examine the descriptions, as presented in court case files, of the abuse and neglect experienced by the children of recurrent mothers, health related issues for those who are infants, and the outcomes in terms of placement arrangements and changes in level of contact with the mother.

4.1 Element A child profile

Table 4.1 contains descriptive statistics for children of all birth mothers in proceedings based on our population-level data. Regarding age of children, 10.8% of children at mothers' index are aged less than 4 weeks when proceedings are issued, this number increases to 47.3% and 53.3% at first repeat and second repeat proceedings. In short, a substantial proportion of mothers who experience a repeat set of proceedings, do so close to the birth of a child.

More broadly, 55.1% of children are less than 5 years old at mothers' index proceedings, compared to 77.3% and 84.1% at the second and third case. Very few older children appeared in mothers' recurrent proceedings, confirming that recurrent proceedings typically involve infants and very young children, rather than older children.

Within mothers' first repeat proceedings, for the majority of children it was the first time they had been subject to proceedings (71.7%). An almost identical percentage is seen for those at mothers' second repeat proceedings (71.8%).

An important observation concerns changes in the pattern of legal orders for infants, when we compare index and repeat proceedings. At the index set of proceedings, 19.1% of all children all children recorded in this first episode record the category of legal order: "Placement Order or Adoption Order", children who appear in a first repeat or second repeat set of care proceedings, are more likely to be placed for adoption; 35.0% and 44.6% respectively. In order to fully understand the increase in usage of Placement Orders, Section 5.2 provides an analysis of the probability of a child becoming subject to a Placement Order or Adoption Order.

Table 4.1: Descriptive statistics of children at all birth mothers' set of index, first repeat and second repeat s.31 proceedings between 2007/08 and 2015/16 (Element A). Note counts are rounded to nearest 10, and, due to rounding, column percentages may not add up to 100.

	Index		First repeat		Second repeat	
Number of children	115,040	(100.0%)	13,830	(100.0%)	2,480	(100.0%)
Child recurrence status						
First time	115,040	(100.0%)	9,910	(71.7%)	1,780	(71.8%)
Return	0	(0.0%)	3,920	(28.3%)	700	(28.2%)
Age of child						
Under 4 weeks	12,380	(10.8%)	6,540	(47.3%)	1,320	(53.3%)
4 wks to 1 year	15,800	(13.7%)	1,800	(13.0%)	330	(13.3%)
1 to 4	35,170	(30.6%)	2,350	(17.0%)	440	(17.5%)
5 to 9	28,630	(24.9%)	1,700	(12.3%)	230	(9.1%)
10 to 15	22,060	(19.2%)	1,370	(9.9%)	160	(6.3%)
16 and above	980	(0.8%)	70	(0.5%)	10	(0.3%)
Missing	33	(0.0%)	–	–	–	–
Final legal outcome						
SO/FAO/ONO	17,960	(15.6%)	2,220	(16.1%)	340	(13.8%)
SG/RO/CAO	25,260	(22.0%)	2,680	(19.4%)	440	(17.6%)
CO/SAO	42,390	(36.9%)	3,470	(25.1%)	510	(20.6%)
PO/AO	21,960	(19.1%)	4,830	(35.0%)	1,110	(44.6%)
Other/Missing	7,460	(6.5%)	620	(4.5%)	80	(3.3%)

4.2 Element C child profile

In this section we present findings by summarising across the children of recurrent mothers in four different ways:

- Newborns in recurrent mothers' proceedings (children aged under 4 weeks, $n = 362$).
- Infants in recurrent mothers' proceedings (children aged under 1 year, $n = 457$).
- All unique children from recurrent mothers' index and first repeat proceedings ($n = 993$).
- All children at index proceedings ($n = 637$), and children at first repeat proceedings ($n = 402$).

Pre-birth conferences

Care proceedings cannot be issued until after the birth of a child. However, statutory procedures do enable local authorities to work with women during pregnancy by completing a pre-birth assessment and establishing a plan for safeguarding the infant following his or her birth. Pregnancy is also a window of opportunity in which timely and effective preventative work may avert the need to bring care proceedings following an infant's birth.

Of the newborns entering proceedings (children aged under 4 weeks) of recurrent mothers, Table 4.2 shows the timings of the pre-birth conference in relation to the birth of the child. The percentages are based on those who we were able to identify a pre-conference date, there is a large number of newborns for whom we were not able to identify a date. The percentages show that a large proportion of pre-birth conferences are happening late in pregnancy (61.8% within 8 weeks of birth or post-birth).

Table 4.2: Timing of pre-birth conferences for children entering care proceedings under the age of 4 weeks (Element C). Note that for the majority of infants we were unable to identify a date from the court case files. The percentages are for those for whom we were able to identify a date of the pre-birth conference.

	Count	Percent
Number of newborns	362	100.0
Pre-birth conference timing		
More than 8 weeks before birth	52	38.2
8 to 5 weeks before birth	43	31.6
4 weeks to birth	33	24.3
Post-birth	8	5.9
Missing	226	–

Placement and contact arrangements

From the case file review, we have been able to explore the presenting harms, which were detailed by local authorities in their court statements, regarding the children of recurrent mothers. In addition, we have captured legal order outcomes, placement types and contact arrangements. We have captured very limited information regarding the health outcomes for infants, given paucity of detail in case files.

Table 4.3 describes the child legal and placement outcomes as well as contact arrangements with mother for children. We present this information at the index and first repeat episode. Making comparisons between the index and first repeat set of proceedings, we can see that there is an increase in those placed under a Supervision Order (SO) with parent(s), a similar proportion placed under a Special Guardianship Order (SGO) with kin, a general reduction in those placed under a Full Care Order (FCO) (with kin or with other foster caregivers?), and a general increase in those placed under PO/AO and

Table 4.3: Legal status, placement outcomes, and contact arrangements for children in mothers' index and first repeat proceedings, for recurrent mothers (Element C).

	Index		First repeat	
Number of children	637	(100.0%)	402	(100.0%)
Legal status & placement type				
No Order	6	(0.9%)	7	(1.7%)
RO with Parent(s)	54	(8.5%)	21	(5.2%)
RO with Other	13	(2.0%)	8	(2.0%)
SO with Parent(s)	34	(5.3%)	38	(9.5%)
SO with Other	3	(0.5%)	2	(0.5%)
SGO with Kin	84	(13.2%)	50	(12.4%)
SGO with Other	10	(1.6%)	4	(1.0%)
FCO with Foster Carers	112	(17.6%)	47	(11.7%)
FCO with Other	52	(8.2%)	17	(4.2%)
PO/AO with Foster Carers	172	(27.0%)	145	(36.1%)
PO/AO with Prospective Adopters	43	(6.8%)	21	(5.2%)
PO/AO with Other	14	(2.2%)	8	(2.0%)
Other	40	(6.3%)	34	(8.5%)
Placed with siblings				
Not with siblings	313	(49.1%)	278	(69.2%)
With previously removed siblings	29	(4.6%)	73	(18.2%)
With current siblings	295	(46.3%)	51	(12.7%)
Contact with mother				
Direct, unsupervised	81	(12.7%)	67	(16.7%)
Direct, supervised	265	(41.6%)	142	(35.3%)
No direct contact	204	(32.0%)	142	(35.3%)
Not mentioned	87	(13.6%)	51	(12.6%)

with foster caregivers, with successive proceedings. An increase in the use of Supervision Orders is not surprising as the local authority and the courts may be more assured of the child's safety and wellbeing through an extended period of supervision, where these is a history of child removal. It is important to note that children subject to PO/AO with foster carers, are most likely PO with a pending move to an adoptive placement.

Regarding whether or not a child is placed with siblings, we see that children are more likely to be placed separate from their siblings. In a first repeat episode there is a 20 percentage point increase in not being placed with siblings.

Regarding a contact arrangments between a mother and her children subject to proceedings, the trend at index proceedings is similar to that her first repeat. The most common arrangements are either no contact or direct but supervised contact. There is a slight decrease in direct, supervised arrangements between a mother's index and her first repeat.

Health issues for infants

We have been able to produce a limited description of the health outcomes for children aged less than one year. Table 4.4 shows that, for children in this age group at the time of their first proceedings, 15.3% are born pre-term, 16.4% are admitted to the Special Care Baby Unit (SCBU) when born, and 18.4% are affected by mother's substance misuse. In comparison, in 2015, in England and Wales, 8% of live births were considered pre-term (ONS, 2016a).

Table 4.4: Health issues for children of recurrent mothers who are aged less than 1 year at start of their index proceedings (Element C).

	Count	Percent
Number of infants	**457**	**100.0**
Infant born preterm	70	15.3
Infant admitted to SCBU	75	16.4
Affected by mother's substance misuse	84	18.4

Abuse and neglect

Regarding abuse and neglect, we have been able to produce a description of the combinations of harms, for all children linked to recurrent mothers only, and we have focused on harms listed at the child's first appearance. Table 4.5 shows both the prevalence for the nature and perpetrators of abuse and neglect experienced by children of recurrent mothers, as described at the child's index proceedings. Experiences of neglect were the most prevalent (90.8%). Of the children that experienced neglect it was often related to lack of safety (81.5%), meeting of emotional needs (74.3%), and health needs (56.2%). It was found that 73.8% of children experienced emotional abuse, most commonly by a parent or caregiver, and often related to witnessing domestic violence (73.7%). Physical abuse was experienced by 40.3% of children, again most commonly by a parent or caregiver. Details regarding the nature of the abuse were often missing, and the category 'being hit' was the most frequently recorded type of physical abuse (35%). Sexual abuse was experienced by 16.0% of children, the perpetrators of this were a mixture of family within the household (41.5%) and adults outside (41.5%) the household.

In summary, children who have been subject to proceedings are often experiencing abuse and neglect from within the family household. For neglect, emotion abuse and physical abuse, the typical perpetrator was a parent or caregiver, while for sexual abuse it was perpetrated by those inside and outside the family.

Table 4.5: Summary of the abuse and neglect experienced by children of recurrent mothers at the child's first set of proceedings, as described by the local authority (Element C). Within-percentages are shown for the type of maltreatment and perpetrator as appropriate. It is also possible for a child to experience maltreatment of the same type by multiple perpetrators, or in multiple forms.

(a) Neglect and emotional abuse.

	Count	Percent
Number of children	**993**	**100.0**
Neglect	**902**	**90.8**
Type of neglect		
Safety	735	81.5
Emotional	670	74.3
Health	507	56.2
Housing	433	48.0
Nutritional	321	35.6
Hygiene	306	33.9
Clothing	209	23.2
Emotional abuse	**733**	**73.8**
Perpetrator		
Parent or care giver	638	87.0
Friend or family member	39	5.3
Peer	9	1.2
'Unknown'	0	0.0
Other	12	1.6
Not mentioned	91	12.4
Type of emotional abuse		
Witness DV	540	73.7
Shouted at	186	25.4
Physical threat	99	13.5

(b) Physical abuse and sexual abuse.

	Count	Percent
Number of children	**993**	**100.0**
Physical abuse	**400**	**40.3**
Perpetrator		
Parent or care giver	333	83.2
Friend or family member	41	10.2
Peer	7	1.8
'Unknown'	1	0.2
Other	11	2.8
Not mentioned	48	12.0
Type of physical abuse		
Hit	148	37.0
Hit w/ implement	32	8.0
Shaken	14	3.5
Beaten	19	4.8
Burnt	11	2.8
Choked	10	2.5
Sexual abuse	**159**	**16.0**
Perpetrator		
Parent or care giver	66	41.5
Friend or family member	66	41.5
Peer	8	5.0
'Unknown'	5	3.1
Other	20	12.6
Not mentioned	18	11.3
Type of sexual abuse		
Non-contact	30	18.9
Contact	34	21.4
Intercourse	14	8.8

5 Scale and pattern of recurrence

Key findings

Regarding the scale and pattern of mothers who have been in recurrent care proceedings:

- We estimate the risk of returning to court within seven years to be 25.4% within seven years of the issue of their index proceedings. That is to say that approximately 1 in 4 mothers return within 7 years. This risk of returning to court includes returning with children previously seen by the family court as well as children that may have not.
- When considering the risk of returning to court and entering further proceedings with at least one new child, we estimate that 20.6% of mothers return within seven years after the issue of their index proceedings. That is to say, approximately 80% of those that do return, do so with at least one new child.
- The younger a mother at the birth of her first child the more at risk she is at appearing as a respondent in a further set of proceedings.
- There is a strong association between a child being placed for adoption and their age, with children under the age of 1 year being at most risk. Additional factors found to increase the probability of adopting were: if the children was the sole subject of the proceedings, and if the mother was aged less than 25 at issue of proceedings.
- It is possible to differentiate the women appearing in recurrent proceedings into five subgroups derived from presenting issues at proceedings. The largest subgroup of women had co-occurrence of mental health issues, domestic violence and substance misuse, and also recorded non-engagement with services.
- Historically, a mother's repeat care proceedings have always been shorter than her index. However, the difference in duration has decreased over time. The introduction of a 26-week deadline for care proceedings, has proved a legal underpinning for a trend in shorter proceedings which had already started a few years earlier. However, first repeat proceedings, on average, currently remain 3 weeks shorter than the initial index proceedings.

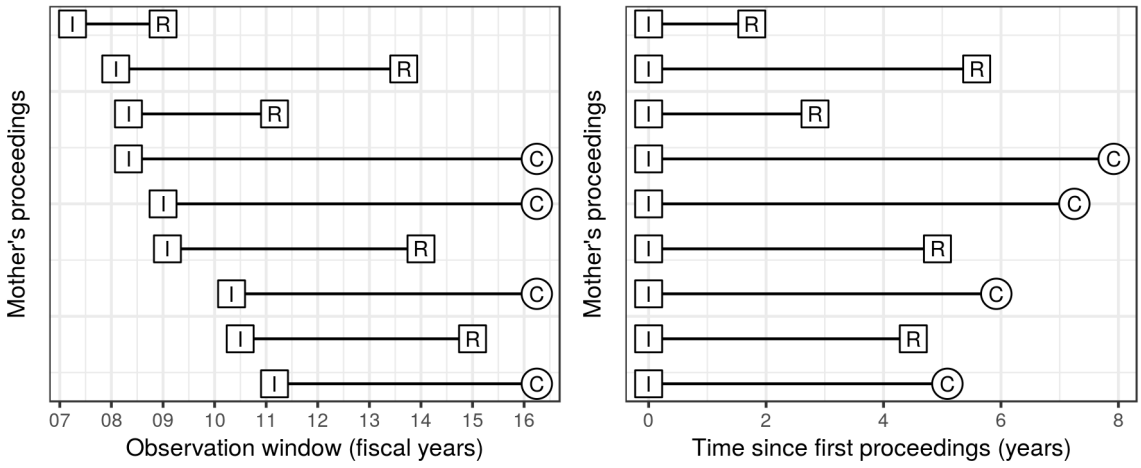
5.1 Risk of mothers returning to court

Having provided a profile of mothers within recurrent proceedings in Section 3.1, in this section we provide an analysis of the rate at which women are likely to return to court over time. To do this we used a sample of mothers from the population-level data from Element A. Mothers were selected for inclusion if they had their index proceedings between 1st April 2007 and 31st March 2011. This gave a sample of 25,526 mothers for which each mother had a minimum of 5 years of follow-up.

Analysis of the time between proceedings was undertaken using Survival Analysis techniques (Clark et al., 2003; Collett, 2015). From the Kaplan-Meier estimator, we are able to compute the risk of a mother returning to the family court over time. In addition, given the observations we made in Section 3.2 about the relatively young age at which these women enter motherhood, we explored how this risk of returning is associated with age at first child.

We defined the duration between proceedings as being the date of issue of an index proceedings to the date of issue of the first repeat proceedings, thus we had a continuous (as opposed to discrete) measure of time since index. The reason for using date of issue of index, as opposed to date of closure, is that proceedings can, and frequently do, overlap. For mothers who do not return to court within our observational window, which finishes at 31st March 2016, their duration is calculated as being the amount of time from the date of issue of their index proceedings, to the end of our observation window, and most importantly, they are denoted as *censored*. This transformation of how women appear in within the time window of our data compared to how this information is used for Survival Analysis is shown in Figure 5.1.

Initially, we provide an estimate of the risk of returning to court for *all* mothers appearing in repeat proceedings (with either new or previously seen children). We then further examine the specific risk for women who return with *at least one new child* subject to proceedings. This is motivated from from the profile of children in mothers first repeat and second repeat proceedings presented in Section 4.1, where we saw that the majority of children were 'new' to the family court.



(a) Element A observation window.

(b) Transformed for Survival Analysis.

Figure 5.1: An illustration of how mothers are captured within the data observation window of Element A, and how this information is transformed for use in Survival Analysis. Index proceedings are denoted by 'I', and the first repeat proceedings by 'R'. For women who do not return to court in the available time their observations become censored, denoted by 'C'.

5.1.1 Risk of returning with a previous or 'new' child

Based on the Kaplan-Meier estimator, Figure 5.2 shows the cumulative probability of entering a first repeat set of proceedings with either a previous or 'new' child. The life table shown in Table 5.1 contains the same information but in tabular form by giving the cumulative probability of returning at yearly intervals, as well as the hazard rates. These results show that the risk of returning within five years is 22.5%, and within seven years 25.4%. This means that repeat clients are far from unusual within the family court system, and we would expect 1 in 4 women to return within 7 years from the issue

of their index set of proceedings. This analysis is an update of what has been presented previously by Broadhurst et al. (2015a). However, our findings here remain in line with the previous work.

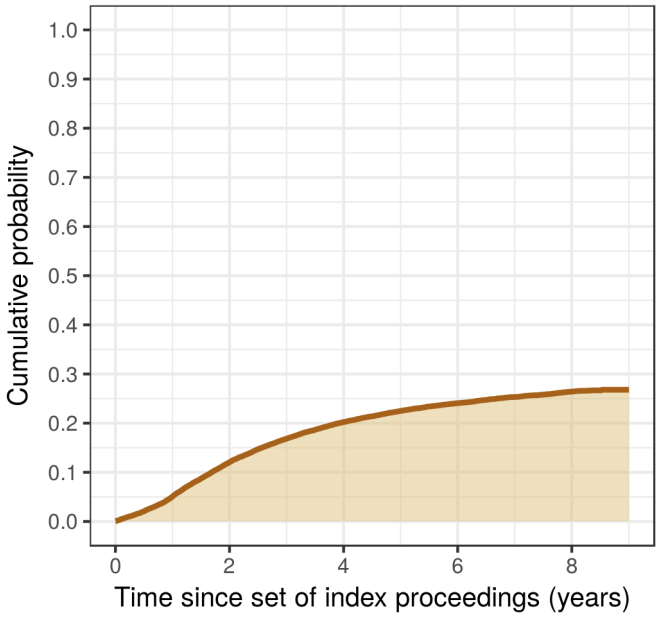


Figure 5.2: Cumulative probability, based on the Kaplan Meier estimator, of a birth mother entering her first repeat proceedings from the date of issue of her index proceedings. (Element A, *n*=25,526).

Table 5.1: Life table of the cumulative probabilities and hazard rates of a birth mother entering her first repeat proceedings, at yearly intervals from the date of issue of her index proceedings (Element A, *n*=25,526).

		Cumulative probability			Hazard rate		
N	Years	Estimate	SE	95% CI	Estimate	SE	95% CI
25,526	<1	0.051	0.001	(0.048, 0.053)	0.052	0.001	(0.049, 0.055)
24,235	<2	0.120	0.002	(0.116, 0.124)	0.076	0.002	(0.073, 0.080)
22,455	<3	0.169	0.002	(0.164, 0.173)	0.056	0.002	(0.053, 0.060)
21,223	<4	0.202	0.003	(0.197, 0.207)	0.041	0.001	(0.039, 0.044)
20,363	<5	0.225	0.003	(0.220, 0.230)	0.029	0.001	(0.026, 0.031)
19,784	<6	0.241	0.003	(0.236, 0.246)	0.021	0.001	(0.019, 0.023)
13,636	<7	0.254	0.003	(0.248, 0.259)	0.017	0.001	(0.014, 0.019)
7,675	<8	0.264	0.003	(0.258, 0.270)	0.014	0.002	(0.011, 0.017)
3,552	<9	0.269	0.003	(0.263, 0.276)	0.007	0.002	(0.003, 0.011)

5.1.2 Risk of returning with at least one 'new' child

Redefining the event of interest as being a mother returning to court with at least one new child subject to proceedings, we then repeated the analytical approach above. Findings are presented in in Figure 5.3 and Table 5.2. These show that the cumulative probability of a mother entering her first repeat proceedings with at least one 'new' child, is 18.2% within 5 years, and 20.6% within 7 years, approximately 1 in 5. As we would expect, because of the more-restrictive definition, this is slightly less than the overall probability of returning to court. But it does highlight that the majority of women returning to court are doing so with at least one new child being subject to proceedings.

Table 5.2: Life table of the cumulative probabilities and hazard rates of a birth mother entering her first repeat proceedings with at least one 'new' child, at yearly intervals from the date of issue of her index proceedings (Element A, *n*=25,526).

		Cumulative probability			Hazard rate		
N	Years	Estimate	SE	95% CI	Estimate	SE	95% CI
25,526	<1	0.037	0.001	(0.035, 0.040)	0.038	0.001	(0.036, 0.041)
24,570	<2	0.096	0.002	(0.092, 0.100)	0.063	0.002	(0.059, 0.066)
23,077	<3	0.135	0.002	(0.130, 0.139)	0.044	0.001	(0.041, 0.047)
22,088	<4	0.163	0.002	(0.158, 0.167)	0.033	0.001	(0.030, 0.035)
21,376	<5	0.182	0.002	(0.177, 0.186)	0.023	0.001	(0.021, 0.025)
20,889	<6	0.195	0.002	(0.190, 0.200)	0.016	0.001	(0.014, 0.018)
14,450	<7	0.206	0.003	(0.201, 0.211)	0.014	0.001	(0.011, 0.016)
8,166	<8	0.214	0.003	(0.209, 0.220)	0.011	0.001	(0.008, 0.014)
3,801	<9	0.219	0.003	(0.213, 0.225)	0.006	0.002	(0.003, 0.010)

Risk of returning to court given mother's age at first child

In order to calculate mother's age at first child, both her date of birth and the date of birth of her first child had to be recorded. Given a number of cases where at least one of these was missing, the number of mothers available for this analysis dropped to 23,082. Again, we have used our more restrictive definition, focusing on mothers who returned with at least one 'new' child.

The Kaplan-Meier estimates were computed for each age group by stratification, with the results shown in Figure 5.4 and Table 5.3. Overall, these results indicate that the older the age at which the woman entered motherhood the lower her risk of returning to court. Looking at the results for returning to court within 5 years, we see that 25.5% of those aged under 20 when they had their first child are expected to return, compared to 21.0%, 15.9% and 9.3% for those aged 20-24, 25-29, and 30 or more, respectively. From this we conclude that age at entry to motherhood is clearly associated with recurrence, and this risk is largest for those who entered motherhood at a younger age.

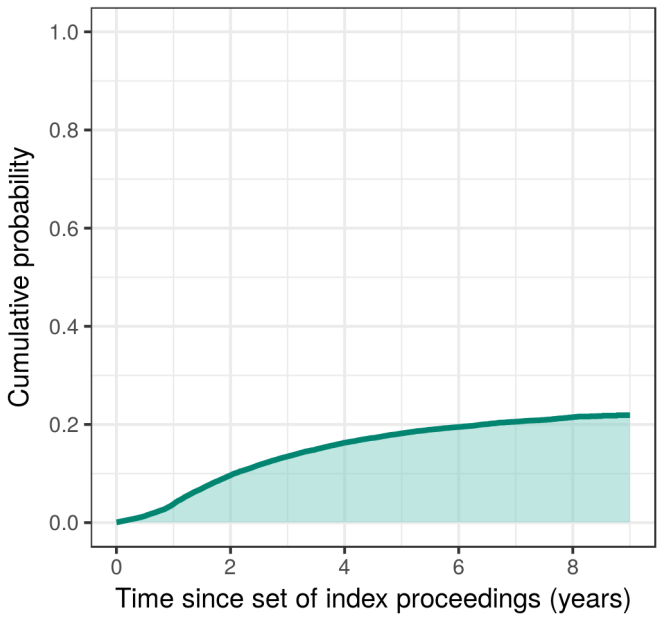


Figure 5.3: Cumulative probability, based on the Kaplan-Meier estimator, of a birth mother entering her first repeat proceedings with at least one 'new' child from the date of issue of her index proceedings (Element A, *n*=25,526).

Further research should examine the life course trajectories of birth mothers in proceedings, with a focus on determining whether or not women age out of recurrence. As records held by Cafcass mature, an extended observational window will enable such questions to be addressed.

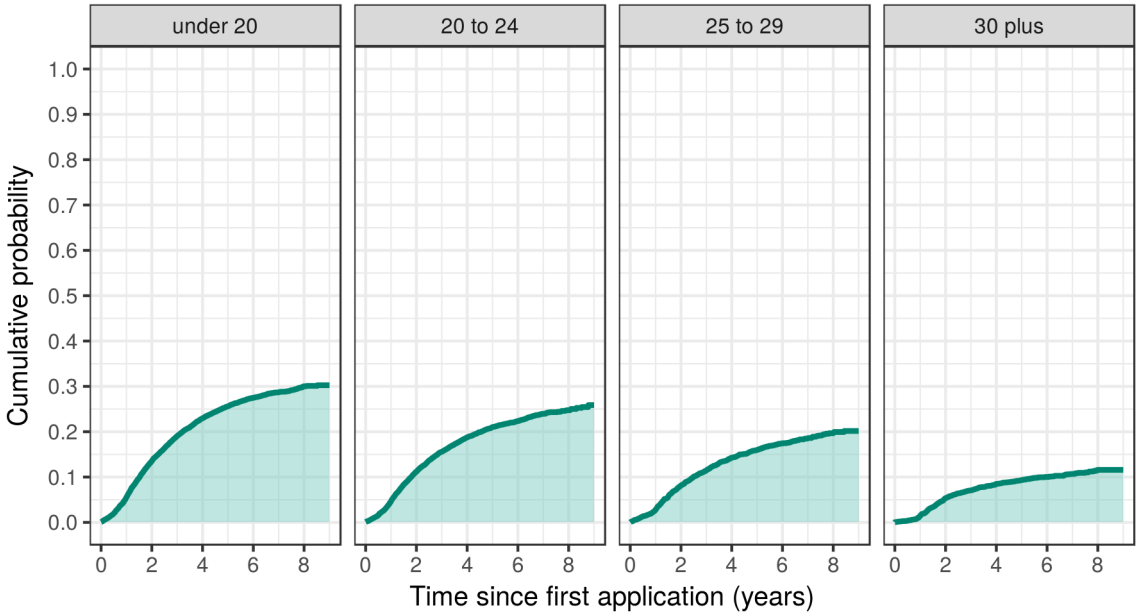


Figure 5.4: Cumulative probability, based on the Kaplan-Meier estimator, of a birth mother entering her first repeat proceedings with at least one 'new' child from the date of issue of her index proceedings, stratified by age at which the mother entered motherhood (Element A, *n*=23,082).

Table 5.3: Life table of the cumulative probabilities of a mother entering her first repeat proceedings with at least one 'new' child from the date of issue of her index proceedings, stratified by age at which the mother entered motherhood (Element A, *n*=23,082).

	Mother's age at first child			
Years	Under 20	20 to 24	25 to 29	30 plus
<1	0.055	0.046	0.027	0.014
<2	0.134	0.111	0.081	0.053
<3	0.190	0.155	0.115	0.070
<4	0.229	0.186	0.142	0.085
<5	0.255	0.210	0.159	0.093
<6	0.274	0.223	0.174	0.100
<7	0.286	0.239	0.185	0.107
<8	0.301	0.246	0.197	0.116
<9	0.304	0.257	0.201	0.116

5.2 Probability of a child being adopted

Previously, in Section 4.1, we stated that a higher percentage of children are subject to a plan for adoption (Placement Order or Adoption Order) at mothers' first repeat proceedings, compared to those at mothers' index proceedings. We know from other published studies, such as Selwyn (2004), that younger children are more likely to be placed for adoption than older children. However, in order to understand more fully, the reasons why we see this percentage change, it was important to explore the impact of a number of other variables as well. Using logistic regression, we examined the probability of a child being subject to a plan for adoption in relation to the following factors:

- Age of the mother at issue of proceedings.
- Age of the child at issue of proceedings.
- Whether or not the proceedings are the mother's index set of proceedings, or her first repeat.
- Whether or not the child is the sole-subject of the proceedings, or is part of a sibling group.

The source of data for this analysis was the population-level data from Element A. The sample was defined as all children at recurrent mothers' index and first repeat proceedings, as they appear for the first time. This gave a sample size of 29,276 children.

To estimate the associations between the listed variables and the PO/AO outcome, a 10-fold cross-validated logistic regression model with a lasso penalty was fitted (Hastie et al., 2011). Table 5.4 shows the estimated coefficients for each of the explanatory variables, while Figure 5.5 visualises the probability of adoption of children for whom mothers were aged 24 or less at the start of proceedings.

Table 5.4: Parameter estimates from a 10-fold cross-validated, lasso-penalised logistic regression model regarding the probability of a child of a recurrent mother being subject to an adoption plan (Element A, $n = 29,276$). Both the log odds ratios (LOR) and the odds ratios (OR) are presented. Reference levels in the category measures are labelled as '(ref)'.

Variable	LOR	OR
Intercept	-0.43	0.65
Child's age at proceedings		
Under 4 weeks (ref)	0.00	1.00
4 weeks to 1 year	0.00	1.00
1 to 4	-0.27	0.76
5 to 9	-1.57	0.21
10 plus	-2.62	0.07
Mother's proceedings		
Index (ref)	0.00	1.00
First repeat	0.22	1.24
Child sole-subject		
No (ref)	0.00	1.00
Yes	0.11	1.12
Mother's age at proceedings		
Under 20 (ref)	0.00	1.00
20 to 24	0.00	1.00
25 to 29	-0.04	0.96
30 and above	-0.10	0.90

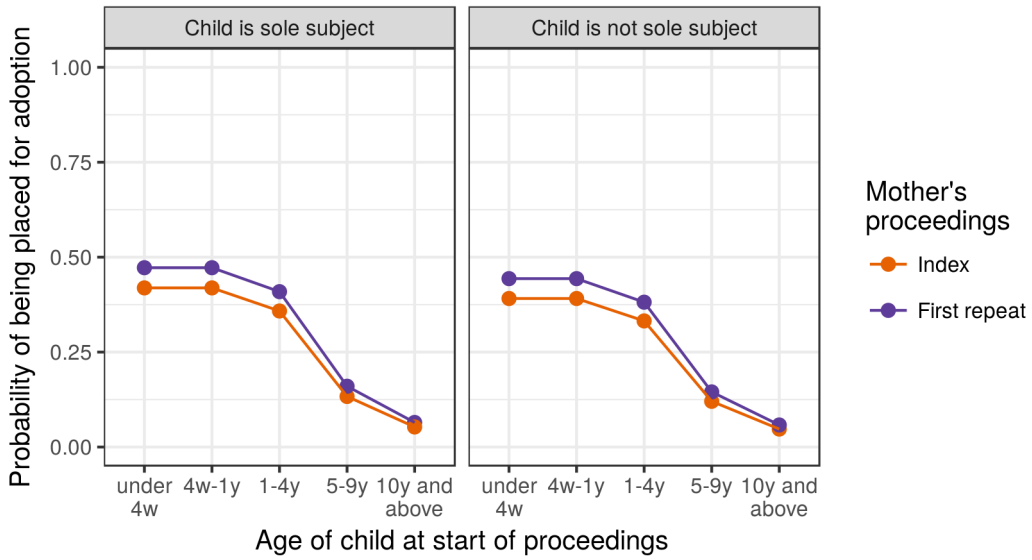


Figure 5.5: A visualisation of the probability of a child, of a recurrent mother aged under 25, being subject to an adoption plan (n=29,276).

Mother's proceedings

The probability of a child becoming subject to a plan for adoption increases by a relatively large amount at the first repeat episode of proceedings (OR: 1.24).

Mother's age

Women aged 20 to 24 years at issue of proceedings have the same chance of their children being subject to a plan for adoption as those aged less than 20 years. While women aged 25 to 29 years have a slightly lower risk of their children being subject to a plan for adoption (OR: 0.96). The biggest difference lies with women aged 30 years at issue of proceedings, who have a lower risk again (OR: 0.90).

Child's age

Children aged less than 12 months, and those aged less than four weeks at issue of care proceedings, both have the same chance of becoming subject to a plan for adoption (OR: 1.00). While, children aged 1 to 4 years old are less likely to become subject to a plan for adoption by comparison (OR: 0.76). And children aged 5 to 9, and 10 years or older have a far lower chance of becoming subject to a plan for adoption, with odds ratios of 0.21 and 0.07, respectively.

Child sole-subject or part of a sibling group

There is an increase in probability of an adoption plan if the child is the sole subject in proceedings (OR:1.12).

Summary

What is shown is that the following all increase the probability of an adoption plan being put in place for the child; the younger the child at issue of proceedings, if the child is the sole subject, the younger the mother at issue of proceedings, and if this is the mother's first repeat proceedings compared to her index.

5.3 Differentiating mothers in recurrent proceedings

Within Section 3.1, we described the prevalence of specific mother-related concerns at index and first repeat proceedings. This section identifies a clear set of concerns shared across the group, and, unsurprisingly, the "toxic trio" of domestic violence, mental health issues and substance misuse were dominant features (Brandon, 2009). However, our detailed understanding built through analysis of the files and the qualitative interviews also indicated that in reality, the women did not all experience the same issues in the same combinations and that a more nuanced understanding was required. In order to better differentiate the recurrent women captured in Element C, a statistical analysis was performed to determine what 'subgroups', if any, would emerge, based on presenting issues at application. The analysis did indeed identify a number of subgroups characterized by differing combinations of presenting issues, indicating some heterogeneity in the sample.

More specifically, to identify the subgroups a Latent Class Analysis (LCA) model was fitted (Collins and Lanza, 2013) to concerns that had a prevalence of at least 10% (see Table 3.4) at both the index and the first repeat proceedings. This resulted in nine concerns being included in the model which were; service non-engagement, victim of domestic abuse, substance misuse, mental health, housing instability, pregnancy, no support network, criminal record, cognitive functioning. As part of the structure of the model, all concerns were treated as statistically independent.

In order to identify the best fitting LCA model, a series of models were fitted with an increasing number of subgroups; one through ten, with the fit of each model being summarised by the BIC value. From this process, a five-group LCA model was identified as having the lowest BIC, 7566.1 (Nylund et al., 2007).

The profiles of the subgroups are shown in Figure 5.6 which is made up of a series of plots:

- Each subgroup has a row of two plots: the first shows the profile for index proceedings, whilst the second refers to the profile at first repeat proceedings.
- Within each plot is a list of issues (on the y-axis), with a bar representing the probability of a given issue being present for a woman in that particular subgroup. Thus the longer the bar the more likely the issue is present.
- The percentage, seen next to the subgroup id, refers to the size of the subgroup expressed as a percentage of the whole sample. The higher this percentage the greater the number of women in that subgroup.
- We considered that an issue can be regarded as a 'common' feature when the probability is over 0.50, and we claim it is a 'core' characteristic when the probability is 0.75 or more. Additionally, we consider any feature below 0.10 as being effectively absent for the subgroup.

Figure 5.6: Subgroup profiles of mother-related issues raised by the local authority at index and first repeat proceedings (Element C, $n = 354$). The subgroups are from a five-class LCA model. The profiles show the probability of each concern being a feature of each subgroup.

By comparing the profile at index proceedings to that at first repeat, we are able to see how the issues in a subgroup changed over time thus offering an important dynamic perspective.

Subgroup 1: 28.7% of mothers

This is the largest subgroup and presents the greatest number of co-occurring issues. The two key characteristic of this group; firstly, is that concerns regarding the mental health of the mother is a core feature (100.0% at index proceedings), and secondly, this co-occurs with both substance misuse, and domestic abuse (88.6% and 81.5% at index, respectively).

As has been broadly discussed within the literature the co-existence of these three problems, commonly referred to as the "toxic trio", raises particular concerns amongst agencies and presents specific challenges in terms of appropriate and effective intervention, this is reflected in the high probability of service non-engagement within this group. It is perhaps unsurprising therefore we see little change in the prevalence of these issues in the subsequent set of proceedings.

Given that this group presents the greatest number of risks, it is perhaps unsurprising that we see little change in the prevalence of these issues in the subsequent set of proceedings. An important question for further research is to disentangle the onset of this combination of problems, in particular the timing of mental health issues and substance.

Subgroup 2: 26.9% of mothers

This subgroup is distinct. In contrast to the other subgroups, the only commonly occurring issue is service non-engagement (59.8% at index proceedings). There is a relatively low probability of any of the other key issues being a feature, with a similar pattern also being evident at subsequent proceedings. This raises questions about what has led this group of women to be repeat clients of the family court. While further work is needed, if the presented issues and concerns are not centred around maternal actions and behaviours, then concerns must relate to either other adults who have contact with the child, or with the child's own behaviour. Importantly this group accounts for approximately a quarter of recurrent mothers in the sample.

Subgroup 3: 17.0% of mothers

This subgroup of mothers is distinctly different from the other subgroups. The key concern relates to maternal cognitive functioning (94.4% at index), with service non-engagement and domestic abuse also being features. The absence of substance misuse when compared to the other groups is striking (15.0% at index). Given that cognitive functioning appears over-riding for this subgroup compared to the others, this certainly suggests a different service response is required. The co-occurrence of domestic violence in this group is also noteworthy, and cognitive impairment may render women vulnerable to coercive and controlling relationships.

Subgroup 4: 14.1% of mothers

The key feature of this group is the co-occurrence of substance misuse, service non-engagement, and domestic abuse (100.0%, 95.1%, and 83.7% at index, respectively). In addition, issues relating to insecure housing are also more common (60.3% at index). We also see very little change at the subsequent set of proceedings, given the very high probability of service-non engagement in this group this perhaps unsurprising (95.1% and % at index and first repeat, respectively).

Subgroup 5: 13.3% of mothers

This is the smallest subgroup, representing 13.3% of the recurrent mothers. There are typically only 2 or 3 concerns for a mother from this subgroup, with the dominant characteristic being maternal substance misuse (100.0% at index proceedings). Concerns relating to service non-engagement and domestic abuse are features, but much less common (59.4% and 54.4% at index proceedings, respectively). Importantly, this group shows the greatest change between proceedings, with a substantial reduction in substance misuse (from 100.0% to 62.3%), as well as reductions regarding the other concerns. This is the only group where we also see a notable change in service non- engagement in repeat proceedings, suggesting that services are more effectively reaching this group. Substance misuse is a preventable problem, with the right help, as the Family Drug and Alcohol Court has demonstrated, women can cease misusing substances (Harwin et al., 2011).

Summary

The results from the Latent Class Analysis have shown some heterogeneity in the presenting issues of recurrent mothers, in terms of both number and combinations. Although the presenting problems are familiar, the way in which they combine in each subgroup does provide new insights and suggests that practice needs to be tailored according to the particular intersectional challenges that each subgroup provides. With the exception of subgroup 5, presenting issues appear to persist for all groups across sets of proceedings. This is perhaps unsurprising given (again with the exception of group 5) that service non-engagement is a persistent concern across the groups and we might expect positive change to, at least, in part depend on services succeeding in engaging women. Given women's experience of harm and maltreatment in childhood, a reluctance to engage with services is perhaps unsurprising. We urge that this challenge of service engagement must be addressed, if a cycle of repeat proceedings is to be broken. In addition, services need to be attuned to the varied combination of presenting issues presented by women, which are rather glossed over by the concept of the "toxic trio". Further longitudinal work is required in order to better understand the longer term outcomes of women within these various profiles.

5.4 Duration of mothers' index and first repeat proceedings

In section 3.1 we presented summary statistics regarding the duration of proceedings at mother's index, first repeat and second repeat proceedings. Whilst, on first impression, these statistics show that the duration of proceedings substantially shortens once the mother is known to the family court and local authority, we must be cautious because of the reforms of the family justice system that took place within the same time-period. In particular, there was a shift in practice for shorter proceedings, which was provided with a legal underpinning from the introduction of the 26-week ruling within the Children and Families Act 2014.

Thus, in order to accurately understand the contributing effect on the duration of proceedings of a mother being known to the family justice system, we needed to control for the year in which the proceedings were issued. Along with year, Table 5.5 lists all explanatory variables included in modelling the duration of proceedings.

The selected sample for analysis were the index and first repeat proceedings of all recurrent proceedings in Element A. The variables considered are listed in Table 5.5. This resulted in a sample of 71,263 proceedings, involving 60,373 mothers, for which all variables were complete. 'Duration' was defined as the number of weeks from when the first application for the set of proceedings was issued to the date of the final hearing. This duration was modelled using a 10-fold cross-validated, lasso-penalised, Gaussian GLM (Hastie et al., 2011). All the features listed above were fitted as main effects, along with interactions as to whether this was the mother's index or first repeat set of proceedings.

Table 5.6 contains the parameter estimates. There are three columns of estimates, the first shows the estimates for the duration of index proceedings, while the second column shows the estimates for the first repeat proceedings, and the third column is the difference between the two.

Table 5.5: Explanatory variables included in modelling the duration of proceedings.

- Year ending March 31st when the proceedings started.
- Any child aged; under 1, 1 to 4, 5 plus.
- Number of children subject to the proceedings.
- Whether or not a Supervision Order or a Care Order is being applied for.
- Whether or not the birth father is also party to proceedings.
- Age of mother at start of proceedings.
- For repeat proceedings: time since previous proceedings closed.

Table 5.6: Parameter estimates for modelling the duration of recurrent mother's index and first repeat proceedings (weeks). Separate effects are presented for recurrent mother's index proceedings, and first repeat proceedings, along with the difference between the two (Element A, $n = 71,263$).

Variable	Index	First repeat	Difference
Intercept	27.28	24.30	-2.98
Fiscal year of proceedings			
2016 (ref)	0.00	0.00	0.00
2015	0.00	0.00	0.00
2014	0.00	0.00	0.00
2013	5.10	5.10	0.00
2012	16.02	15.34	-0.68
2011	24.43	22.52	-1.91
2010	28.05	22.21	-5.84
2009	25.48	23.29	-2.19
2008	23.04	23.04	0.00
At least one child aged			
Under 1	1.40	1.40	0.00
1 to 4	3.97	3.97	0.00
5 or older (ref)	0.00	0.00	0.00
Number of child subject			
1 (ref)	0.00	0.00	0.00
2	3.40	3.40	0.00
3	5.45	5.45	0.00
4+	8.40	8.40	0.00
Application for Supervision Order			
No (ref)	0.00	0.00	0.00
Yes	-0.97	-4.00	-3.03
Birth father is party to proceedings			
No (ref)	0.00	0.00	0.00
Yes	0.00	-0.12	-0.12
Age of mother at start of proceedings			
Under 20 (ref)	0.00	0.00	0.00
20 to 24	0.00	0.00	0.00
25 to 30	0.00	0.00	0.00
30 plus	-0.92	-0.92	0.00
Time since previous proceedings			
Overlapping	–	-5.19	–
Under 1	–	-0.58	–
1	–	0.00	–
2	–	0.00	–
3	–	0.00	–
4	–	0.00	–
5+	–	0.00	–

Baseline intercept

The intercept shows that the average length of proceedings in 2016, involving a single child, in which a Care Order is being applied for, where the birth mother is the only party and she is aged under 20. For mothers who fit this profile and it's their index proceedings, the average duration is 27.3 weeks. We would expect the duration of first repeat proceedings to be 24.3 weeks, a difference of −3.0 weeks.

Fiscal year of proceedings

If proceedings had been issued in fiscal years 2015 or 2014, compared to 2016, then we make no adjustment to the expected length of proceedings, as the estimated effects for these years are 0.00. However looking back further in time, we see the length of proceedings increases, with the longest duration being in 2010, where the average was 55.33 weeks for the baseline (28.05 + 27.28). This is approximately double what we would currently expect. Regarding first repeat proceedings, whilst historically the duration of repeat cases were considerably shorter, this difference is at an all-time post 2013. This change can be accounted for the change in practice for shorter proceedings, followed by the implementation of the 26-week ruling, and the wholesale reduction in duration of proceedings that then followed. Whilst recurrent cases may be able to dealt with more expediently by the courts, due process must still be followed which necessitates a minimum duration.

Age of child

Proceedings that contain at least one child under the age of one year, on average, take 1.4 weeks longer. The association with at least one child aged between 1 and 4 is that proceedings take an additionally 4.0 weeks. There was no association between length of proceedings and at least one child being aged 5 or older.

Number of children

There is a positive association between duration and the number of children subject to proceedings. Proceedings involving two child subjects took, on average, an additional 3.40 weeks when compared to those involving just 1 child. Proceedings involving 3, or 4+ children, the duration increased by 5.5, and 8.4 weeks respectively. Where the number of children subject to the application remains the same, the duration of proceedings remain static regardless of whether it is the mother's index or first repeat proceedings.

Type of application

The application type appears to have a small effect on the duration of proceedings. If the local authority is applying for a Supervision Order, compared to a Care Order, we see a small shortening of proceedings of 1 week at index proceedings. This increases to a shortening of 4 weeks in first repeat proceedings (−0.97 + −3.03).

Father as party to proceedings

There is no effect where fathers are parties to cases at index proceedings but there is a small negative effect seen at first repeat proceedings which on average shorten by 0.1 week.

Mother's age at start of proceedings

There is only a small association with the duration of proceedings and mothers age and only at index proceedings. In cases where the mother was aged 30 or older at index proceedings the duration reduces by 0.9 weeks (6 days). There are no statistical differences found between index and first repeat.

Time between proceedings

The time between the end of one set of proceedings and the start of a second set does have an effect on the duration. Consolidation and overlapping proceedings, as would be expected, decreases the duration of first repeat proceedings by an average of 5.2 weeks. Where there is less than one year between sets of proceedings, the duration of first repeat is shorter by −0.6 weeks. There is no effect once the gap in proceedings extends beyond one year.

Summary

In summary, there are a number of factors that influence the duration of a mother's index proceedings and her first repeat: the number of children, age of the children, who is party, and the age of the mother. We have been able to quantify the general shortening of proceedings that had been occurring, which was underpinned by the Children and Families Act 2014. Over the years, proceedings have approximately halved in length, and the difference between a mothers index and her first repeat is the smallest it has ever been. With everything else being held constant, the duration of a mother's first repeat proceedings is currently expected to be 3 weeks shorter than her index.

With the exception of the year in which proceedings were issued, these factors appear to modify both a mother's index and first repeat in the same way, this shows that the system does not seem to be making decisions more swiftly given these factors beyond the general three week difference.

6 Birth mothers' perspectives

Capturing the experiences of birth mothers who have experienced recurrent care proceedings formed an important part of this study. In this section we report on what is the largest qualitative studies of birth mothers in public law proceedings in England. In-depth interviews were undertaken with 72 women across seven local authority areas. Women's first person accounts have proven invaluable in understanding the factors and processes associated with their repeat appearances in the family court. Common themes across women's accounts reveal completely new insights about the aftermath of child removal, subsequent pregnancies as well as positive turning points. Whilst a full descriptive profile of the sample is provided below in Table 6.1, statistical testing (see Appendix A.7) showed that across most variables differences were not significant, at the 1% level, between this sample and the sample from Element C. However, the high number of women in our sample who had a child in their care at the time of the interview, suggests that this self-selecting group of women were more engaged with services, than women in the broader population of recurrent mothers.

6.1 Profile of birth mothers participating in interview

Table 6.1 provides a descriptive profile of the women participating in the study, based on the information gathered from a questionnaire following interview. We can see that women participating in our interview sample were very young at the birth of their first child, with almost 80% aged 19 years or younger. Almost all women (94.4%) reported at least one unplanned pregnancy. Just over half of this sample of women had experienced the removal of at least one child at birth (51.4 %).

Also in Table 6.1, we can see women's exposure to multiple forms of harm and maltreatment in childhood. We discussed this in detail in Section 3.3 of this report, but interview data confirms the picture we gained from court files. With 47.2% women reported sexual abuse in childhood and 45.8% were formally looked after children, confirming very difficult childhoods and further harm in adult relationships. The women's accounts of domestic violence are indeed troubling, with 87.5% of this group of women having experienced domestic abuse in adult relationships and often across multiple intimate relationships. We now turn to explore many of these factors in detail from women's subjective accounts of their lives.

Table 6.1: Descriptive statistics of interviewed recurrent mothers regarding their demographics, experiences and motherhood (Element B, $n = 72$).

(a) Demographics and experiences.

	Count	Percent
Total	72	100.0
Ethnicity		
White	62	86.1
Black	5	6.9
Other	5	6.9
Adulthood experiences		
Domestic abuse	63	87.5
Mental health	60	83.3
Substance misuse	43	59.7
Lack of support network	35	48.6
Housing instability	25	34.7
Childhood experiences		
Looked after	33	45.8
Domestic abuse	32	44.4
Significant loss	40	55.6
Physical abuse	43	59.7
Sexual abuse	34	47.2
Mother's parents		
Cognitive functioning	12	16.7
Mental health	25	34.7
Substance misuse	24	33.3

(b) Motherhood.

	Count	Percent
Total	72	100.0
Pregnancy planning		
Any planned	35	48.6
Any unplanned	68	94.4
Age at first birth		
Under 16	9	12.5
16-19	48	66.7
20-25	13	18.1
Over 25	2	2.8
Number of live births		
One	1	1.4
Two	17	23.6
Three	22	30.6
Four	16	22.2
Five or more	16	22.2
Number of fathers		
One	11	15.3
Two	33	45.8
Three or more	28	38.9
Children removed at birth		
None	35	48.6
One	24	33.3
Two or more	13	18.1
Has child in FT care		
No	31	43.1
Yes	35	48.6
Missing	6	8.3

6.2 Maternal childhood

Key findings

- Women described histories of maltreatment and neglect, primarily as a consequence of difficulties their own parents had in providing adequate or safe care (parents and parents' partners). However, women also described experiences of abuse and further adversity resulting from their broader familial and community networks.
- Women's childhoods were marked by instability in relationships; they typically did not feel sufficiently cared for by either family or professionals.
- Nearly half of the sample of women had spent time in local authority care during their childhoods, and frequent moves between placements were common.
- The concept of developmental trauma provides a useful framework for helping us to understand the impact of childhood experiences and why women may find it hard to engage with services.

The women participating in our interviews had experienced high levels of maltreatment and abuse in their own childhoods. The interviews provided women with an opportunity to reflect on their own childhoods, and in most cases they provided vivid recollections of harmful early experience. A lack of felt emotional security was evident and in many cases, the level of maltreatment and neglect experienced whilst in their parent(s) care was very apparent. Below, Lisa describes her early experiences:

> Lisa: I had my mum and dad. . . he was a lot older than my mum, I think there was about 20 years difference. And my mum got pregnant with me and it was been there, done that, it's another kid, kind of thing, I want to go out with my mates. . . My mum rebelled against my dad going out all the time, so it was a case of leave me with whoever will have me, I'm going out to do my thing and I'll stay over wherever, and my dad will do the same thing. So there were a lot of different things going on in the household, a lot of people in, a lot of people out. And a lot of confusion, and I grew up not feeling very loved at all. My dad died when I was 12. . . she (my mother) went off the rails; it was like we can't stay in one place and be happy, we have to keep moving all the time. And although she made beautiful homes, don't get me wrong - we'd only be in it for a month and she'd get itchy feet and we'd be moving again. . . And we'd have to live in a refuge because there'd be nowhere else for us to go because we didn't have a house because she'd give it back. And we didn't have no stuff because she'd sold it all. One day I came home she was trying to hang herself from a light fitting up on the hall way. She took loads of tablets; she nearly died like I say, because she was on dialysis. What happened was when I was 14 or 15 I got into a relationship with a man really older than me, he was 42. . . because I was so vulnerable and I was so like I don't want to fall into something like this, but I want someone to notice me and I want someone to love me. And that's why I gelled with him so quick I think.

As we can see from this extract, the lack of care and protection from her parents, predisposes her to a relationship with a much older man, when she is a teenager. Later in her interview, she describes how this relationship quickly became very violent and emotionally abusive.

Gemma's difficulties (below) also began early in childhood and appeared to pre-dispose her to further difficulties; her mother and step-father are both implicated in her abuse. It is noteworthy that Gemma describes her childhood as "horrible". Gemma was sexually abused by her step-father from age of seven.

> Gemma: I was seven. And it stopped when I was 13, and that was the one that my mum witnessed. But that was the full force. It was only. . . I say only. It wasn't full intercourse from seven, but when I hit 13 it was the first time that he'd done it. Me and mum's never had a proper mother/daughter relationship. It's always been fisticuffs and knocking each other out and throwing plates at each other. She's whacked a frying pan round my head after she's just used it, and I've got a big scar down my head where she's smashed my head off a wall. . . My childhood was just horrible.

In common with the sample as a whole, these young women's detailed accounts demonstrate the multiple adversities they faced and the consequences. Gemma also describes how she became vulnerable to further harms as she attempted to block out her memories of being sexually abused. She began using heroin aged 14 and a series of unstable intimate partner relationships followed. The high level of reported sexual abuse was particularly concerning given that sexual abuse has been described as a unique victimisation experience, with particular developmental consequences (T. Lewis et al., 2016). Both Lisa and Gemma's interviews demonstrate their vulnerability as they entered adolescence and made the transition to independence.

When asked, a minority of women initially described their childhoods as "normal", however from the perspective of an interviewer looking in on their stories, they too appeared very vulnerable. As their stories unfolded it was clear that they had experienced high levels of adversity. Women's references to a normal or happy childhood frequently referred to particular memories of one parent or caregiver who had shown them love and support and who appeared to reduce the sense of neglect that they associated with their childhoods. The extract below provides an illustrative example of this point. Amber initially describes her childhood as 'perfect' but then quickly proceeds to describe a number of very difficult events:

> Interviewer: Would you mind just telling me a little bit more about your childhood? You've said you were quite a troubled teenager. What was life like for you growing up?

> Amber: Fine, it was perfect, but my mum had MS [multiple sclerosis] for 12 years so she couldn't speak, she couldn't walk, she was bedridden. I was about five or six when she got ill and she's been in a nursing home ever since then. So, I had to put up with, like that, but it was like round the age of 14, I think it was about Year 9. . . yeah, third year in school that I started. Cause I can't really say I got in with the wrong crowd because I didn't. I had my own like little group of friends. It might have been through growing up with my mum, me dad getting with someone else. . . Which was fine at first, but as I was growing up, I hated her [my step-mother]. We've never seen eye to eye until this day but I suppose its step-parents with step-kids. Yeah, I think, cause I got into my teenage years so. . . I'm well known for bottling things up, I don't really let things out so must have just built up over seven years and just got to me and then I just started going off the rails running away. They'd find me in [city] with me mate. Me and me mate, it was me and her we just used run away together all the time. End up in [cities] everywhere.

Women's accounts often referred to a history of Children's Services involvement, but perhaps unsurprisingly rarely did they appear to understand the detail of this involvement. Most commonly their perspective was simply that the involvement had not protected them from harm at home.

elow, Carla describes "a lot of abuse at home, physical abuse" and that her stepdad "controlled the whole house". Hers is a history of repeated episodes of running away from home, which research evidence indicates is linked to further secondary vulnerabilities or abuse, such as substance misuse and sexual exploitation (Tucker et al., 2011; Meltzer et al., 2012).

> Carla: I never got on with my stepdad, and there was a lot of abuse at home, physical abuse with my mum. My stepdad, kind of, controlled the whole household. So I've never got on with him at all, and I used to run away from home all the time. I think I must have run away about 30 or 40 times from home. Social care were involved, but they never did anything about it. He wouldn't feed us for days, he would keep us locked up in our bedrooms, and I never had any support or anything from social care at the time. They just, kind of, left me to it.

We can conclude from women's first-person accounts that childhood neglect and maltreatment were clear features of women's childhoods. The broader context of women's lives was also of unstable housing and exposure to poor parental mental health, substance misuse and violence. As shown in Table 6.1, over a third of the women when asked said that frequent house moves were a feature of their childhoods. In addition, women made reference to poor home and housing conditions. Women's accounts confirm the findings we have drawn from court files (Element C), that childhoods were characterised by instability and multiple adversities, which were enduring.

Experience of Care (foster care, kinship care and residential care)

Within the interview sample nearly half the women had been in the care system for part of their childhoods. Again, in keeping with the observations we have drawn from case file data, women reported unstable care histories. Women's first person accounts offered a picture of multiple moves both within the care system, but also between home, kin and care. Cassie provides an illustrative example:

Cassie: I've had them [social workers] involved since I was one. My mum weren't caring for us right, and then there were opportunities when my mum had us back. My nan lived direct over the road from us, so my nan got a Residence Order for me, for a year. And then obviously after that my mum got allowed to have us back and then my sister sustained an injury in my mum's care, which meant her being hospitalised, which got us took again. . . So, the order came that it was either we go to family or we go to strangers. So my [great] nanna ended up lying about her age, saying she was 68, when clearly she was 74, just to get us obviously. I left when I was 13 because things were getting rough at home, there were issues with my mum. . . I'd started talking to my mum again, and I was sexually assaulted in my mum's care, with my mum watching it - by my mum's partner. Then obviously I left, went into different kid's homes, and then after that I went and got my own flat at 16.

Neglect and maltreatment were features of Cassie's life from a young age. It is evident from her own account that she had little stability of care at any point in her childhood. She experienced frequent moves in and out of care in her early years before moving to her maternal great-grandmother. However, her exposure to maltreatment continued and she eventually entered local authority care permanently at 13. In care she was moved to several different residential settings in a 3 year period. Age 16 Cassie is living independently.

For this group of women, being received into care did not appear to avert further harm. In the example below, we see a young girl very much out of control and an escalating picture of risk during adolescence:

Ingrid: I was in care at this time, I was in a care home because my mum had. . . at the time I'd been raped, my mum had just met a new man and I clashed with him. Because, obviously I realised after that shouldn't have happened, and with everything else that had happened to me when I was little I didn't get on with my stepdad. So, I had run away from home, I'd hit my mum, I'd done all sorts, so in the end I asked to be put into care [aged] twelve. I had been in foster homes as well and after the care home, but I'd run away that same night, or the day after. The care home was the only place that I stayed, I stayed there for nearly a year. . . From there I came back out of care in the care home, I stayed with my mum again and then I met a boy and moved in with him. I was out of control, my mum couldn't control me, I started drinking, started taking base, speed, I'd be walking up and down this road hallucinating when I was 13, and drunk at 6 o'clock in the morning. I'd go round in cars with people, I was really out of control.

Whilst, women were also able to recount some positive care experiences, they tended to be spoken about as glimpses of happier times, set within a broader context of marked instability and unhappy memories. However, as we can see in the extract below, for some young women relationships with their foster carers were reflected upon positively. In the extract below Candice describes her foster placement:

Chloe: I loved it. The best bit of my life. I wish I could just go back now.
Interviewer: What did you love about it?
Chloe: That I had a mum and a dad but they weren't my real parents, it was someone who actually cared and loved me and brought me up as the same as their own children.

Although in the placement for less than a year, she clearly holds on to it as an important time in her

life. Her words convey this foster placement as her place of safety "someone who actually cared and loved me" and still holds it in mind in her adult life "I wish I could go back now".

Summary

Based on women's accounts of their childhoods, it is perhaps unsurprising that they went on to experience poor adult outcomes. As we describe in Section 6.2, studies of adverse childhood experiences emphasise continuities rather than discontinuities between childhood and adult experience (Taussig, 2002; Felitti et al., 1998). Furthermore, the international literature confirms that developmental harm in the context of the primary parental or caregiver relationship predisposes individuals to further harms from those outside the family. Qualitative interviews provide invaluable insights into the roots of the complex difficulties women presented in their adult lives and confirm observations from case file data. Women's self-reports of childhood adversity are highly consistent with what we have been able to learn from our review of case files (Element C). However, from these first person accounts we are able to capture how women adapt to very difficult childhood experiences. Adolescent substance misuse presents as a strategy of blocking the emotional pain of being harmed and maltreated in childhood. Equally running away, or leaving home at a young age and quickly setting up home with a partner early into a new relationship, were further strategies of escape in the face of unstable home environments. Women were able to reflect on and link their own childhood experiences to difficulties they experienced in their own parenting. For women across our interviews, there is a lack of a secure base and adult protection (Schofield, 2002; Schofield and Beek, 2009). Unfortunately, their accounts also suggest that from their perspectives professional services either through non-intervention or ineffective intervention failed to assuage this harm. This compounded feelings of abandonment and fear and impacted on their willingness to engage with services when they became parents.

The concept of developmental trauma disorder, variously referred to as complex trauma or complex trauma disorder, provides an explanatory framework for understanding the roots of the complex difficulties that beset the lives of this population of women (Broadhurst et al., 2018). Developmental trauma disorder (DTD) has become the preferred description for capturing enduring harms in the context of interpersonal dependence. Harms can be emotional, sexual and physical. Informed by DTD, the difficulties that we see emerging as externalising behaviours in adolescence are best understood as complex adaptations to trauma, developed in childhood and which pose a significant challenge to the helping professional. As these children grow up, they become harder to engage; their expectations, as we see, and experience of professional services, are very poor.

Professional help needs to be longer-term and attuned to helping women find alternative ways of managing difficult emotions and resolving past trauma. Dealing with entrenched and complex difficulties takes time. Professional relationships that offer continuity and consistency will have a greater chance of success. In this context, there is a fundamental mismatch between standard case-work social work services and the needs of this population of children and adolescents. In addition, this population of children requires highly skilled substitute carers who can help children find a sense of safety, given these difficult histories (Schofield, 2002). In the final discussion to this report we pick up these observations in more detail and consider implications for service change and prevention.

6.3 Contraception, pregnancy and first-time motherhood

Key findings

- Women typically became mothers during their teenage years.
- Women largely described their pregnancies as unplanned.
- There are varied reasons for unplanned pregnancy resulting from women's personal biographies and decision-making capacities.
- There is clearly a role for targeted advice or advocacy to better support informed choice about contraception and pregnancy.
- First-time pregnancy was experienced as difficult given women's very challenging personal circumstances and a lack of practical and emotional support.

Understanding unplanned pregnancy

Analysis of all three datasets provides clear evidence that the population of women who experience repeat care proceedings enter motherhood at a markedly younger age when compared to the general population. In the context of the previous chapter, this is not surprising given young women's dislocation from protective adults in adolescence, coupled with childhood experiences of neglect and maltreatment. In-depth interviews with birth mothers provided an opportunity to talk to women about contraception and pregnancy planning.

In keeping with the international literature on unplanned pregnancy and socially disadvantaged women (Finer and Henshaw, 2006; Ryan et al., 2008; Lucke and W. D. Hall, 2012), the women who participated in interview, consistently described their pregnancies as not being actively planned. Responses indicated a lack of personal agency in terms of reproductive decision-making: "I fell pregnant", "I found myself pregnant" or "I ended up pregnant". Recent population surveys in the UK suggest that only 54.8% of pregnancies are consciously planned (Wellings et al., 2013), but the figure from our self-report data suggests the far fewer pregnancies are planned for this population. Almost all the women reported at least one unplanned pregnancy (94.6%). Given that 78% of women were teenagers at first pregnancy, high rates of unplanned first pregnancy are not surprising.

In over a quarter of cases (28%), mothers reported that their pregnancy was as a result of failed contraception. However, more frequently the women spoke of not using contraception at all (46%). In the case of failed contraception the mothers most often referred to use of the oral contraceptive pill and stated that this method of contraception had not prevented a pregnancy for a variety of reasons. Rachel, for example, discussed that being on antibiotics interfered with the effectiveness of the oral pill in one of her pregnancies. However, she also indicated that none of her pregnancies were planned.

Rachel: I just fell pregnant. I weren't out to get caught pregnant, or on any of them. It's like with B now, I slept with somebody, got caught pregnant, told him, he told me to go and get rid, but I couldn't do that.

Interviewer: And at any point, did you think about using contraception or long-term contraception, or?

Rachel: Well, I was on the pill at that time, but because with everything, with antibiotics and things like that, it wasn't working.

User failure in oral contraception been much documented in the literature, particularly among very young mothers or mothers with problems of substance misuse. User failure also varies by socio-economic status (Arai, 2003; Harden et al., 2009; Ryan et al., 2008). However, despite the failure in effectiveness many women in this study described their continued use of this method.

Similarly, whilst unplanned pregnancy was most commonly associated with first pregnancies, for over half of the women (52%) all their pregnancies were described as unplanned. It is important to note, that although unplanned pregnancy was a consistent theme across women's accounts, the reasons behind lack of planning or effective use of contraception were complicated.

Unplanned pregnancy: substance misuse and mental health

Within the interviews, women frequently stated that in the face of their difficulties they were simply "not thinking about contraception". In keeping with the broader literature (K. S. Hall et al., 2014). significant problems of mental health are associated with difficulties in self-care and decision-making, including accessing contraception and making informed reproductive decisions. In the extract below, Ruth recalls undiagnosed depression, which left her feeling unable to muster the energy or motivation to take control of many aspects of her life, including contraception:

Interviewer: So were you using contraception?

Ruth: Not really. I mean, I was on the pill for a while and then I was having the injections but I wasn't sticking to the dates and times and stuff and kept getting them wrong.

Interviewer: And do you think that was because you sort of wanted to get pregnant or because you just couldn't get your head around it, or what do you think?

Ruth: It was a. . . just couldn't be bothered attitude that came with the depression at the time, but as I say, I didn't know it was depression then. It was just I can't be bothered, I don't want to. . . sort of thing.

As described in the published literature (Connery et al., 2014; S. E. Black et al., 2016), substance misuse was similarly described as a major factor in unplanned pregnancy. Where drugs and alcohol dominated women's lives, their capacity to consider contraception appeared to be very much compromised:

Jodie: I certainly weren't looking to have another child. I hadn't set out to get pregnant whatsoever. . . And I know, I'm not naive obviously, but I just hadn't. We were drinking a lot at the time you see.

Similarly, in the extract below Sonya, a long-term heroin user, describes how thinking about contraception was just not her priority:

Sonya: It just happened. The first three pregnancies just happened.

Interviewer: So you weren't using contraception?

Sonya: No. . . I will be honest; it wasn't on the top of my list

As Sonya succinctly expresses, and in keeping with an international literature, for women where substance misuse was a serious issue, decisions regarding contraception became much less of a priority and there is a higher risk of unplanned pregnancies and poorer pregnancy outcomes (K. I. Black et al., 2012; Mundt-Leach, 2014).

Unplanned pregnancy: personal agency and choice

Problems of mental health and drug misuse erode personal agency. However, many women described feelings of limited control and difficulty in making decisions across many domains of their lives. Women described feeling unable to steer their lives; rather life events happened to them. The published evidence indicates that neglect and child maltreatment can erode personal agency and confidence, which undermines the capacity to exercise autonomous choice (Jackson and Day-Sclater, 2009). Furthermore, for this group of women, intimate partner relationships typically continued a pattern of instability and abuse experienced in childhood, further eroding self-esteem. Again, studies have highlighted a clear association between intimate partner abuse and unintended pregnancy (Miller et al., 2010).

> Wendy: It was good in the beginning. He was giving me all the attention that I wanted. He was making me feel special and then I fell pregnant. About six months, I was in the relationship. And then when I fell pregnant he wouldn't let me leave. He kept hitting me, telling me I was ugly, "no wonder your mum and dad didn't like you". And because he was the only one I had, I tried to hold on to him for a long, long time. Because I never had any family to go and talk to. And then the violence got so much, obviously I had a second baby as well, and my baby passed away because the oxygen to the baby stopped, from him punching me in the stomach.

Unplanned pregnancy: the search for love and belonging

Whilst some women described simply "not thinking" about contraception, other women appeared far more aware of the risks they were taking through unprotected sex. Given histories of a lack of security and care in their own childhoods, including periods in state care, some women described a strong desire to create a family of their own. This led to a more ambivalent attitude towards contraception.

> Kelly: When I was with [Child 1]'s dad... it was like... because we were together, you know, it was my first proper relationship with a man, because I was a lesbian before that. And it was, like, so I started thinking that's what you do. I don't know why. I was young as well and I thought, you know, that's what you do after a while, you trust them now, so you can use no protection. Yeah, I'm not going to lie, it was stupid... I wasn't thinking, like, I don't get want to pregnant and I wasn't thinking that I want to get pregnant. It was like if it happened, it happened. Because I did love him at the time, so it wasn't that I was thinking I don't want to be pregnant for this guy. At that time, I was thinking, yeah, if I do get pregnant, you know, we'll have a nice little family, a nice life.

Kelly was brought up in care. She was physically and emotionally neglected by her own mother and later severely emotionally and physically maltreated by other relatives with whom she was placed. She frequently moved care placements until she finally ended up in a youth offending institution. Although she described herself as not consciously planning a pregnancy reflecting "I wasn't thinking, like, I don't get want to pregnant and I wasn't thinking that I want to get pregnant", she also saw the potential of creating "a nice little family, a nice life".

Diana, another care leaver, gave a similarly moving account of her desire to be a mother, following discovery of an unplanned pregnancy:

> Diana: Children are innocent in the whole equation. They don't have to be born into the world. We bring them into the world out of our own selfishness and stupidity because we want to know what it's like to have unconditional love really.

Interviewer: Is that how it felt for you?

Diana: Yes. . . Holding my kids was the first time I'd ever felt unconditional love.

It is noteworthy that many women did not choose to terminate an unplanned pregnancy and often felt positive about the prospect of having a baby, particularly a first child, despite difficult personal circumstances. Pregnancy can be seen as a positive life event, even when unplanned, for women who have a sense of fewer alternative life chances (Arai, 2003; Tabberer et al., 2000). In the face of adversity, the prospect of a first baby can signal hope and a new future and can also be viewed as way of accelerating commitment in a newly formed intimate partner relationship. As Kelly attests, not using protection was a way of showing trust in her relationship. However, a desire to create family appeared to predispose women to forming hasty, intimate partnerships. Darcy provides a vivid illustration of these points. A single mother, bringing up two sons alone, following a violent relationship and estranged from her own family, she became pregnant within a few months of meeting her new partner. Soon after her pregnancy was confirmed, this relationship also became very violent.

Darcy: I brought [child 1] up on my own, so I kept [child 2] and I brought [child 1] and [child 2] up, two children up on my own. My eldest son was 11 and my youngest son was five when I met my ex-partner. Like I said, in the few months after I'd been with him, he turned violent and then I got pregnant.

Interviewer: And was that [pregnancy] planned?

Darcy: I wouldn't say planned, I wouldn't say not planned, it's just. . . well

Interviewer: You weren't using anything?

Darcy: I got caught pregnant with [child 3] on the pill so. . . But at the time it was like, he looked after my sons, he looked after me, his mum and dad welcomed me into their house so I wasn't bothered that I was pregnant

Within the extract above, Darcy suggests that although the relationship was still new she had hoped that things would be better and so she did not consider the pregnancy to be a problem. Having a partner and other adults to support her was in stark contrast to managing alone with her sons as a single mother.

The challenge of parenting in face of multiple adversities

Despite the hope of a'fairy tale ending' associated with some pregnancies, women were also candid in their descriptions of the difficulties of caring for a baby:

Kim: I didn't even think I'd get pregnant. It was not even on my mind. But then I was, I was happy. I didn't want to have an abortion. I wanted to keep him. But I didn't realise how hard it actually would be. Being so young with the lifestyle that I had, I didn't realise how hard it would be to actually look after a baby.

Across many of the interviews, women described difficulties coping following the birth of their children. Breakdown of couple relationships and domestic abuse were frequent and women were left coping alone in very challenging circumstances, ill prepared for the demands of parenting and with very few resources to help them cope. Becoming a parent often led to the surfacing of unresolved issues from women's childhoods. In the following extract, Angela's anxiety is very apparent:

> Angela: It was quite traumatic. So obviously, then going on to have my own child, you know, I didn't think I could do it. I kept saying I can't do it and her dad was like, I'm here, I'll support you, you know, don't get rid of her, you know, I've been brought up Catholic, so you don't do abortion, you know what I mean, you don't do things like that. And I thought there's no way out. I felt trapped, you know, because it's not her fault and I love her to pieces, but I felt trapped within myself because. . . well. . . I hadn't dealt with my own issues. I needed my gran and granddad, you know, I relied on my nan to take me to hospital. I couldn't look after myself. . . even though I had my own flat, my nan used to come up and do my washing. You know, I couldn't even keep up with my own washing and stuff, you know.

The internal battle faced by Angela is clear when she says "it's not her fault and I love her to pieces, but I felt trapped". This young woman had faced serious physical and emotional abuse from her mother and her partner. She was a young carer from age eight being left responsible for her younger siblings care. Age 12 she was taken into local authority care and subsequently went to live with her grandparents. By this time she had developed an eating disorder. She became pregnant soon into the relationship with her partner, and whilst at times the relationship was positive, violence was a frequent feature and it ended soon after the baby was born. Her insight into her own difficulties within this interview extract is clear. Whilst the support offered by her grandparents was crucial, in the end it was not enough for her to cope with the demands of parenting in very difficult circumstances at the age of 19 years.

Women relayed stories of early contact with Children's Services but the legacy of their own pasts together with the constraints professionals face in over-stretched public services, often appeared to block opportunities to build a co-operative working alliance with professionals. With few resources of their own and limited informal or formal support, parenting frequently overwhelmed these predominantly teenage first-time mothers, ultimately bringing them before the family courts.

Summary

It is clear that this population of women is not benefiting from the current approach to prevention of teenage pregnancy, nor given the difficulties many face in their own personal circumstances, are they prepared for the challenges of first-time parenthood. It is also clear, that women who did not readily anticipate the harm that they experienced in their adult lives, from intimate partners. Findings raise questions about what might be done through targeted support to help this population of women to be better prepared for a first pregnancy. Any approach to pregnancy prevention needs to engage closely with women's subjective thinking about pregnancy, family and relationships, if women are to make more informed decisions. In an earlier article on this subject, we considered in some detail the ethics of targeted reproductive health care and would continue to endorse a differentiated approach to contraception and pregnancy counselling, highly attuned to women's personal biographies and presenting needs (Broadhurst et al., 2015b). There is clearly a role for skilled professional support, where women need a higher level of assistance to make an informed choice about contraception and pregnancy. As Jackson and Day-Sclater (2009) argue, equitable access to health care may require enhanced support for some women. The protection of autonomy does not simply equate to'an absence of state interference', rather it may require the'positive provision' of resources. That there is no mention of men's responsibilities towards contraception in the women's accounts is also noteworthy.

Half of this sample of women had been in care, which raises questions about what is required with regards to specialist advice and assistance within the care system to enable young women to be better prepared for the implications of pregnancy (Fallon et al., 2015). In particular, there is a clear need for more targeted support to help children in care to address unresolved childhood issues concerning

relationships and attachment which are likely to surface in their own adulthood and thus help prevent women from further harm in adult relationships.

6.4 Child removal and experience of the family justice system

Key findings

- Women consistently reported a lack of understanding of legal terminology and the legal process.
- Women did not feel they could meaningfully participate in court and a sense of isolation reinforced mistrust.
- Women described being damaged not only by the loss of children, but also by the stress of the family justice process.
- Where women did feel heard during the court process, they described feeling a greater sense of justice.
- Women did not understand the content of psychological assessments or mental health diagnoses.

Given that the women in our sample had experienced multiple sets of care proceedings, they were very well placed to comment on experiences of the family justice system. Our findings from interviews add to a rather limited literature on parental experiences within the system (Hunt, 2010). Findings from interviews with women confirm observations made in earlier studies about the difficulties that parents face in making sense of complicated legal processes and language. In addition, women reported difficulties in accessing and benefiting from legal representation. Women consistently reported negative experiences of the court environment. In addition, we have been able to gain women's views on post-proceedings and the extent to which women were able to continue to work with services beyond child removal and access treatment recommendations made during the course of proceedings.

Understanding the legal process and language

Women described being very confused about the legal process and the language of the family justice system. Confusion arose in pre-proceedings and extended through the whole court process and beyond.

> Dawn: I know that they're trying to adopt one of my children out and I'm not going through that at the moment and they're coming to me with all this adoption stuff and. . . she's left me all this paperwork to read but she knows I can't understand it so I've not even read it. It's just in the flat. So knowing that I've got problems and she says like. . . I had to sign all this paperwork to say that she had given it to me, and all this lot, which I did. But I don't know what it says because there's no point because I ain't going to understand it.

Dawn is clearly confused by the paperwork associated with adoption – she was presented with paperwork and asked to sign it, but as she states very clearly she didn't know what the paperwork meant. Women rarely accurately used legal terminology or gave accurate descriptions of process; rather they referred to "this form" or "paperwork". Where they made reference to a particular order or section of the law, this was often as an example of language that they did not understand. Dawn continues her

interview by saying:

> Dawn: There are all these different adoptions. I think they said open/closed and they told me they're going for closed adoption. I don't know what that means anyway.

Women were confused by the complicated documentation associated with child removal and sometimes this appeared compounded by professionals changing plans for children. Decisions taken by busy social workers are made in far from ideal conditions, however, changes of plan that involve compulsory intervention are hugely consequential for parents. Hannah provides an example of her reaction to what appears to be an initial request to sign a s.20 agreement, which is then superseded by a decision to take court action.

> Hannah: Well, what's it, the manager, or whatever she's called, got me to sign this form. And she said... right, she went "that stops you going to court", "you don't need to go to court if you sign this form". I went "alright then". So I signed it because I were... you know. And so two days later, she rings me up, yeah, "we're going to court, right". And then, what's it, I didn't get to see my kids for a few days. So then I'd have to go to court, then to (different town) to see them.

In this case, Hannah was left shocked that plans changed so quickly and felt misled. Although only a small percentage of women in the study had a diagnosed learning disability, cognitive difficulties were frequently referred to in the case files. However, given the very particular language of law and statute, it is vital that professionals help parents to engage meaningfully with the family justice system, taking into account capacity issues. The following extract from an interview with a 19-year-old mother, describes her experiences following her daughter being removed from her care on an emergency protection order.

> Sammy: That's when it just spiralled out of control then. I was having supervised contact. It was conference meetings, case conferences I didn't have a clue what any of it was. I was about 19 then, but that was new to me. You know, they were... I'm in this big room with about nine professionals. I had nobody by my side... I didn't understand a word they were saying. Didn't understand... I just didn't know what was going on.

Experience in court

The negative experience of formal court proceedings has been documented in a limited, but important body of literature (Lindley, 1994; Freeman and Hunt, 1998; Hunt, 2010). Our interview data would suggest that little has changed since publication of this earlier work. First-person accounts described fear, shame and isolation within the courtroom. Laura is a young woman who had had two children removed and placed for adoption; she describes her experiences in court as follows:

> Laura: It's your kids. It's your life. They talk around in the court like they're little rag dolls, they ain't nothing... I don't think they see you as a mum. Court is overwhelming for mums.

This mother's vivid description of her children being treated "little rag dolls" speaks volumes about what she perceives as the de-humanising experience of the family courts. For her, court was an entirely negative experience and "overwhelming". Similarly Sammy describes her ordeal and complete lack of understanding of the language of the courtroom:

> Sammy: Terrible [the court]. Absolutely terrible. I was, you know, a young vulnerable mum in the court fighting for my daughter and I just didn't understand a word of it. Just didn't understand.

Once formal pre-proceedings are initiated, parents are entitled to legal advice within care proceedings. Parents can also access legal aid to cover the costs of legal representation within court proceedings. However, we found instances of women being without legal representation:

> Cheryl: I went to court twice. I didn't have any [solicitors], I can't say the word,. . . to represent me because I didn't know a lot about legal aid and stuff.

Where women were represented, their accounts of their lawyers and advocates varied greatly. Women described a huge sense of loss when children were removed from their care, but as we will discuss later in this report, grief was complicated by intense feelings of injustice particularly in cases where they had not been sufficiently helped to understand the legal process. Busy professionals will undoubtedly make lists of local solicitors available to mothers but this group of women require more than signposting to services. Women posed their own solutions in interview, indicating a real desire to make sense of the court process and its language:

> Cheryl: Yeah. I think maybe if you've got someone who you could go to court with. . . Because some people don't understand. . . I know you've got your solicitor but they still talk a lot of jargon as well. So I think somebody that understands the legal system but can put it on your terms.

Court protocols and received ways of behaving in the family court were alien to mothers. Women described how difficult it was to endure court proceedings particularly given the almost exclusive focus on the most negative aspects of their lives or behaviour and that this detail was shared with strangers. This was humiliating, and felt to be unfair and exaggerated. In addition, they felt they had limited opportunity to voice their own opinions in ways that the court deemed acceptable. Women described leaving the court, feeling not only by the loss of their children, but also damaged by the process itself. Emotional recollections of negative court experiences within the interviews indicated that these painful memories stayed with women because they left a lasting sense of frustration and injustice:

> Sonya: They could have at least like explained what was going on. . . I went in the courtroom they could be saying all sorts of stuff and I wouldn't even. . . I wouldn't have known what they were on about, because I didn't. . . it's like it would be nice to have someone actually explain to you what is actually happening. . . Because I was like, to be honest I couldn't even make heads or tails of it, to be fair. It was like they never let me have a chance to speak.

Examples of positive courtroom experiences stood out from the majority of very negative accounts. In the example below, Hannah discusses her experiences and highlights both the quality of her legal representation and the impact of the judge's direct address.

> Hannah: I had a brilliant solicitor this time, she were brilliant. It's like this court proceedings I had last year with my son, the youngest, the judge were talking to me, directly to me. It made me cry. He's, like, "they've give you a chance and you've took it". And that's all I asked for, a chance. And what's it, and then he's going, "he's at home where he belongs with his mum", and "you're doing brilliant". I was like a blubbering mess.

Emotional isolation was a consistent theme running through the lives of the women we interviewed. This sense of isolation was felt acutely in the courtroom. Women observed that professionals working in particular courts knew each other well and even when they were on opposite 'sides of the fence' in the courtroom, they were connected through informal exchanges outside of the formal court business. In contrast, mothers felt on the outside often trying to understand what was going on in a language that made little sense to them. In some cases women's sense of exclusion and vulnerability was so severe that they concluded that the system was conspiratorial:

> Yasmin: And the worst thing is when you're up in court and they're slam dunking you the barristers and the judges, they know each other. The barrister... the judge walked in, he greeted Social Services' barrister, "you alright mate, how was your weekend?" They knew each other outside the court. Therefore, whatever the other barrister's turned round and said, or other people turned round and said, they're not believing, they're believing the other barrister and taking it for gospel.

Of course for women who return to court, negative experiences of a first experience shape their expectations of the next. Thus, it is perhaps easy to understand why women find it so hard to engage with professional help with subsequent children.

Expert assessments

The lack of understanding of process and outcome also extended to the use of expert witnesses and in particular to independent psychological assessments.

> Cheryl: They [the assessing psychologist] just failed us, said stuff like, we've got this like personality, or something. Like just completely described me in the wrong way and I was annoyed about that because I wasn't that sort of person but he tried making me out like I was a psycho or something. I didn't understand it. It was too like complicated for my vocabulary.

The lack of understanding expressed by Cheryl about her psychological assessment was an experience shared by a number of women in the sample and is concerning given the weight that is placed on such assessments in court and the enduring nature of diagnostic labels. Laura similarly reports her confusion following a psychological assessment:

> Laura: You just feel labelled mental. That's what it does. That's how you feel. And they don't tell you nothing about it. You just get a piece of paper with she's got borderline personality disorder and she needs therapy for 12 months and she can't look after her kid. That's all I got.
>
> Interviewer: So you don't know what that means, those words?
>
> Laura: No. You don't, no. You have to look it up yourself. I went and Googled it.

Getting help beyond child removal: psychological therapies

Whilst there was some regional variability, the difficulty of trying to access psychological treatment that had been recommended in court was a consistent theme across the interviews.

> Lois: And then, yeah, when it came to court and they said that I can't keep her because I didn't undergo psychological therapy, I said to them, hold on, you asked me to do psychological therapy, I didn't know where to go to get that, and none of you told me where to go, none of you said that you were going to sort it out, plan it out for me. And they just kept on going on about my past, your past, it's your past.

The women describe falling between 'a rock and a hard place', without a child in their care they no longer qualified for services from Children's Social Care; however, frequently they were also unable to access services from adult mental health. This appeared to be either because they did not meet their criteria, i.e. their mental health was "not bad enough", or because the recommendation made referred to a very specific treatment that was not widely available unless accessed privately. For birth mothers who experience recurrent proceedings, a huge weight is placed on whether the mother has acted on the recommendations from one set of proceedings before the next. As discussed below, many women spoke of the difficulties they had accessing psychological services post-proceedings. Given the material circumstances of the women, this placed them at a particular disadvantage in subsequent proceedings. In some cases, the women had gone to great lengths to try and access the treatment and yet they felt these efforts, or the barriers faced, had little impact on subsequent proceedings.

> Emma: We spent ages trying to get this therapy. I went to the [mental health services], they turned me down for it. So all the people that was in my life, like [advocate] went to appointments with me, and [advocate] and the solicitor even write to the psychiatrist to see if you can get it, and we've tried every avenue; I can't get it, else I'd have to go private for it. And then they said it's going to be thousands if I have to go private, and I can't afford to get that. . . If they say people, women, need this treatment, need that treatment, need this, they should make it more easier to access it, not just say you need it and know fine well you can't get it; they should make it easy, access for the support for women, not just recommendation you need this, you need that.

> Lisa: They kept putting me to IAPT, to different places. Got in touch with IAPT, I was screaming down the phone please help me! This is about my children. Whatever you can do I need help. And they were like no, you don't fit, you're not severely depressed at the moment, you're not anxious. I said I don't care, I'll tell you whatever you want to hear to just put me on this work. Wouldn't help me at all. Every time we went to court, every time we went to a meeting, well, this is still outstanding, you haven't bothered doing this. We went to [independent sector service] which is to do with domestic violence, they also do counselling, went there to try and get CBT. They only have so many workers. . . . I looked into another service as well, they couldn't do it either. It was only literally private places that could do it at between 60 pounds an hour to 90 pounds an hour.

As the quotes above demonstrate women felt frustrated and unfairly treated in regard to access to psychological therapies following recommendations by experts. In addition, they felt that post removal counselling which is available where children are adopted was insufficient. As the work of Cossar and Neil (2010) illustrates, despite changes to the law in the form of the Adoption and Children Act 2002, in practice assistance may be minimal. Our study concurs with these findings. Very few of the 72 women interviewed had received post-adoption support and for those who fell outside of the legal requirement for support because their children were either placed in the care of kin or foster care, an offer of post

proceedings service was rare. The majority of women felt abandoned by services once proceedings had concluded. Women also commented on the manner in which services were offered and often did not feel helped to access post-removal services; for example, a leaflet was simply posted through their door. The timing and approach also appeared very important. Information regarding post-adoption counselling was often passed on by the child's social worker at the end of proceedings. This was received as insensitive and added to feelings of animosity.

> Holly: I think it would need to be someone that isn't a social worker, you know. Independent where they've got no ties to social workers, because that's where they went wrong with me. They said, "Oh, you know, you've got a support worker, you've got this person." But yet they've got ties to the social worker, because they work in the same office and I don't trust them.

In the extract below, Carla makes clear the trauma associated with child removal and the enduring nature of the loss. We return to this theme in Section 6.5, when we discuss the broader collateral consequences of child removal.

> Carla: I think after he had been removed they should have offered, like, some sort of counselling, or something. Because it is really hard. It's really traumatic, especially for the mum. I carried him for nine months. I love him. I absolutely adore him. It's just unfortunately through the circumstances I was unable to care for him. But I was offered no help, and I felt that I should have been offered some sort of help and support. . . When you've had a child, it's really, really difficult when that child's been removed from you and you can't see that child.

Providing appropriate post-removal support is crucial given that, as this study has shown, a sizeable number of these women will return to court. Furthermore, as we discuss in our 'Turning Points' section, where accessed, counselling and other psychological intervention did appear to be of benefit to the birth mother.

Summary

For this population of women, legal process and vocabularies are confusing; few women reported meaningful engagement in decision-making or the court process. Women's isolation is a consistent theme in the interviews and the court process serves to compound a sense of isolation and a life apart. The traditional spatial configuration of the court, received language and protocols serve to further alienate women and reinforce a deep-rooted sense of mistrust that follows from childhoods of neglect and maltreatment. Although there is no doubt that judges in England are absolutely committed to upholding the highest standards of justice - there is something about the traditional set up of the English family court that disenfranchises this highly vulnerable population of women.

The complaints women raised about the traditional adversarial court process are largely not new; they confirm observations reported by Lindley (1994). Continuity rather than discontinuity in observation is unsurprising because little has changed in the way that the court deals with care proceedings. A problem solving movement has emerged but its impact is not widespread despite evidence from parents' first-hand accounts that the experience of FDAC is very different; for example, even in cases where children are removed, parents express a greater sense of fairness, but also self-understanding vital to parents' rehabilitation (Harwin et al., 2013).

6.5 Beyond child removal: grief and role loss, and maternal identities

Key findings

- Women experience acute grief following the removal of their children, and this grief is enduring.
- Resolution of grief is complicated by women's anger towards children's services and feelings of being insufficiently understood or helped.
- Many women describe mental health symptoms that warrant a professional response.
- Emotional responses to loss and lack of professional support meant that women often found themselves in a far worse position than prior to child removal.
- Women's own experiences in the care system create great anxiety about their own children's futures in public care or with adopters.
- A compromised maternal identity and loss of the mothering role has a profound and enduring impact on the women in this population.

In this section, we describe women's acute sense of loss that resulted from court ordered removal of children, and also the particular difficulties women described in resolving this form of loss. Removal of children to public care or adoption also creates particular anxieties for women who have been in the care system themselves. We consider role loss in relation to mothering and maternal identities beyond child removal. Women's relationships with their children, who remain very much psychologically present, if physically absent, have been subject to insufficient discussion with the research literature despite women's enduring connection to children being a powerful driver for positive change (see Section 6.7).

Loss and grief

There is a substantial published literature on the subject of grief that results from the relinquishment of infants to adoption (Winkler and Van Keppel, 1984; Millham et al., 1986; Howe et al., 1992; Wells, 1994; Logan, 1996). The literature is however much more scant regarding grief that results from court ordered removal of children. In this section, we describe both the acute and overwhelming sense of loss that women felt once it was clear that children were not to return to their care, but also the enduring nature of this grief.

Without exception, the mothers in our study described an acute sense of loss when their children were removed from their care. In addition, this profound loss is enduring and very difficult to resolve. The following extract from Lisa illustrates both of these points:

> Lisa: It's heart-breaking, absolutely heart-breaking. . . I go into a mode where I'm a recluse and I won't go out because, because it's like when you do go out there's kids everywhere. And you'll sit on a bus and there'll always be one in the buggy and you're thinking gosh, that's so like this one and they'll be doing the same thing, I wonder what they're doing now. . . Going past a school and you see them all playing or hear them playing, it's anything like that, one's in the buggy, older ones. . . It's anything because everywhere you go there's children and everywhere you go there's reminders. And it's just always there, it never leaves you and it's so hard to just swallow back and think gosh, can I do this.

For Lisa the loss of her children is "absolutely heart-breaking". Moreover, the sense of loss "never leaves you". Other people's children remind her on a daily basis that her own children are absent from her life. Lisa captures the challenge of this particular form of loss because "reminders" are everywhere. To avoid the pain of seeing other people's children and routine family life, Lisa simply does not go out.

Across the interviews, women reported the very negative impact on their mental health resulting from child removal. Like Lisa, many women spoke of isolating themselves because they felt unable to face the outside world. In a number of cases women spoke of contemplating or indeed attempting suicide, because as Kylie describes, "I've got nothing left":

> Kylie: I was going to kill myself, you know, like. And I actually said to my counsellor, because I had to have counselling as well when it happened, and I says, "do you know what, I've got nothing left". I says, "they've took them and I've got nothing left, so I might as well go and jump off a bridge", you know, like. And I left there that day and I thought, what was the point of all this. What was the point of coming off it [drug], going through what I went through, to take them away, you know, like.

The enormity of the loss of the care of children is clearly highlighted in this account. Again, across interviews, were descriptions of giving up rehabilitative efforts following the aftermath of proceedings. The removal of children impacted negatively on many women's incentive to bring about life changes. Whilst for some women, as discussed in our 'Turning Points' section, the loss of children later motivated change, across the interviews women reported a significant and immediate downturn in their functioning following court proceedings. Life without children seemed futile and women lost motivation to care for themselves, particularly as professional support was also withdrawn at this point.

> Linda: When they take children away, they leave you feeling, like, empty, you've got no reason to wake up in the morning, you've got no reason to, say, live, in a sense, so going out drinking, doing drugs, having a laugh makes you forget what you're going through, but you wake up every morning still the same, your life hasn't changed, because you've gone out and had a drink, but you don't see it like that, because there's no counsellor there, there's no support team there to say, right, I know we took the kids away, but we took them for their own safety, because you're not in the right place, but we're going to help you get back to the place you need to be in.

Linda's words and her description convey a deep sense of hopelessness. She returns to drink and drugs to help her "forget what you're going through". However, she also indicates that because there is no professional support at this crisis point, there is no challenge to dealing with hopelessness through a return to life of drink and drugs. Seeking an escape from the pain of removal of children led to many

women making other potentially damaging choices that increased their vulnerability. Linda's words act as stark reminder of the importance of support being offered in this post-proceedings space. In the following extract, Ebony also describes becoming homeless as a consequence of a serious downturn in her life following child removal:

> Ebony: I drank, took drugs... was going out. Just making things worse for myself, basically... trying to forget about everything. I couldn't afford to stay at the flat. I gave it to him [ex-partner], said to him, he can have it. We got it swapped over into his name and that.

The statement from this mother "just making it worse for myself" succinctly captures her increased vulnerability and the invisible, but hugely consequential, events that follow which leave her in a far worse position than prior to child removal. Below, Hannah similarly describes her severe downturn following the removal of her first two children. Unable to cope with being in her home without her children, Hannah becomes homeless:

> Hannah: Basically, once they took my kids, they left me to rot. I couldn't even go back into my house after that, I'd have panic attacks. So I made myself homeless. I turned to alcohol. I ended up drinking from half past seven in the morning 'til half past three in the morning. I didn't care where I was... It killed me. I couldn't even go into my own house. I couldn't. Physically, every time I'd go in, I'd just drop, so I had to go out.

Grief that results from court ordered child removal is also difficult to resolve because, as we described in the last section on women's experiences of the family justice system, women may not agree, or fully understand, the reasons for this. A huge sense of injustice complicates grief response – loss is bound up with anger and hostility towards services.

Women's grief responses are also complicated if they themselves have been in care. As described in Section 3.3, women generally had unsettled experiences in care and as a result, women's sense of loss was also bound up with huge anxiety for their own children's well-being. In addition, they felt "punished twice" because they felt that their own care backgrounds prejudiced professional opinion in regard to their potential for parenting.

Loss of maternal role and a compromised identity

For many of the women in the study, their childhood and adult lives were marked by multiple adversities. Childhoods did not prepare them well for a life in which they could exercise many choices; women often lacked confidence and self-worth. Positive accounts of education or work rarely featured in women's interviews and education was frequently disrupted. Thus, child removal became all the more devastating in the context of more limited life choices. In the extract below, the loss of purpose and focus experienced by Ebony is very clear:

> Ebony: I think six months after I lost the children I started using heroin... to block out how I was feeling, not having them... having [children] for eight years and then having nothing. You're not in a routine, you haven't got the dinner to cook, you haven't got to get them up for school, you haven't got the uniforms to sort out. It's just from being busy to doing absolutely nothing. Sitting around and wondering what was happening.

Ebony describes a void which is left by the removal of her children, but also, her loss of role as mother. This emptiness takes the form of an absence of routine daily tasks associated with caring for children. However, even the mundane becomes highly significant, when there is little to fill this void: "you haven't got the dinner to cook. . . the uniforms to sort out". No longer with a sense of purpose or demands on her time – this woman feels her life is now redundant: "It's just from being busy to doing absolutely nothing". The vast majority of women in our study were unemployed, had left school early or had periods out of education. Implicit to their life stories was economic and social disadvantage. In addition many had complex and compromised familial relationships. Whilst motherhood is a particularly salient social identity for women generally, there can be no doubt of the pronounced significance for women where they may have had few opportunities to develop other socially significant and valued roles (Thoits, 1991).

The devastation conveyed by the women consistently across the interviews went deeper however, than the impact suggested by the loss of the day to day role as mother. Paying close attention to the words of the mothers in our sample, we are able to indeed see the centrality of motherhood to their identity:

> Kelly: It really broke me. It ruined my life, for a little while, I'm not going to lie I was drinking, I was taking drugs, I was having sex with everyone. Like, you know, I was just. . . I weren't living life. . . because I felt so alone. I just felt like they just took away my life, you know. So it was hard.

For this woman her identity as mother is synonymous with life, enacted in the words "they took away my life". Unemployed, estranged from her family and having escaped an abusive intimate partner, being a mother was perhaps her only positive sense of self. With the children gone her very identity appeared under threat. Laura describes similar feelings:

> Laura: They're everything to me. They was anyway. They was everything to me. Being a mum was the first thing I felt proud of in my whole life, and then they took it away. . . And then when they take them away it just shatters everything. I felt like the only thing I was good at after the rape and being beaten up and everything was being a mum. And then when that's taken away from you you just absolutely don't know where to turn. Then when you're going through it again it is life shattering. You just want to kill yourself, to be honest with you. That's how you feel.

The psychological distress felt by this young woman and the significance of her maternal identity is clear. The impact of the court's decision is far-reaching for this mother. Of particular consequence is her vivid depiction of the centrality of her identity as mother. She has experienced the successive removal of three children from her care and is pregnant with her fourth. The adversarial nature of the family court process is deficit focused âĂŞ a picture is constructed of multiple difficulties, but women's strengths remain largely out of view. As we discuss in our related paper (Broadhurst and Mason, 2017). In addition to the impact on role and identity discussed here, social and we argue legal stigma, are further collateral consequences of court ordered child removal.

All women participating in our interviews talked extensively about their children who had been removed to out of home care or who were adopted. As we will discuss in Section 6.7, the continued psychological presence of children was, for some, a powerful driver for change. Even if children had been adopted and women had no direct contact with their children, they did not lose hope that in the future they would be reunited with their children. However, this need to keep alive the memory of their children and their own maternal identity, however compromised by the absence of their children, often felt at odds with the approaches of professionals. Women stated that professionals often encouraged

them to "move on" beyond child removal, and showed a pronounced lack of understanding of the enduring nature of their sense of huge emotional connection to their children. This incongruence between mother and professional appeared to alienate the women from services and had an impact on their ability to positively engage with contact arrangements. In the extract below, Lisa describes her difficulties in engaging in letterbox contact:

> Lisa: And I will never write a letter that's cold and hasn't got no heart in it. I would rather write every feeling and every bit of emotion I've got and stick it in a shoebox and they can read it when they're 18, rather than give them satisfaction of hi, it's a lovely day here, how are you? And never getting a reply. Well, no thanks. I'm sorry, I'm not willing, not willing at all.

The women's accounts provide important insights into the emotional challenges presented by contact and help to explain why they may not comply with contact arrangements.

Summary

Whilst many of the messages from the substantial published literature on the subject of grief that results from the relinquishment of infants to adoption continue to be important, (Winkler and Van Keppel, 1984; Millham et al., 1986; Howe et al., 1992; Logan, 1996), our findings suggest that court ordered child removal impacts on women in very particular and complicated ways. From birth mothers' first person accounts, it is clear that the impact on women's health is a major concern and warrants a mainstream response from mental health services. Findings resonate with an international literature that reports long-term psychological damage that can result for birth parents who have either relinquished their children or lost their children through court order (Neil, 2003; Neil, 2007; Cossar and Neil, 2010; Schofield et al., 2011b). However, as we described in the last section, accessing psychological therapies is very difficult even when experts in proceedings have stated that such therapies are critical to women's rehabilitation. In addition, given the published research evidence is weighted towards child relinquishment and is mostly several decades old, the evidence base concerning grief and resolution of loss for parents who lose children through court order requires substantial updating.

Women's grief responses fit with what the mental health literature refers to as complicated grief reactions. For a number of reasons, this form of loss is very difficult to resolve. First, children remain psychologically present, but physically absent, the extant literature indicates this is difficult to integrate as there is no end point (Logan, 1996; Schofield et al., 2011a). Second, loss is also hard to resolve because of a lack of acceptance of child removal decisions in some cases and in others, a deep sense of not being given a chance because help has not been forthcoming. Therefore, much can be learned from the clinical literature on complicated and/or traumatic grief responses to build a therapeutic response (Horowitz et al., 1997). This is an interdisciplinary project that requires close engagement of clinicians alongside other professionals, social scientists and parents themselves.

Women's enduring connection to children in public care or kin care or adoption is also worthy of greater acknowledgement within services. This enduring connection, as described in Section 6.7, if harnessed, can act as an important driver for change. However, where there is a lack of acknowledgement of a mother's enduring connection to their children and maternal identities are ignored we risk adding to the psychological burdens of this vulnerable group of women.

6.6 Subsequent pregnancy and infant removal

Key findings

- A downturn in functioning following court proceedings and child removal heightened women's vulnerability to subsequent pregnancies.
- Grief and loss following child removal are undoubtedly complicating factors in the subsequent reproductive decision-making process.
- Following a previous child removal, women's responses to a pregnancy raised feelings of anxiety and fear. This was exacerbated by pre-birth assessments and subsequent care planning being initiated late in pregnancy.
- Removal at birth warrants special attention given the physical and emotional vulnerability of women.
- Women felt unprepared and unsupported leading up to and following the removal of their infant at birth.
- Insufficient attention is paid to mothers' needs for privacy within the maternity setting in the context of infant removal.
- The pre-emptive nature of the removal of an infant close to its birth added to many women's sense of injustice.

Understanding repeat pregnancy

There is a complete dearth of published literature on the topic of pregnancy, subsequent to a previous child removal. Subsequent pregnancies will typically concern babies, as illustrated from our analysis of Element A. Furthermore, our data on the spacing between proceedings illustrates that the greatest risk period for reappearance is within three years of the end of previous proceedings. Both these findings raise important questions regarding women's subsequent pregnancies following the removal of her first child(ren). The women's accounts of these pregnancies again offer us important insights. Many women struggled to articulate the reasons behind multiple pregnancies and again many repeat pregnancies were described as unplanned. However, in listening closely to women's stories, it was clear that an acute sense of loss about a first child often resulted in an exacerbation of substance misuse and mental health difficulties, which actually reduced women's abilities to care for themselves and make informed reproductive choices. This rendered them highly vulnerable to a repeat pregnancy.

> Tara: Yeah, they took K [child], like I said, from hospital. It wasn't easy, it did upset me, but the thing is, when you take drugs it kind of hardens you, it cuts off your emotions a bit. So I was taking more drugs to stop me thinking about everything that was going on.

Tara describes how she increased her heroin use in order to block painful emotions "to stop me thinking about everything". Unable to take control of her contraception adequately she became pregnant

again.

Grief and loss are undoubtedly complicating factors in the reproductive decision-making process for this group, with some women making an explicit link between loss of first child and a subsequent pregnancy. This was not a desire to replace a child in public care or adoption – the women very clearly still hold these children in mind, but there was a distinct desire to fill an emotional gap left by a child physically removed and to reclaim their public identity as mother. In Broadhurst et al. (2015b), we made reference to the published research concerning parents bereaved through miscarriage or stillbirth. The statistics on repeat pregnancy reported in this literature are particularly noteworthy because, a key finding is that becoming pregnant again within 12 months of perinatal loss or child death is not uncommon (Estok and Lehman, 1983; Armstrong and Hutti, 1998; Robertson and Kavanaugh, 1998; Lamb, 2002; Layne, 2003; Scheidt et al., 2012). Furthermore, in the US, Grant et al. (2011) argued that compulsory removal of an infant from a mother increases the likelihood of a subsequent short interval. The following two examples illustrate these linked but different reasons behind repeat pregnancy.

We return to Laura, who at the time of the interview was pregnant with her fourth child having had her other three children removed through recurrent proceedings. She had experienced a very difficult childhood. She was raped at age 12 and subsequently had entered a relationship with an older man who had been convicted of previous offences against children. After being physically assaulted by him on a number of occasions he was sent to prison. She lived in fear of him seeking revenge. In the previous section we described the significance that her maternal identity held for Laura. During the interview she talked about her fourth pregnancy which she stated helped fill the vacuum left by the removal of her older children:

> Laura: I think that this baby's more planned than any of my kids have been. But I think part of the reason why I'm pregnant again is because I'm so lost. I feel I deserve to be a mum.

This extract portrays both the loss she feels through the absence of her older children, but also the importance of motherhood to her very identity. Turning to Jill, she had seven children, whom she described as all unplanned. She had a series of turbulent short-term relationships and had had long-term involvement from Children's Social Care. Her children had been on child protection plans for a number of years, with intermittent periods of removal and reunification. At the time of the interview, five children had been removed permanently from her care and care proceedings were ongoing in respect of two younger children. In the interview, Jill reflects on how her own childhood experiences were bound up with her serial pregnancies:

> Jill: At the end of the day, like all the shit I went through with my family, it was like that only people that you felt ever loved you was your kids. You know? So the more kids I had the more people I had that would love me, you know, sort of thing? Likely because I was living alone with no help, no counselling or nothing, so that was just the way I was thinking then.

Pregnancy following removal: fear, anxiety and tentative attachment

Although, this population of mothers shares much in common with other women vulnerable to unplanned pregnancy (Stevens-Simon et al., 1998; Thrane and Chen, 2012; Fallon et al., 2015), the experience of losing infants and children to the state brings particular emotional challenges. Subsequent pregnancy is haunted by a previous removal – where pregnancies fall in short succession, women must orient themselves to a new pregnancy whilst still grieving for a child recently removed. Thus, a mix of very difficult and conflicting emotions often manifest in very high levels of anxiety.

The published literature offers very few insights about the impact of child removal on a subsequent pregnancy. This is a significant omission given the size of the population of women affected by child removal and the likelihood that a high number will have further babies, given their age profile (as described in Section 3.2). A focus on the population of women who have experienced recurrent care proceedings, provides a unique window into women's responses to a subsequent pregnancy. A subsequent pregnancy often raised feelings of anxiety and the fear of a further removal loomed large. The women were, for the most part, painfully aware that with the confirmation of the pregnancy would come a notification to local authority Children's Services. We return again to Laura who, in the following extract, vividly describes this fear:

> Laura: I'm absolutely terrified now I'm pregnant with my fourth kid to be honest with you. I am absolutely terrified. Because so far they've been saying if you do your therapy you get to keep your kid, and now they're telling me it depends what your therapist says. If the report's bad then you ain't going to get to keep your kid. It's like you're putting me through it again? Why keep telling me? Why do you let me get to a point half way through my pregnancy when I'm five months' pregnant when it's too late to do anything about it to say you might lose the kid anyway. . . It was my boyfriend that talked me into it. I still don't want a baby because I'm scared. I'm absolutely terrified. I'm emotionally exhausted?

Sometimes, as we discuss later, fear resulted in women avoiding services when they discovered they were pregnant. However, for the majority of women in our interview sample, following the discovery of a pregnancy, they quickly self-referred to Children's Social Care or midwifery services, as they knew that sooner or later their pregnancy would come to the attention of professionals. A percentage of women also felt that an early self-referral to Children's Social Care, would give them longer to demonstrate positive change in their lives and prevent a further child removal. However, as Laura describes above, early self-referral did not necessarily equate to an early response from services. In keeping with our case file findings, reported in Section 4.2, in interview, women frequently described pre-birth assessments as being delayed until the third trimester of pregnancy. Whilst this practice is largely a response to the continued pressure on resources within local authorities, as Laura illustrated in the extract above, this can add to women's anxieties about the likelihood of a further child removal. Further, late response to a pregnancy arguably limits the opportunity to support the pregnant woman to achieve change and therefore, maximize the health and well-being of mother and foetus. For some women, anxiety that the baby might also be removed from her care stood in the way of her bonding with her unborn child.

In the extract below Maddie describes how her fear impacted on her ability to bond with her subsequent child:

> Maddie: The court proceedings went on for about a year from then and like at the court proceedings I found out I was three months' pregnant with my second daughter. . . You know the day I lost (child 1) the day it was official that she was getting adopted that was the day I found out (about the pregnancy). . . So I couldn't bond. I love her to pieces but there's nothing there, there's no bond. Because I was scared. I put up a wall. I still didn't have a clue what to do with her, you know, and it was. . . I was still 17, you know I was still young. I didn't have a proper home, didn't have a family, didn't have any partner at that point, yeah, so, and there was no. . . the Social Services didn't get involved again until after she was born. . . They knew but there there's lack of funding so they don't do pre-birth assessments there.

The mother in the extract above, highlights the impact that her first child's adoption has on her

next pregnancy; "I couldn't bond. . . I put up a wall". Her words resonate with the concept of'delayed or tentative' attachment discussed within historical and anthropological literature describing women's responses to pregnancy in communities where infant mortality rates are high (Ross, 1993; Layne, 2002). Despite professionals being aware of her subsequent pregnancy, and her acute sense of isolation, "I didn't have a proper home, didn't have a family didn't have any partner" the lack of resources impede any statutory assessment or intervention prior to the birth of her second baby.

Raising the bar: a non-erasable history

We turn now to women's accounts of their service experience in the context of a subsequent pregnancy. As explained in Section 6.4, many women spoke of subsequent assessments being prejudiced by previous judgements of their parenting capability, and that as such the bar had been raised. The women believed that 'good enough' was no longer sufficient. For many women previous proceedings impended, and whist they may understand the need to engage in early assessment, their accounts suggest they saw this assessment activity as distinct from asking for or receiving help. Despite professional reassurances, previous encounters with the family justice system left women with a pervasive belief that in the context of a subsequent pregnancy, any admittance of difficulty would be dealt with punitively; proof that they are not coping or that previously identified problems were resurfacing. Given what we know about the vulnerability faced by this population of women, it is of course very likely that many women will have ongoing difficulties and require professional support. Perversely, the women's accounts suggest that as a consequence of their previous experience of the family justice system they are more cautious about seeking professional help for any difficulties with a subsequent child. Clearly, this presents a huge challenge for services trying to engage birth-mothers post-proceedings and offers a further explanation for the enduring nature of' non-engagement' for this population of women. Laura explains her reservation at seeking help from her GP in her third pregnancy following the adoption of her first two children. For Laura, as for many of the women interviewed, trusting professionals continues to be a key issue:

> Laura: If I felt down or something I couldn't go to my doctor because I'm too scared that social services would. . . They'll put it oh, she's feeling low again on her pregnancy and she ain't going to be able to cope. It makes you feel as though you can't trust anyone

A further critical issue for women was the professional response to their history. Courtney recounts her experience of going through proceedings a second time:

> Courtney: I think social services, when they deal with young mothers that have gone through a lot, I think in some cases they need to take the time and give the benefit of the doubt. You don't just say, okay because you've got a history of doing this, I'm not going to give you a chance. Everyone deserves a chance, everyone deserves a second chance. There are murderers that get to keep their kids. There are heroin addicts, someone on crack, smack the lot and they get to keep their kids. Then you've got someone like me who has got a bit of a paper trail and won't even be given an inch, let alone a mile. So I think in some cases they need to have a lot of support and a lot of depth. The problem with social services is they do everything at the last minute. So I think that they need to kind of give people a chance.

This mother expresses the frustration felt by many women in their interviews that their history becomes immutable. In keeping with a number of women, Courtney expresses her frustration at

not being given sufficient time to show change, she says "the problem with social services is they do everything at the last minute". As discussed earlier in this section and in Section 4.2, this was particularly pertinent to pre-birth assessments. Together with a number of women, Courtney gives a clear message that she feels harshly judged, that the system is unfair if you have a "paper trail". A sense of unfairness was evident in many women's interviews and led to a profound mis-trust which permeated subsequent work with professionals.

This lack of trust of Children's Services in particular, and professionals more generally, following child removal was central to many women's narratives. Whilst not always the same worker, for many women, social workers were simply agents of the state and they held them all equally responsible for the removal of their child. Unsurprisingly then, any interaction was tarnished with memories of the past. However, as we will return to in Section 6.7, there were examples where mother's spoke with animation about a worker who had been'different'. In these cases, there involvement appeared to have been crucial in bringing about change and provide important messages about both the conditions and skills required to overcome mistrust and resistance.

Concealment

Active pregnancy concealment was described by a very small number of women. Given the recent high profile coverage of women leaving the UK in order to conceal their pregnancies from UK authorities, it is important to note that there were only five cases of pregnancy concealment mentioned in this set of interviews. Furthermore, for three this was a short-term strategy early on in pregnancy, and in only two cases did women describe active strategies of concealment, in which they intended to hide the full term of pregnancy from professionals. In these latter two cases, women's actions can be seen as acts of desperation, typically following multiple infant removals.

Infant removal at birth

As we described in our profile of recurrent care proceedings (Section 3.1, women entering repeat proceedings are much more likely to be doing so with a child aged under 4 weeks, compared to their index proceedings. In our interview sample, more than half of the mothers (51

Given this prevalence, removal at birth warrants separate attention. The tension between balancing the safety of young infants, whilst also respecting the right of birth parents, raises important legal, ethical and practice issues. To-date the literature on this topic is particularly scant (Masson and Dickens, 2015), despite the fact that many infants are removed from parents at birth (Broadhurst and Mason, 2017). In addition, detailed insights from birth mothers about their experience of removal at birth are absent from the literature.

The interview component of this study enabled the team to engage closely with women's accounts and to understand the particular nature of separation of mother and baby at birth. Our argument is that removal at birth is different from the removal of older children because of the particular physical and emotional vulnerability of mothers in the immediate aftermath of birth, the public nature of the removal in maternity settings and difficulties in accessing legal advice and advocacy. Much can be learned from common themes within the birth mother interviews.

Timing of decision making

As described in Section 4.2, pre-birth assessments, timing of the pre-birth conference often occurred late in a woman's pregnancy. Women in interview commonly complained that the local authority response to their pregnancies came too late and therefore this often meant that women were unclear about the local authority's plans at the point of their infant's birth:

> Tracy: Well they told me they were going to court, getting some form of a protection act or something or other, and then left me hanging for days in the hospital. Then it was like the midwife came in and said, "oh by the way, the social worker's been on the phone, they're coming today and going to take baby N to the foster parents". I was like, "cheers".

In this example, the mother conveys her lack of clarity regarding the plans for her new baby. It is not possible to ascertain what relationship the mother had with the midwife on the ward, but she is clearly aggrieved that critical information arrives via the midwife, rather than in person from her social worker. She refers to "some form of a protection act" indicating a lack of understanding of the potential legal options for the local authority and implications for her and her baby.

In the extract below, Michelle describes how unprepared she felt for the decision to remove her baby. For her, it was an expectation that she was to be given a chance to take her baby home that is so much part and parcel of the emotional pain she experienced. Her efforts to prepare for her baby's homecoming are clear "I had everything at the property, I bought everything". Again, her account focusses on feeling outside of the decision-making process and being unaware of the fundamental changes to the care plan:

> Michelle: It broke... it killed me, it literally... still, to this day I sleep with her baby grow sometimes, I've still got all of her clothes; it did kill me. What killed me, it wouldn't have hurt me that much if they'd come in and took her straight away, you know, and if I wasn't that interested and not fighting or anything like that, it was the matter of fact that... that I thought I was going to take her home and have a good chance; I had everything at the property, I bought everything, so I told my social worker, I told my solicitor to come round to the property, that I've got everything for (child); and, no, they just took her. They granted foster parents to come in the hospital the day after to have a meeting with me and then to take (child) from me.

Timing of removal of infant

Removal at birth takes place when women themselves are particularly vulnerable physically and emotionally, in the immediate post-natal period. The following extract illustrates this point:

> Lydia: ... went out, bought everything for her, and that was it, social services come in and took her. Didn't even have a chance to hold her, that's how sick they were. Come out of surgery, just like all knackered and pure white face, that was it. They just took her. Trying to literally push her into my arms, taking pictures of me when I'm lying there like... it's horrible.

Of particular salience, for this mother is her sense of denial "Didn't even have a chance to hold her". Her account conveys a sense of confusion and haste, which appears very at odds with her own internal state post-surgery. Women's personal accounts challenge us to think critically about professional action in this very difficult terrain of practice. Local authorities take pre-emptive action to remove babies at birth, in cases where there are very serious safeguarding concerns. However, the birth mother's accounts raise serious questions about current practice with regards to timing and what constitutes a proportionate response to risk.

Privacy needs

A removal of an infant that takes place in a maternity ward is a very different experience from the removal of children from the family home. A maternity ward, although not an open public space, does comprise professionals, a number of mothers and a range of visitors. Thus, privacy for all mothers, unless in a private or individual side room, is reduced. However, privacy considerations take on a new salience in the context of infant removals. Being on a ward with other mothers who both have the opportunity to hold and care for their babies and who also leave the hospital to take their babies home, is acutely painful for women who leave without their babies. The extract below illustrates these points:

> Sacha: I was on a main ward with three other people. . . It was hard, because I got to see all the others take their kids home with them. And I knew that I wouldn't be able to take my baby home with me. So I just cherished every moment I had with her. . . Because really I wanted a room to myself, just me and my baby, because we were told there was a possibility that. . . we were told my partner could stay with us overnight, but he wasn't allowed on the ward, because I was in a room with three other people, because they had no side wards available at the time, just a single room. If they had have done, I know he'd have stayed that night. And a part of me was wishing that they had a room available, because I'd been promised a room all week, and then at the last minute they turned around and said that they didn't have one available. And that kind of hurt a bit as well.

Physically leaving the hospital with her baby is described as very important for the mother in the following extract:

> Chloe: So it wasn't, like, the police come to hospital and they took her or the Social Services come and took her, (partner's) mum took her and I got to walk out with her, which I didn't with [child 3], like, but I got to take her to the car and I got to strap her in and then (partner's) mum brought her every day to see me, because she was allowed to supervise the contact.

In this case, her partner's mother was allowed to care for the baby following the baby's discharge from hospital because; the identified foster carers were on holiday. However, this chance set of circumstances ensured that this mother's experience of a removal at birth took a different course. This example provides a potential template for how separation of infant and mother might be handled differently, if this level of pre-emptive intervention is warranted. Thus, much can be learned and translated into practical actions, from birth mother's first person accounts.

A more positive experience is again described by Marie who had her own room and the kindness of staff again provides valuable learning:

> Marie: I had my own personal room. . .
> Interviewer: Did that make a difference?
> Marie: Yeah, because it was just one-to-one. It weren't like there's four people in. . . another three people plus you and babies, it's just you and your kid, and the hospital knows what's going to happen and everything, so. . . they were really nice to me.

In this case, the one-to-one interaction was very important to Marie, just her and her baby. In contrast to other women's accounts, she felt she had been treated with considerable care and understood the plans for her baby. So, again there is important learning from the mother's own reflections. Time with her newborn, planning, preparation prior to removal and privacy are hugely important for women who

are to be separated from their babies at birth. The challenge for services is how to offer a more flexible and sensitive service, given the considerable pressures on resources.

Pre-emptive action and proportionate response

A number of high profile cases have raised questions about a proportionate response to risk in the context of infant removals at birth (Re P (A Child) [2013] EWHC 4048 (Fam)).[1] Questions of appropriate and proportionate responses to risk are brought to the fore where the police are involved with infant removal. The following example illustrates these points:

> Darcy: I didn't know the security guard was outside my room. . . I was still in that delivery room because they had to find somewhere specific to put me in the ward because of my circumstances so I got kept in the delivery room all day and all night. . . and (my cousin) he came in and said there's a guy sitting out there, and I just thought it was procedure of the thing. No, and it was only when gone 11 o'clock at night, they were wheeling me down, this guy had to follow me, had to stand in front of me, and I just thought that is absolutely disgusting, that, that a guard has been sat outside that room while I've just given birth, you've been sat outside all day. Now to me, people could have thought I was like. . . well, that was disgusting, absolutely disgusting and I mentioned it to the social worker. I said do you know I had a security guard, and she told me she didn't know. Whether she did or not, I don't know, but she told me she didn't know but I just think that is disgusting, a security guard outside.

The mother does not know there is a security guard outside her room (and it also appears the social worker does not know why he is present). In the absence of any formal practice guidelines around care for women in these circumstances, practice is open to the individual discretion of professionals and availability of resources. What birth mother accounts expose, is the additional distress such action causes, particularly if they have not first been discussed. Whilst there are cases in which such action is essential in order to safeguard the infant, the mother or indeed professionals, critical engagement with questions of proportionality are essential if we are to minimize further emotional harm to birth mothers in the context of infant removal.

Infants, who are removed at birth, can be born with developmental problems stemming from exposure to drugs and alcohol in the womb. The case for removal is made on both actual and likely harm. However, in a number of cases the case for removal is pre-emptive. By pre-emptive, we mean that in many cases, it is the likelihood of future harm, which is the basis for removal and likelihood is predicated on women's past actions or circumstances. For mothers, a frequent complaint was that removal at birth robbed them of the opportunity to demonstrate adequate care, and in the absence of actual harm to their infants, they frequently felt action was very unfair. This sense of unfairness and not being given a chance to care for their new baby clearly had a particular and long-lasting impact on women's mental health and attitude towards services long after the event.

In the extract below, the mother differentiates removal at birth from the loss of her other children who were removed at a later stage:

> Sasha: I was in the hospital for five days with her, while they were trying to find foster parents for her. And even though we've had contact and stuff, I think the fact that she didn't come home with me affected me a lot more than it did when I had my other children, because I got to bring them home with me from the hospital.

[1] http://www.familylawweek.co.uk/site.aspx?i=ed123247

This mother's words "the fact that she didn't come home with me affected me a lot more" indicates the need to consider grief responses that arise from removal at birth, which arguably requires special attention.

Summary

Whilst birth spacing is likely to be helpful to women's recovery following child removal, we need to understand and connect with women's own rationales regarding contraception and pregnancy and the meaning this holds for them. We argue that sensitive case work is required in order to provide opportunities for women to examine and manage the loss of previous children and to renegotiate their identity as a mother in the face of compulsory child removal. Work is required to build personal agency and self-care, as well as to consider future family planning. Particularly skilled and sensitive practice is required within the context of compromised cognitive functioning or chronic long-term substance misuse. The prevalence of domestic abuse, and for many women the sequential nature of relationships in which coercion and violence are features, adds a further layer of complexity to women's reproductive decision making. Working with women to overcome blocks and helping to identify potential and actual harm in their intimate partner relationships is crucial.

As we might expect, the experience of the removal of an infant close to birth, is an acutely difficult experience for women. Close analysis of women's first person accounts also suggests that removal at birth presents very particular emotional challenges that are poorly understood and differ from cases of removal of older children. This is not to suggest that the removal of older children carries any less of an emotional burden but rather it is to claim that the circumstances of removal at birth warrant focused policy and practice attention to ensure that an understanding and concern for the welfare of mothers runs in parallel with safeguarding action.

6.7 Turning points: what prompts positive change?

Key findings

The following factors appeared to drive positive change

- Women's commitment and enduring sense of connection to children in care or adopted.
- Forming more positive intimate relationships.
- A subsequent pregnancy.
- Learning from experience and developing a stronger sense of personal agency.
- Maturity, which can bring greater insight, a reduction in risk-taking behaviour and improved self-care.
- Access to psychological therapies.

Gaining an understanding of the factors associated with positive change is critical to the development of preventative services. Women's retrospective accounts of continuity and change provide detailed insights into how they turned their lives around, despite the multiple difficulties they experienced. At the time of interview, 43.1% of the women participating in the study, had a child in their full-time care, having previously had children removed through a court order. In Section 6.6, we discussed subsequent pregnancy as a major catalyst for change, hence in this section we focus on other factors or processes.

Women's commitment and enduring sense of connection to children in care or adopted

All the women interviewed talked extensively about their children who had been removed to out of home care or who had been adopted. The continued psychological presence of children was a powerful driver for change. Even if children had been adopted and women had no direct contact with their children, women did not lose hope that in the future they would be reunited with their children:

> Laura: The only thing that pulls me through things at the minute is, when I think that my kids will come back to me, because they will one day want to know who I am. I don't want to be sitting there feeling sorry for myself and they're saying "mum, what have you done with your life?" and I say well, "I've just sat here feeling sorry for myself because I ain't got you". I want to say well, "I did this because you went in there and I tried to better myself for you when you come back".

Consistent across women's accounts were references to children returning to women's care. Whilst the pain associated with the loss of their children, for some women, led to further entrenchment of problems, for others it was an enduring firm sense of connection with children, which even at a distance, prompted change. As Kelly describes in the extract below, bringing about change in her own life was important because she wanted to protect her adopted child from the future pain of discovering that her birth mother was "a drug addict, or an alcoholic or she's dead".

> Kelly: Yeah, and that I've fought temptations with drugs and alcohol to go down that road and sit there in self-wallow and say, oh, you know, "poor me". Because I don't want her to get further pain at the age of 18. She's already going to have to find out she's adopted but why should she have to find out your mum's a drug addict, or an alcoholic or she's dead, she killed herself. No, that's selfish, even more selfish, you know, than having them in the first place when I knew. . . because I don't 100% blame social services. I know I wasn't perfect but I still do think that they could have helped me, rather than just took my children away. But I made it easy for them.

Kelly is able to recognize her own culpability "I don't 100% percent blame social services. . . I made it easy for them". However, an imagined future reunited with her grown up daughter, prompts her to change her self-destructive lifestyle. The personal accounts of birth mothers offer important insights into how services might work to help women harness this motivation and bring about change.

Reflective capacity and growth in personal confidence and agency

In response to child removal, women described intense feelings of guilt, self-blame and hostility towards services. In order to make positive changes in their lives, women needed to find some resolution to these very difficult emotions and somehow accommodate their losses. Women's responses were very varied, ranging from paralysis and entrenchment of problems, through to positive adaptation and insight. Returning to Kelly's interview, gaining insight into the harm she was inflicting on herself, appears to be a turning point. Kelly describes a desire not only to turn things around for her children, but also for herself:

> Kelly: I started thinking like, you know, I'm not hurting myself as well, everyone hurts me, so why am I hurting myself as well? You know, everyone's against me and I'm against myself. No, I felt like I'm not having that no more, why am I going to now go back to that dark place, yeah. Basically, I was in hell when I was drinking and taking them drugs.

In the extract below, Ebony describes "determination" as key to change. She indicates that wanting to change is critical in turning lives around and that child removal can be a catalyst for change if the person is determined to "get things right this time":

> Ebony: I think it's determination, that's what I said earlier. I think it depends on the person, and whether the person wants to change. And whether they've. . . I think if. . . how do I put it properly? I think if you've had children removed. . . yeah, if you've had one child and you've had that child removed, and then you have another child. . . I think you're more determined and more want to get things right because you're too scared of the feelings to come back

In the following extract, the mother makes explicit reference to her own internal resources, clearly capturing her own sense of personal agency:

> Interviewer: You said you, sort of, took control and turned your life around and decided to go to college. What do you think gave you the motivation to do that? Where did you find that from?

> Ebony: I think from having him taken away from me. I was, like, you know, I don't want to have to go through this mess again. I need to make changes. I need to do better and I need to make something of myself. I can't make my past hold me back from where I want to go in the future. . . From within myself I did that. That was hard. I think it probably took me about a good two to three years to get to that point.

Ebony clearly wants to break with her past and starting a college course marks a turning point for her. Change has taken time ("a good two to three years") but she was able to muster her internal energy and strength to "make something of myself". Gaining a sense of self-efficacy was difficult for this group of women given childhoods that had eroded sense of self and control; however, interviews suggest that change is possible, although it takes time.

These extracts clearly illustrate that all is not lost beyond child removal. Women's accounts indicate that they can persist on a journey to change even in the face of what might appear to be insurmountable losses. Personal characteristics matter, in terms of capacity for insight and personal determination, but there is clearly a role for professionals and indeed the family courts to foster insight through skilled work that enables reflection on difficulties beyond child removal.

Positive relationships with professionals

Unsurprisingly women expressed anger and hostility towards professionals involved with the removal of their children. As described in Section 3.1, non-engagement with services was the most commonly cited maternal risk factor in care proceedings. However, convincing professionals that their lives had changed in the context of a subsequent pregnancy required women to manage their anger and re-engage with social workers in particular. For the women in our interview sample who retained care of a child, making best use of professional help despite previous removals was critical to turning their lives around.

Women again demonstrated very different strategies of re-engagement. In the extract below, the mother's approach remains combative and angry, but at the same time she engages with what needs to change:

> Linda: Yeah, no, they weren't doing this to me again, they wasn't going to do it to me again, no matter what. . . So they went around, they asked the Police what they thought, the Police said that she hasn't been in trouble, she has changed her life around, that speaks a lot to us. Then the mental health team stated that we can't fix her mental health, but we can monitor it, so she should be given the chance, my doctor said, we see her on a weekly basis, give her a chance, there was. . . The home was prepared. . . the child had his own room, not that he would sleep in it straight away, but he did have a room, there was bottles, there was a buggy, there was milk, there was nappies, there was clothes, everything was there for them to see and every time they came I'd make sure that I'd show them everything new.

Linda provides a detailed and determined description of her efforts to show her preparedness for her next child. She draws on the opinion of other professionals, which appear persuasive as the local authority ultimately agrees to give her a chance. Hers is a list of concerns, but each one she has addressed. So, although her approach to the local authority is one of a personal battle, she is able to understand and comply with all the concerns that she feels will be raised in her case.

In some 'turning point' cases, women described very positive relationships with new workers. Women's accounts were of a very genuine connection with an individual who they felt really helped and understood them and had been prepared to go the extra mile in order to achieve a positive working alliance:

Ingrid: Because, when I was pregnant, if she said to me she was going to do something she would do it, straight away, no faffing around. If something was going on, if her manager had said something to her, she would come and tell me, she'd ring me up, "this is what's going on". She said to me, "I want to help you keep your daughter", she's the only person that's ever said, I want to help you.

This worker succeeded in conveying care to this young woman through consistency and an explicit helping stance. The mother responded in turn, and through a positive and reciprocal relationship change was achieved. It is interesting to note that the worker's highly consistent actions fostered trust in a young woman who otherwise felt very let down by others in her life.

Kelly: And my probation worker, she was lovely as well and she was really helpful.
Interviewer: What made her lovely? What was it about her?
Kelly: She was just caring. And plus she gave me my tag. You know, I thought I wasn't going to get that, I've breached the tag ten times before, before I went to prison the first time, cut it off ten times, 'til in the end they took it off and said, just let her out without it. And I was shocked, you know what I mean, I was like. . . but she believed in me enough to give me the chance to get a tag. I could have messed up and made her regret that decision, but she did give it to me, so I wanted to prove to her I mean all these things I'm saying, it's not just because I want to get the tag. I want to get out of prison quicker so I can get my daughter back. And she gave me that opportunity, so I worked well with her.

Here trust and a belief that change was possible were highlighted as pivotal in change. Given the high level of adversities faced by the women in our sample, their resistance to engagement with professional relationships might be expected. However, trust can be fostered by skilled practitioners which, as this example illustrates, creates a working dynamic between mother and professional.

In the next example, Gina provides a further example of the positive impact of an effective alliance with a worker who is felt to have the mother's interests genuinely in mind:

Gina: We had a professionals meeting to decide what was the best way to go and whether or not she could come home with me. . . because it was a high risk given the history, I was told. Then the social worker was like, well everything has changed, how is she. . . we can't. . . you know, how are we supposed to prove that she's capable of doing it now unless she's given a chance? You know, the social worker fought for me and she was the one that got (child 3) home with me and now I feel good because we're one of those success stories now because we went from the most intense package we could have to no involvement within a year.

For Gina the experience of having a social worker who "fought for me" was profound and clearly bolstered this mother's own resolve to be a "success story". The women's narratives provide a number of important messages about the nature of professional relationships that did make the difference. In accounting for this difference, the women emphasised the importance of respectful communication:

Joanna: Because I had one social worker and she said something and another social worker said the exact same thing and it's not what you say it's how you say it. (It) made a real difference, yes, treated me like a human being basically. It made a big difference because I more took it in. I took it on board when you're talking to me with respect.

> Ruth: My new one, (social worker) she was brilliant and that's why my attitude started to change because she was getting me the help I needed, she was giving me the motivation I needed. She got me skips so I could clear the house and things like that, so. . . I think she gave me the kick I needed but she was there when I needed her so if I needed to ask her anything she was always on the other end of the phone and she'd always ring you back. She was more of a support than my old social worker definitely. . . She'd give me a list of things she wanted done by a certain day and I'd do it. I don't know. If I didn't get it done, she'd say, well, why haven't you done this? There's no reason for it, go and do it. ..She was straightforward and honest, and I liked that about her. She was down to earth. She didn't stick her nose up at you and make you feel uncomfortable.

In the extract above, Ruth cites both the approach of worker - "she was straightforward and honest" and the worker's expectations "she gave me the kick I needed" as important. However, in this extract, she also highlights the importance of the emotional support offered by the worker: "she was there when I needed her". This 'straight talking with warmth' was an approach that many women appeared to value. Finally, she refers to the practical help that she received which gave her the "the motivation I needed".

Personal relationships and informal networks of support

Consistent across the interviews were accounts of life-changing positive informal relationships. New chance meetings that brought women into contact with more positive partners who offered support were hugely helpful. In other cases, women described a renewed ability to accept help from existing family networks. In keeping with the published literature, improved informal social support was critical for this population of women. For example, a supportive partner could serve as a bridge between women and professionals, often helping them to engage with services (Laub and Sampson, 1993; Masten, 2001; Sampson and Laub, 2003). In some cases, as described in the extract from Gemma below, a father without a negative history with Children's Services could serve as the primary caregiver for a new-born infant buying women time to engage with professional assessment and demonstrate change:

> Gemma: I've not touched a drop since being with him [new partner]. Even when [child 4] got moved. . . I don't know. It's just everything that me and [new partner] have done together has just felt right more than anything else than I've ever done. . . They don't think that I can put my son's priorities and needs before my own, which is a pile of shit. Pile of crap. My last fiver I'd rather get him a pack of nappies if he was on his last nappies than get myself a pack of fags if I was on my last fag. . . But then they said that [new partner] would be main carer, so there was a glimmer of hope at the end of the tunnel.

A new more positive personal relationship certainly appeared significant in the women's accounts of change but, in addition, new relationships brought a new network of friends and family who also provided support. As we see from these accounts, new adult relationships can help to counter the effects of early adversities (Rutter, 2012). In the following example, Jane is clear that it is change in her informal network that has helped her turn her life around:

> Jane: Because I live with my boyfriend and his parents, so I've got a stable home, I've got a supportive. . . well supportive parents of his and yeah that's the only thing that changed really.

In some cases, a new partner took women physically away from negative relationships implicated in child removal:

> Maddie: Well he's always had a job since the day I met him and he was on hired vans for other companies and higher pay, hence why we moved here. You know, he got offered higher pay and yeah, it was the best thing we ever did... It was getting me away from my family, getting me away from my memories. It changed everything... It sort of changed everything and then meeting [partner's] family, seeing how a family should be... we're always like going for dinner and things like that together. Yeah, it's sort of shown me what a family should be like.

Maddie vividly depicts the impact of being integrated into a new family network "showing her what a family should be like". However, as well as offering a new network of support, she also highlights that new relationships helped her to achieve separation from her previous life. This opportunity to start afresh and move on from damaging relationships for some women was vital. Exiting a violent or emotionally abusive relationship was cited as critical in a number of the women's accounts. However, for some this was brought about through chance circumstances rather than their own actions:

> Rachel: Then one Christmas time, he decided to get up and walk. And when he walked out of my life, that's when it all changed.

Rachel had had seven children removed from her care when the father of the children, a violent and controlling man, finally left the relationship. No longer controlled, this woman felt able to make different choices, she sought and received support from services and kept her eighth child at home in her full time care.

> Rachel: I've worked with Social Services. I've worked with [social worker]... I've worked with nursery. I've gone to groups and everything. But I haven't got no-one having a go at me, for doing it, because I still live on my own, and I'm staying on my own.

The departure of men from women's lives often was a major factor in change. Some men left women's lives because they received custodial sentences, others left to form relationships with other women, whereas others died. Whilst these maybe chance happenings, they do indicate that even for women who appear powerless within relationships, when circumstances turn in their favour, they can realise levels of confidence and personal agency, which appear unexpected. Violent and controlling relationships can serve to block women's access to services; conversely, escaping such relationships can prompt women's re-engagement with professional help.

Maturation: ageing out of risk

As stated in Section 6.1, over three quarters of the women interviewed had their first child in their teenage years. In this context, it was not surprising that women stated that simply "growing up" led to different and better choices. Developmental tasks associated with adolescence can conflict with demands of parenting and often teenage parents succeed because challenges of parenting are buffered through the support offered by their own parents or wider family. Again, women described considerable insight in their interview accounts, describing the challenges of competing priorities in their teenage years:

> Becky: When I had my own kids I wanted. . . because I had him from the age of 16, then I got pregnant (again) at 17, so I never had that teenage life. So, I think, I'm not going to blame that because it's my own responsibility for what I did, and now I'll admit that it was my own fault, but I don't think I had managed to be able to go out like normal people or, you know. . . So I never really had that. And then I got to 17 and when I got pregnant, I got my own house, and at the beginning I was fine, but then I started partying. So I wanted the best of both worlds, I wanted the kids as well as a life.

Becky reflects on her first pregnancy and parenthood at 16 years of age. She says "I started partying" and "I wanted the best of both worlds". Carla below similarly illustrates the conflicting emotions she felt at the time her child was removed. In this extract, she is able to articulate the love she felt for her child but also to acknowledge her own immaturity which led her to conclude that she wasn't ready to care for a baby and leave the mother and baby foster placement:

> Carla: I was just really too young. His social worker at the time, I said to her that I think, you know, it would be better if he was with his dad. That's what I wanted for him. I didn't want him to be adopted or anything. I loved him dearly, and I see him all the time now. But at the time I felt that I wasn't ready.

When accounting for the changes in their lives, the women referred to an'ageing out' of many of the problematic behaviours that appeared to plague their adolescence, in particular, alcohol and substance misuse. However, also of significance was how maturity affected their willingness to engage with services and accept help and advice:

> Gina: I think because I'd completely changed as a person. I wasn't this immature, stubborn 17 year old not willing to accept help. You know, I'm 27 now, you know, and I will. . . accepting every help going and, you know, it was nice for it to be offered to me though and it was nice to say, right, we've got these available, we're going to throw them your way, see how you go on, it'll help towards the assessment process, let's do it. You know, it's nice to go, oh thank you. You know, you're fighting for my corner.

At the beginning of this section we described how the factors that seemed to be important in the'pathways to change', described within these women's accounts, should not be seen as mutually exclusive but rather that they interacted in a number of complex ways. The extract above provides an illustration of how this young woman's growing maturity led to her acceptance of the advice and support she had rejected at 17. Similarly in the account below, Bernie demonstrates the important interaction of a number of the factors highlighting maturation; motivation following loss; self-efficacy and engagement with services:

> Bernie: But at that time I'd grown up from being that, because what I'd lost was so much, I'd grown up from it. I'd stopped partying, I felt better in myself even though I'd lost my kids. I felt like I was building myself up even though [partner] was trying to drag me back down. And then I was pregnant with [child 4]. I went to every appointment, even though I knew they could remove him, I went to every midwife appointment before that, every like scan, everything. So even before they got involved, there was proven engagement. I went to [ante-natal] groups, I'd never done that in my life. What else? I went to every group they told me to do. I was in every time the midwife came round, and Social Services.

Importantly, this mother attributes her growing maturity to the impact of losing her children to state care "because what I'd lost was so much, I'd grown up from it". This loss appears then to act as a catalyst for change and she found a renewed sense of her own self efficacy, which then enabled her to be more open to the need to engage with services'.

Access to psychological services

Earlier in this report we discussed the difficulties that many women had accessing psychological services following treatment recommendations received in court. Similarly we also highlighted the lack of post-proceedings support available to birth mothers.

Within the group of women who had brought about change, access to psychological help appeared important in accounting for their journey to change. Whilst the women's referral routes and treatment models varied, many women cited such services as helping them achieve change:

> Angela: I'm a lot stronger, the counselling helped me cope in a whole different way... I had to have a lot, lot of therapy... counselling within the doctor's surgery in the end... Four times I went to the local mental health team, who give me a few sessions and discharged me. Even though I tried to commit suicide, they said that I wasn't meeting the criteria, which was an out and out joke really. And in the end, the GP said, "I've had enough of this", I'll give you counselling within the service. And I had that for nearly two years. It's only supposed to be, like, a certain amount of time but they kept continuing it and continuing it... Yeah, because that calmed me down a lot, my therapy.

Interestingly, in Angela's account it takes a particular professional to find support for her outside of the main referral route. In keeping with other women, Angela expresses how the counselling has helped her to "cope differently".

Summary

There is an extensive research literature which suggests that individuals react differently to adversity and that developmental pathways are not set in stone. Positive experiences can lead to turning points in the life course, disrupting negative trajectories (Kaufman et al., 1994; S. S. Luthar et al., 2000; Masten, 2001; S. S. (Luthar, 2003; Rutter, 1985; Rutter, 2006; Rutter, 2012). As Rutter (2006) reminds us, positive adaptation is possible even in the face of adversity, and helps explain some divergence of maternal pathways in our study. Women's unique stories provide important insights into the complex interplay of personal characteristics and external factors that shape the life course and can afford opportunities for change. Paying close attention to the factors that we have highlighted in this section, in developing preventative services, may yield positive results, which for some women appear currently to occur more by chance than by design.

7 Discussion

In this final discussion we summarise the main observations made in the report and make links with relevant empirical and theoretical literatures. In addition, we consider key policy and practice recommendations, as well as avenues for future research.

7.1 Recurrent care proceedings and recurrent losses

This study has firmly established that a sizeable number of women return to the family court having had a child removed from their care in previous proceedings. During the course of this study we have published findings about the scale of the problem, with an initial estimate published in Broadhurst et al. (2015a), and an update published in Broadhurst and Bedston (2017). Our estimate is that 1 in 4 women will return to the family court in s.31 proceedings when measured over a 7-year period, with the youngest women at heightened risk. Our most recent analysis indicates that as yet, we are not seeing any reduction in the proportion of women who experience recurrent proceedings. However, we are seeing an increase in number of repeat cases over time, as more families are coming before the family courts. Thus, recurrence is an enduring issue for the family courts in England such that repeat cases feature routinely in the work of professionals within the family justice system.

In this report was have been able to extend our earlier observations by identifying through manual case file review that prior to losing a first child through court order, a number of women had also lost the care of a child to either kin or the State through voluntary agreement (s.20 of the Children Act 1989) or private arrangement. Thus, an exclusive focus on court ordered removals, underestimates the actual number of losses that this population of women have experienced.

We are also able to confirm that intervals between proceedings and subsequent pregnancies are frequently short, which mean that women face the emotional challenge of resolving the removal of their children, whilst also dealing with a new pregnancy coupled with anxiety about a further child removal. Short interval, repeat proceedings leave women with little time to evidence their rehabilitation.

Policy and practice challenges

Skilled post removal support is vital in helping women avoid a subsequent pregnancy that falls during or shortly after a first set of proceedings. New initiatives such as Pause and Positive Choices are expanding, but policy and legislative change would provide a stronger mandate for mainstream provision of post-removal support. At present women's access to intensive help is uneven across the country and attempts to lobby for change, particularly in relation to care leavers, have stopped short of achieving formal statutory change.

Future research

As national datasets mature, future research should focus on differentiating women's trajectories through care proceedings. Questions that remain unanswered are as follows:

1. What proportion of women 'age out' of recurrence?
2. What proportion of women present with a chronic pattern of recurrence?

Drawing together the learning from different, new initiatives is vital to ascertain immediate and longer-term impact on women's lives and care demand. New initiatives are in their infancy and hence, approaches to evaluation will also need further careful revision. Follow-up of women beyond programme involvement is vital.

To-date, in partnership with Cafcass, the Centre for Child and Family Justice Research at Lancaster University is the only research centre able to monitor recurrence. This situation needs to change, such that local and national government can routinely monitor this routine problem for the family courts. In the absence of this capability, it is difficult to see how local agencies in particular can ascertain the impact of investment in preventative projects.

7.2 Maternal childhoods

Detailed manual review of a sample of court case files has enabled us to build a first picture of women's child and adolescent histories. The picture we have gained from interviews with mothers is largely consistent with observations from our case file review, but provides further detail of the consequences of very difficult childhoods from women's perspectives. It is of little surprise that our population of recurrent women had experienced considerable neglect and maltreatment as children and adolescents. Of particular importance is that neglect and maltreatment arose, predominantly in the context of the parental or primary caregiver relationship. Women's own parent(s) largely failed to protect these women in childhood because of their own difficulties or they perpetrated maltreatment. Our findings regarding high rates of sexual abuse are particularly concerning, given the association between child and adolescent exposure to sexual abuse and unplanned pregnancy as well as further sexual victimization in adult lives (Briere and Elliott, 2003).

Neglect and maltreatment, coupled with lack of adequate supervision in adolescence pre-disposed women to secondary victimization from peers and from intimate partners in their adult lives. Thus, women's problems started early in life, but were cumulative in nature and clearly impacted very negatively on their development. Whether we approach our understanding of women's histories through percentage counts of instances of harm, or ACE scores, or subjective interview accounts, we arrive at a picture of multiple and cumulative harms.

Yet, few of the women in either the case file or interview samples had received a formal mental health diagnosis in childhood or adolescence. This is perhaps unsurprising because children and adolescents with complex emotional needs all too easily fall through the net of mental health services. For example, CAMHS, up until very recently, declined referrals concerning children who were not in settled placements. Given that mental health first emerges for 75% of the population before the age of 18, it appears that for this group of women, mental health difficulties are missed in adolescence, but uncovered when women are subject to assessment of parenting capacity.

In Section 6.2, we introduced readers to the concept of developmental trauma disorder (DTD) variously referred to as complex trauma or complex trauma disorder. This body of theoretical work helps to explain why harms in childhoods can have such profound effects (Broadhurst et al., 2018). Developmental trauma disorder (DTD) has become the preferred description for capturing enduring harms in the context of interpersonal dependence. Harms can involve emotional, sexual and physical abuse, exposure to violence or neglect (D'Andrea et al., 2012). Children typically turn to their primary caregivers for care when they are afraid, hurt or otherwise in need. Where caregivers are unable to offer the care and protection that children seek, proponents of DTD argue that children become intolerably distressed such that they experience their environments as intrinsically unsafe (Bransford and Blizard, 2016). The developmental consequences of enduring exposure to unsafe childhood environments for children are multiple. Typical consequences for children as they grow up include difficulties with regulation of emotion, self-perception, attachment and interpersonal relations (Cook et al., 2005; Briere

et al., 2008). In addition, individuals are vulnerable to chronic problems of low self-esteem, limited capacity for self-care and forward planning.

DTD also helps explain why children and adolescents can be hard to help. In many ways these children and adolescents have a hidden disability, an emotional disability that makes engaging in education and peer relations very difficult. We know that traumatized children often have difficulty making and maintaining healthy attachments and in trusting adults especially those in a caring role.

Policy and practice challenges

There has been a raft of recent child and adolescent focused policy and guidance (2012 - 2016), but we are yet to see this translate into the systematic testing of promising interventions.[1] The DTD literature offers promising framework for making sense of difficulties, but also a set of practical tools for both screening and safety work with children, adolescents and young adults. Children and adolescents will continue to come to the attention of services or be received into care, once a level of developmental harm has already taken place, thus investment in the skills of those working directly with children and adolescents, for example using DTD resources, may yield positive results.

Future research

Drawing together the international evaluative evidence on promising initiatives with children and adolescents who have suffered enduring developmental harm is needed, to stimulate and inform national innovation. Given women's experiences of harm in childhood, this will no doubt impact on their adult relationships, including with professionals. The challenge for services is how to develop effective relationship-based support attuned to women's emotional difficulties, including mistrust of services. This latter point is a long-standing issue, but as yet insufficiently resolved for frontline social work.

7.3 Care experience and care-specific trauma

Based on findings from the file study and interviews, we can conclude that 40% of our sample of recurrent mothers had experienced period(s) of formal out-of-home care. In addition a further 14% were in informal out of home care arrangements. This is the first study that has formally identified a relationship between care experience and subsequent child removal, albeit based on women with a recurrent profile. In addition, we have been able to identify the kind of care trajectories that women have experienced. Typically women entered care as older children, with the majority aged 10+ years. They moved around in care; between kin, foster care and back home. Residential care is also recorded as a placement type for a significant percentage (39%). We have also observed that 12% of women were placed in secure accommodation and 20% experienced further maltreatment in care. Thus, the care trajectories that we have uncovered evidence unsettled experiences, that we know lead to poor outcomes. Given our observations above, regarding women's exposure to harm in childhood, it is of little surprise that they found it difficult to form positive attachments with substitute caregivers.

Although care can be protective for children and a proportion of children fare better than they would, had they not become looked after, for women in this study, care did not appear to avert harm. Indeed, we might conclude that many women experienced 'care-specific trauma' because of their experience of multiple moves, residential and secure accommodation.

It is also important to stress that half our sample of recurrent mothers, despite recording high ACE scores, were not received into care, although may have been living apart from their parents with kin or

[1] Policy and Practice Seminar Lancaster University, July 2016. Slides and further information available from Dr Jasmine Fledderjohann.

friends, or were homeless (i.e. they were 'on the edge of care'). This population is in many respects are even more challenging at they fall outside the radar of services. They are most likely to be picked up by police as young runaways or missing from home.

When we compared age at transition to motherhood and timing of first child removal, we found little difference between those who had been received into care and those who had not. Both groups of women as adolescents present major challenge to services, as they are currently organised.

Policy and practice challenges

The sensitive use of screening tools designed to identify developmental harm/trauma prior to external manifestation of difficulties, may lead to more timely therapeutic work with these children. It is unlikely that we will seen any reduction in children coming into care, beyond infancy or primary school years, which raises questions about how we differentiate the large cohort of older entrants, such that problems are intercepted at an earlier point. Women in our recurrent sample evidence high levels of emotional difficulties, which require a highly skilled therapeutic response. It is likely that this population of children would struggle to make use of formal timetabled mental health therapy sessions (at least in the first instance), however, highly skilled relationship based work that addresses attachment issues is critical. Intensive case-work, that includes substantial outreach work is essential. Much can be learned from new initiatives such as Pause and Positive Choices.

Future research

Future Research is needed to more clearly establish the relationship between care experience and adult appearances in the family court. Again, as datasets mature, linking data held by Cafcass, DfE and MoJ holds out the promise of providing far greater insights into this relationship. Developments underway at the Ministry of Justice (MoJ) to create better intelligence are very important as is close working between the MoJ and academic/analytic communities.

Review is needed of how current methods of screening for emotional difficulties in LAC impact on care plans/intervention (e.g. SDQ). It needs to be established whether or not there are better methods of screening for trauma/DTD that might be used. Additionally, data held by the police on runaways/missing children is very useful and could potentially feed into the identification of children and young people who have experienced developmental harm. Equally, prospective follow-up of cohorts of care leavers is needed in order to establish why some young parents do well in parenting their own children, whereas others see children removed from their care will also be important.

7.4 Reproductive choice and pregnancies

We discovered from interviews with women, that unplanned pregnancy was common. However, what women meant by 'unplanned' required some further unpacking. For some women, problems of substance misuse were so distracting that contraception was simply not thought about, or reliably used. For others, non-use reflected broader problems of planning and decision making difficulties. Childhoods in care appeared associated with an ambivalence towards contraception. A willingness to have unprotected sex also appeared bound up with an urgency to cement new relationships. For other women, multiple psychosocial difficulties indicate a more protective role for professionals, particularly where coercive or violent relationships were implicated in pregnancies.

This population of women typically enters motherhood at a far younger age than the general population in England. Young motherhood is not uncommon for girls whose lives are characterized by socio-economic disadvantage, but the proportion of women in our national sample who were pregnant

as teenagers is striking. In addition, there appear to be drivers of unplanned early pregnancy, which have more complex psychosocial reasons, than simply limited options in life. Women in our study were more likely to continue with a pregnancy, than seek a termination. There is limited literature on this topic, but our study confirms findings from other recent UK-based research (Craine et al., 2014). Moreover, care-leavers, who have an elevated risk of care proceedings, are more likely to continue the pregnancy to full-term and present with a second pregnancy, despite being offered long-acting reversible contraception. Although we have uncovered high rates of sexual abuse, interviews were not a suitable forum for further probing the impact of sexual abuse on women's choice of intimate partners or sexual behaviour. However, published research evidence would suggest that sexual abuse is linked to later sexual victimisation (Humphrey and White, 2000; Messman-Moore and Long, 2003) high risk sexual behaviour and unprotected sex (Fergusson and Lynskey, 1997).

It is very clear is that a pregnancy, which follows removal of another child, is haunted by the memory of the previous removal. In addition, this subsequent pregnancy cannot be enjoyed because the fear of further court-action and the loss of the new baby are ever-present.

Yet pregnancy is a window of opportunity, strongly linked to turning points in our interview sample. Contrary to popular opinion, we found very few cases of active pregnancy concealment, rather the majority of women wanted help early in pregnancy. The pre-proceedings process offers a potentially valuable opportunity to work closely with the mother, but much will depend on the timing of pre-birth social work involvement, the intensity of service input and support and on the relationship between the social worker and mother. If involvement only begins in the final trimester of pregnancy and the recommendation is removal, it may compound distrust of the local authority.

Policy and practice challenges

Professional efforts to support informed reproductive decision making must be highly attuned to women's personal biographies and capacities – one size does not fit all. Practitioners need to understand how both loss but also trauma in the context of interpersonal relationships influences choice of intimate partners and reproductive decisions. Pre-birth assessment and the statutory child protection conference need to happen earlier in pregnancy. Based on evidence drawn from court case files, the pre-birth conference is taking place too close to birth, in many cases.

Future research

There are multiple initiatives emerging and more established, which we have not fully covered in this report. However, future research needs to establish the impact of the range of new preventative initiatives such as Pause, Positive Choices, Breaking the Cycle (After Adoption) and Reflect (Wales) and others, to establish whether women develop greater capacity for self-care beyond their involvement in intensive interventions, regarding contraception and birth spacing. Equally, the Early FDAC pregnancy programme, funded initially by the DfE, requires detailed evaluation to establish its impact on subsequent pregnancies.

7.5 Impact of removal and need for better recognition within mental health response

In our earlier work we raised questions about the impact of court-ordered child removal on young women's developmental journeys (Broadhurst and Mason, 2017). From women's interview accounts we are now able to confirm that child removal leads to complex grief responses and for all women in our sample, a downturn in well-being and return to unhelpful methods of coping. By complex grief

reactions we refer to responses that are difficult to resolve which in the case of court-ordered removal of children result from the following:

- Children are psychologically present but physically absent.
- Women may strongly disagree with decisions that resulted in child removal.
- Women's role as above are restricted, thus, women are unable to find distraction from loss through work or education.
- Isolation and shame – few opportunities for communal experience.

As stated there is scant literature on court-ordered child removal, the bulk of the literature concerns relinquishment. In addition, within the published literature there is insufficient reference to the clinical literature on complex grief responses, which is informative in terms of better understanding presenting symptoms and therapeutic responses. For example, within DSM-5, the 'candidate diagnosis' of persistent complex bereavement disorder – referring to prolonged/unresolved grief that interrupts daily living is helpful. Overall, however, we need to see a far better acknowledgement and understanding of the profound effect of child removal on mental health and life chances, within mainstream social work and mental health services. The severity of mental health symptomatology as described by women warrants a far better mainstream mental health response. Typically women could not access mental health therapies as recommended by experts in care proceedings, which may have helped prevent return to court and fostered better ways of coping.

All of the women in interview described an escalation of problems following child removal. This included homelessness and housing instability, further interpersonal violence, instances of criminal behaviour and unplanned repeat pregnancy (Broadhurst and Mason, 2017). Descriptions of suicidal thoughts were common, and in the majority of cases, women described self-harming behaviours, typically excessive drinking or drug taking and entering into very negative intimate relationships. Overall, we need to see a far better acknowledgement and understanding of the profound effect of child removal on mental health and life chances, within mainstream social work and mental health services. The severity of mental health symptomatology as described by women indicates warrants a far better mainstream mental health response. Typically women could not access mental health therapies as recommended by experts in care proceedings, which may have helped prevent return to court and fostered better ways of coping. In this context, lack of access to mental health services created a deep sense of injustice for women because they knew that professionals would require evidence of improvements in mental health in any future assessment of women's ability to safely parent

Policy and practice challenges

We would recommend increasing the skills of social workers and mental health professionals working with women who have lost children to out of home care and adoption, to develop greater awareness of profound and enduring impact of loss, particularly in context of subsequent pregnancies.

Future research

The evidence base concerning grief and resolution of loss for parents who lose children through court order requires substantial updating and improvement. Much can be learned from the clinical literature on complicated and/or traumatic grief responses.

7.6 Removal at birth

Women who experience recurrent care proceedings appear to prompt a swifter response from the courts in subsequent proceedings. Our data indicates that local authorities and the courts both sanction earlier removals of babies from mothers, if the mother has appeared in care proceedings before. In addition, women are more likely to see their children adopted in a second set of proceedings. Thus, for women caught in a cycle of repeat proceedings, this is a story of multiple losses, often in short succession, which compound histories of disadvantage. Women's interview accounts gave very negative accounts of removal at birth.

Future research

There is a pressing need to establish good practice guidance, which would ensure better planning for mothers and infants, where babies are removed at birth. This would also provide greater assurances for professionals in these very challenging practice circumstances. Equally pressing, is a better understanding of why removals at birth are increasing in number and to compare trends with those in a range of comparable international contexts. Further research is needed to establish best practice in reunification mother and infant and infant contact.

7.7 Family justice experience

We have found that women found court processes very difficult to understand and negotiate given complex rules and language, and formality. Thus, the court process compounded women's sense of isolation and injustice. It is also important to note that many women were left feeling that they had not meaningfully participated in the FJ process.

The further roll out of the Family Drug and Alcohol Court National Unit that takes a non-adversarial, problem-solving approach to family justice holds out the promise of helping parents to understand and develop the necessary skills to avoid repeating unhelpful patterns. In addition, evaluation evidence is that parents take away a far greater sense of justice having been through FDAC, than standard proceedings (Harwin et al., 2011).

A significant percentage of women in our recurrent sample appeared as respondents in a first set of s.31 proceedings, aged less than 20 years. To date we know remarkably little about how courts address the issue of young motherhood and it is striking how little focused attention young age has received in the literature on care proceedings. Age per se simply has not been singled out for investigation in the literature on parental perspectives on the family justice system. However, from interviews, it is plain to see the serious obstacles that standard care proceedings pose to meaningful participation for this group of very young parents.

Policy and practice challenges

Investment needs to be made in testing models of problem solving justice. FDAC and alternative US youth court models that offer a family network approach to court proceedings most likely offer better alternatives to standard proceedings for young parents.

Future research

There is substantial international evidence that family treatment courts deliver a better experience for parents (Harwin et al., 2013). It is imperative that work continues to test alternative approaches to public

law proceedings, that place more emphasis on the family experience, and reduce the adversarial nature of proceedings

7.8 Turning points

A proportion of the women interviewed were caring for a child at the time of the interview (48%) having made marked changes in their lives. Women self-selected for interview with the support of agencies, hence our sample may be biased towards those better engaged with services. However these women's accounts provide very important illustrations of positive change, despite histories of multiple adversities (Broadhurst and Mason, 2014). In addition, another group of women, who did not have children in their care, also described positive change in regard to recovery from substance misuse, better interpersonal relationships, employment and education. Given that all the women in the study had experienced multiple harms and adversities in childhood, the study confirms that ACE scores may be predictive of poor adult outcomes, but with the right change in circumstances, marked changes in developmental trajectories are possible (Rutter, 2012).

Women differed in their reactions to court ordered child removal. Although, across the group, an immediate downturn in functioning was evident, we see divergent longer-term reactions. Some women were able to bring about change, whereas for others, child removal further entrenched mental health and other problems.

The common factors associated with positive change, across the women's accounts, were combinations of:

- Positive change in intimate partner relationship and wider informal networks.
- Ability to reflect and learn from experience.
- Being offered better professional help and making better use of that help.
- Commitment to children, both those removed from a woman's care and those in her care.
- A sense of purpose and ability to plan for a different future.
- Access to post-proceedings counselling and/or mental health services.

Intimate partners were frequently central to women's difficulties and loss of their children, on account of violence and emotional abuse. However, a supportive intimate partner and connection to a new and more positive extended family network were equally transformative.

For all the women who demonstrated positive turning points, learning from experience was also critical in their journeys towards recovery. From our population-level data, we observed that risk of return to court as a respondent in care proceedings reduced with age. A reduction in risk is evident from the age of 25 years, dropping again after the age of 30. This cannot be attributed to a drop in fertility but does suggest that maturation plays a part in reducing the risk of recurrence. In interview, women themselves indicated that they had learned from experience and with maturity, gained insight into partner and lifestyle choices that were damaging.

Relationships are at the heart of help seeking and help giving. For all the reasons above, this population of women may present as hard to help. However, it was clear that a percentage of professionals were able to foster trust and engagement where others had failed. This can be attributed to the skills of the worker who is attuned to women's emotional needs, but also to timing. Some women demonstrated resilience to child removal and a greater willingness to receive and respond to professional help with maturity. Women themselves reported a change in how they perceived help over time, on account of both changing personal circumstances but also skilled and sensitive professional help.

Women consistently described a keen sense of the presence of their children, and an enduring maternal identity, despite their physical absence. Wanting to 'do better' for their children was a very powerful driver for change. In addition, subsequent pregnancies acted as a powerful catalyst for change.

Policy and practice challenges

The group of women within our interview sample who had brought about positive change following great adversity and multiple losses of children, provide evidence that change is possible. Often changes in circumstances, such as meeting a new partner, or a change in worker were transformative for women. However, internal psychological shifts also appear key. Our interviews would suggest that access to psychological services for some was critical, but for others an attuned, supportive professional or personal relationship appeared to spark the necessary change. Our findings clearly confirm observations from a wealth of international that the following ingredients are critical in promoting change: (a) consistent relationship-based help, (b) informal support, and (c) learning from experience. In addition, interview accounts highlight the importance of harnessing women's commitment to their children, to improve contact with children in care. Responding to an impetus for change that a new pregnancy can bring is vital. A greater awareness within services of these factors and further efforts to create the conditions for practitioners to deliver consistent and longer-term support to women with complex difficulties, would mean that intervention has more chance of improving lives.

Future research

As stated above, as national datasets mature, we will be able to test out hypothesis that a percentage of women 'age out of' recurrence. New preventative initiatives are collecting a wealth of data regarding turning points, which needs to be effectively used, where women consent, to substantiate observations regarding factors that prompt positive change.

7.9 Outcomes for children

The primary focus of this project was women. However, we have been able to draw some important observations regarding children, not least that many infants born into this cycle are born into care (removed at birth). We also noted that a high percentage of children appeared to record different permanency outcomes from their siblings at index proceedings (49.1%) and at first repeat this increased to 69.2%.

Regarding health outcomes, infants born into a recurrent cycle appear to experience poorer health outcomes than infants in the general population – they are at heightened risk of pre-term birth, being admitted to Special Care Baby Units at birth and 18.4% are affected by mother's substance misuse. However, we also noted that for a high percentage of infants, no developmental problems were recorded at birth.

Policy and practice challenges

Where women give birth to multiple children it is highly likely that large sibling groups are split across permanency placements. This provides a child-centred warrant for tackling recurrent proceedings.

The health profiles of infants, based on our limited data, again underscore the importance of post-proceedings support for mothers, and timely support in subsequent pregnancies to reduce maternal anxiety and maximise maternal and fetal health.

Future research

We have made best use of available data to being to uncover health profile, but further research is need to gain a better picture of both health and permanency outcomes. It appears from the limited data on file, that for a large percentage of babies, no developmental difficulties are recorded at birth.

To date, we know little of how infants 'born into care', fare over time regarding permanency placements, sibling contact or reunification. Given that removal at birth is pre-emptive and raises human rights questions regarding the child's right to family life, this omission needs to be addressed.

7.10 Conclusion

Given the evidence of widespread innovation on the part of practice agencies to help prevent recurrent proceedings, it appears that the case has been made that recurrence is a major national issue for England, which must be tackled if care demand is to be reduced. In addition, it is heartening that innovation is also driven by an ethical imperative to help women, their children and wider networks avoid the distress caused by recurrent care proceedings. Our work has now stimulated a related programme of work, not just in the UK, but also in Australia. New studies will yield valuable research evidence, addressing questions that we have been unable to answer, or will shed light on recurrence in comparable jurisdictions. However, more immediate work needs to be done, as at present, because women's access to intensive therapeutic help is uneven across England. Efforts on the part of the Family Rights Group (FRG) have made some progress towards making the case for change to primary legislation, but have fallen short of achieving this. However, in response to campaigning by FRG, Edward Timpson (former Minister of State for Children and Families) stated that changes would be made to practice guidance regarding care leavers to ensure post removal support.[2]

Moving forward investment needs to be made in robust evaluation of preventative programmes in order to make the case for and ensure the wider roll out of best practice. Alongside this, investment must be made in ensuring that local authorities and the courts collect the necessary data to ensure that recurrence, which is a routine feature of the family justice system, can be identified and measured. The lack of national intelligence regarding women in the family justice system becomes all the more clear when we compare the readily available national data regarding women in the criminal justice system.[3] With marginal costs, the inclusion of additional variables to datasets collected by local authorities and the courts (and in turn DfE and MoJ), would enable recurrence to be monitored at a national level. As data on the national family justice system matures, it will become increasingly valuable but only if there is: (a) a willingness on the part of government departments to ensure revision of national indictors and (b) an increase in analytic capability.

An overarching message from birth mothers, but also from our detailed review of case files, is that relationships matter. This statement is not new, but needs to be re-stated because as yet, our public services do not sufficiently provide the conditions for workers to offer bridging relationships that afford the kind of continuity and consistency that will bring about change. Where parents, and indeed children within child welfare services, are isolated and disconnected from nurturing and

[2]David Burrowes, Conservative MP for Enfield Southgate, proposed an amendment to the Children and Social Work Bill during its passage through parliament in 2016-2017. It applied specifically to the provision of therapeutic support for care leavers who subsequently have children removed from their care. Whilst no change to primary legislation was agreed the (then) Minister of State for Children and Families, Edward Timpson, did agree to an amendment to local authority statutory guidance on care planning.

[3]The lack of intelligence regarding women in the FJS becomes all the more obvious, when we consider national data regarding women in the criminal justice system. For example, reconviction rates regarding women in prison are calculated annually by MOJ, together with offender profiling and cost data. Yet, the prison population of women is smaller (n=4,020 at 2017 in England and Wales) and forms only a very small percentage of overall prison population (5%).

supportive relationships, difficulties will persist or worsen, as we have shown in this study. Again, much can be learned from new preventative solutions such as Pause and Positive Choices. These are demonstrating alternative ways of reaching this population of women, where mainstream services report 'non-engagement'.

This study has, for the first time, clearly identified an association between unsettled pathways through care, characterised by multiple moves, and subsequent adult appearances in the family justice system. This is both a deeply concerning finding, but is not surprising given the wealth of international literature which indicates that serious childhood harm and adversity are predictive of attachment difficulties and placement instability. Given that the largest percentage of the cohort of recurrent mothers in our sample entered care at the aged 10 years or older, this raises the question of how we might identify these women far earlier in their lives and intervene before further problems arise. Again, there is a wealth of international literature, which indicates the value of the ACE methodology and accompanying screening tools for frontline practice with children and adolescents. In addition, there is a burgeoning literature on trauma-informed practice, which could be better applied to children entering care (Murphy et al., 2017).

In cases of recurrent proceedings, 60% of care proceedings are issued within 4 weeks of birth. This is the first UK study to use finer infant sub-populations to arrive at a clearer picture of infant removal practices. The removal of an infant from his or her mother close to birth is a very serious form of pre-emptive action, which of course, raises questions of whether state action is proportionate or fair. Nevertheless, some circumstances will mean the infants cannot be safely cared for by their mothers following birth. Work to establish best and humane practice in these difficult circumstances is urgently needed to ensure professionals work in partnership with mothers as far as possible and that clear pre-birth plans are in place at a timely point. Birth mothers' first person accounts provide important insights into how the distress associated with this particular form of child removal might be reduced. Our work demonstrates that birth mothers who experience recurrent care proceedings are willing to be involved in service development.[4]

As we have seen in this study, pregnancy can also be a window of opportunity, but as yet we know very little about how local authorities make use of this window in their work with recurrent mothers. Evidence from this study is that the pre-birth conference is often held close to an infant's birth, which raises questions about why local authorities are not consistently responding early in pregnancy, given we know that pregnancy can be a powerful motivator for change. Initiatives such as the pregnancy pathway that has been piloted by the Family Drug and Alcohol Court National Unit[5] (Early FDAC), require detailed evaluation to establish programme impact.

Finally, evidence of turning points in the face of adversity indicates that although ACE is predictive of poor adult outcomes, ACE scores do not determine adult outcomes. This is an important distinction and has been made by leading scholars such as Michael Rutter in his work on resilience (Rutter, 2012). In this study we have described the common factors that are associated with positive turning points and which resonate with an accumulated body of knowledge that provides similar messages (Collishaw et al., 2007; Bonanno and Mancini, 2008). Our work, together with the broader relevant literature, provides a clear steer for those who wish to help women bring about positive change.

[4]This study has produced a short film in collaboration with birth mothers in which they provided rich insights into their positive turning points in their lives. In addition, women have helped to design a new preventative pathway within the Family Drug and Alcohol Court (FDAC) aimed to help pregnant women who have had a child removed from their care previously.

[5]FDAC National Unit: http://fdac.org.uk/

Appendix A. Study methodology

A.1 Overview and research questions

A mixed methods study was carried out between 2014 and 2017, focused on birth mothers and their children in care proceedings under s.31 of the Children Act 1989. Building on a feasibility study completed in 2013-2014, the study aimed to provide the first national picture of the scale and pattern of recurrent care proceedings in England based on population-level data, derived from national records held by the Children and Family Court Advisory and Support Services (Cafcass). The study also sought to understand the factors or processes associated with a woman returning to court and the implications for her children, through interviews with birth mothers and detailed reading of a representative sample of court files. With this in mind, the following research questions framed the study:

1. What is the scale and pattern of recurrent care proceedings nationally and what is the profile of birth mothers involved in this cycle?
2. Is it possible to differentiate the population of birth mothers caught in a cycle of recurrent care proceedings and what are the implications for intervention?
3. How can a dynamic understanding of risk and protective factors and processes over time, inform the development of preventative services?
4. Where mothers exhibit recovery of parenting capacity, how is this achieved?
5. How might reproductive health services be delivered differently to intercept a cycle of repeat pregnancy and recurrent care proceedings?
6. What are the implications for children, fathers and kin networks of recurrent care proceedings?

The study comprised three main elements:

- Element A: extraction and secondary analysis of quantitative data from routine administrative court records concerning approximately 65,000 birth mothers.
- Element B: 72 qualitative interviews with women who had experienced repeat removal of children.
- Element C: detailed review of court files concerning 354 women in recurrent care proceedings.

Each element is described to include an outline of data sources, methods of data collection and analysis.

A.2 Legal and ethical aspects

Approval for the study was granted by the President of the Family Division, the Cafcass Research Governance Committee, participating local authorities and Lancaster University. Regarding data drawn from electronic records held by Cafcass, a System Level Security Policy (SLSP) was drawn up by the University for the purposes of the project to agree the requirements of safe extraction and storage of de-identified data. In accordance with guidance from Meystre et al. (2014), data was processed and de-identified on the Cafcass system. De-identified data was then securely transferred to and stored at Lancaster University, according to the separation principle which is deemed best practice for the

storage of sensitive data (NSS, 2017). Datasets were stored within an access-restricted data share on the university networked storage, compliant with the UK 1998 Data Protection Act. Where de-identified data files were downloaded to approved laptops for analysis, these laptops were encrypted at disk-level and data-sets were returned to the share immediately after scheduled analysis. In 2017, our population-level data extract was updated via Cafcass and request for this update were approved by Lancaster University and by the Cafcass Research Governance Board. The same restrictions on use, outputs and data sharing were agreed. All members of the research team received updated training in data protection, were mindful of the data subject's rights throughout the life cycle of the project and obtained enhanced clearance from the Disclosure and Barring Service (DBS).

Regarding the qualitative interviews, birth mothers clearly present as a vulnerable population and their involvement in this project required careful consideration. Mothers were approached via 7 collaborating local authorities who were well placed to ensure potential participants had sufficient capacity to understand the implications of their involvement. Protocols with participating agencies were established to enable an effective response to women's distress or disclosure. Written informed consent was sought from all participants underpinned by principles of voluntarism (BSA, 2002). Birth mothers were provided with £20 high street voucher as a thank-you and all travel expenses covered.

Regarding Element C, the case file study, permissions to access the court records were sought from the Her Majesty's Court and Tribunal Service (HMCTS). Details about the study were submitted to the HMCTS Data Access Panel and clearance subsequently granted. In addition, all members of the research team accessing the files were required to sign an HMCTS Privileged Access Agreement (PAA) and to submit an advanced disclosure and barring service check certificate (Advanced DBS).

A.3 Role of the advisory board

The project timetable was planned to enable active engagement of the advisory group throughout the project's life cycle through formal face-to-face meetings and though ad-hoc consultation. The advisory board was invited to comment on all project outputs, including this final report.

A.4 Element A: population-level court administrative records

Element A of the study aimed to establish the scale and pattern of recurrent care proceedings, using population-level data (Research Questions 1 and 2). The source of data for Element A was the electronic case management system (ECMS) maintained by Cafcass, a national, administrative, electronic case management system. Cafcass records information regarding all applications made to the family court under s.31 of the CA 1989, making ECMS an invaluable resource for population-level analyses. Data covers all 40 DFJ areas, 254 courts, and 152 local authorities.

A feasibility study was initially completed which identified the research potential of the Cafcass ECMS. This work found that there was a large amount of missing data regarding individuals' background details, such as ethnicity and disability, but details such as date of birth and gender were much more reliably recorded. Additionally, details related to the court proceedings, such as application start and end dates, type of application, and the children and adults involved was much more routinely collected. Also routinely recorded was the local authority in which applications were issued, as well as the court and DFJ in which the case was being heard. Legal outcomes for each child were also routinely present in the ECMS. In Appendix B is an annual summary of proceedings from years ending March 31st 2010/11 through to 2015/16.

A.4.1 Sample criteria

In order to begin working with the ECMS, we had to define who and what we were interested in. Since the purpose of this study was to analyse birth mothers in recurrent care proceedings, the main unit of analysis was the mother herself, with her journey through the family justice system being a sequence of s.31 proceedings concerning her children over time. Given this, in order to be included in the sample, all three of the following criteria had to be satisfied:

1. The person was an adult female party to proceedings.
2. The proceedings had to contain at least one s.31 application.
3. She is the birth mother to at least one of the children subject to the application.

We were limited to proceedings which started between the years 2007/08 through to 2015/16, as reliable electronic data were not available before 2007/08. Having identified women according to these criteria, we then retrieved information regarding the case and all the adults and children involved, as described in the following section.

A.4.2 Data transformation

Records within the ECMS are stored in a relational database. Thus, with the appropriate permissions and ethical clearance in place, members of the research team were able to manipulate the ECMS using SQL (Standard Query Language) to create a data structure that was more suited to the research aims of the study.

Extraction and transformation of the data enabled the research team to work with far larger samples than would have been possible if manual reading of case files was required. Figure A.1 shows a diagram of the general structure of the ECMS. In the diagram, each rectangle is a table in the database, with the arrows representing the direction of a one-to-many relationship. What this shows is that the highest unit in the structure is the *case*, everything is associated with a case in one form or another, and each case has one local authority associated with it. The main purpose of a case is that it contains at least one application, and on that application are a number of people; adults and child as parties and subjects of the application, this information is recorded in the *application* and *person on application* tables respectively.

Actual details about the person, such as gender and date of birth, are stored in the *person* table. The parental relationships between the adults and children are recorded in the *person relationship* table. Over time, we would expect a case to have one or more hearings, these are recorded in the *hearing* table with a link back to the associated case, and similarly we would expect legal outputs to be generated though these are directly associated with an individual on the application as well as the case.

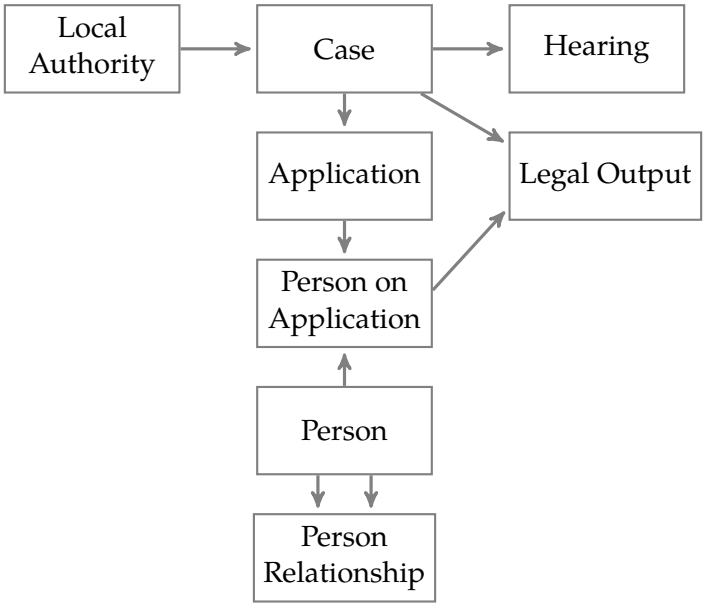


Figure A.1: Summary of the relational structure of the main data tables in the ECMS. The direction of the arrows represents the one-to-many relationship between two tables.

Working with the ECMS database, the main steps for transforming the source data tables to produce the data table structure for our research as shown in Figure A.2 were:

- Separate out the list of people on an application into two groups; adults and children, and associate them directly with the case, rather than the application. Thus, creating two new tables; *case child*, and *case adult*.
- Aggregate the s.31 applications involved in a case to create application summary measures at the case-level. For example, 'first application start date' and 'first application type'.
- For the children involved in a case, identify the final legal outcome, and the associated hearing in which that was made.
- Create a new table, *case adult child*, mapping the known relationships between all adults and children on a given case.

Part of the transformation process was to also bring in information that was being stored in lookup tables such as the name of local authority, and names of legal outcomes into the main tables themselves. The full variable list of the information we stored in the data tables shown in Figure A.2 is described in Table A.1, along with the percentage of missing values.

A.4.3 Variable list

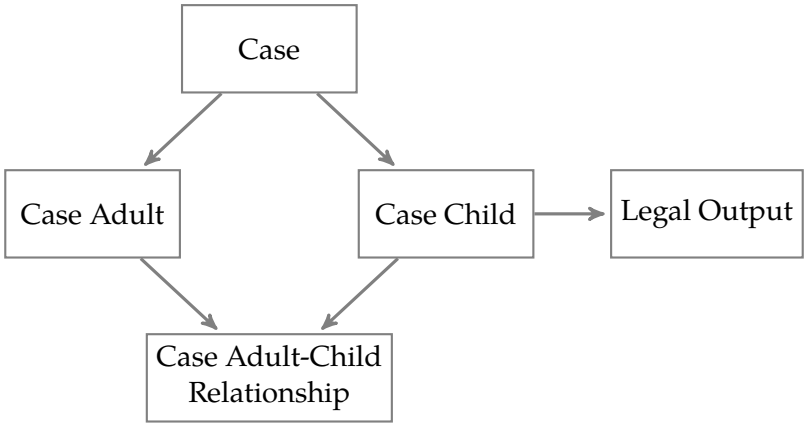


Figure A.2: Summary of the tables and their relationships generated by the research team from the source ECMS. The direction of the arrows represents the one-to-many relationship between two tables.

Table A.1: Transformed data tables and variables sourced and derived from the Cafcass ECMS for use in Element A.

Table name Variable name	Type	Percent missing	Description
case			
case_file_id	int	0.0	Unique system ID given to each case file.
case_file_status	text	0.0	System status for case; open or closed.
date_closed	date	3.8	Date case was closed by Cafcass.
is_consolidated	int	0.1	Derived variable from 'consolidated' legal output associated with case file.
law_type	text	0.0	Case heard under public or private law.
local_authority	text	0.0	Name of applicant local authority.
court	text	0.0	Name of court in which the case is being heard.
circuit	text	0.1	Circuit region of the court.
dfj_area	text	0.1	DFJ area of the court.
first_app_date	date	0.0	Date first s.31 application submitted.
first_app_type	text	0.0	Type of first s.31 application (care or supervision).
has_app_s31_care	int	0.0	Indicator if case contains any application for a care order under s.31.
has_app_s31_supervision	int	0.0	Indicator if case contains any application for a supervision order under s.31.
final_hearing_date	date	3.8	Date when final order was made.
has_final_legal_outcome	int	8.0	Indicator that at least one child has a final legal outcome.
child_count	int	0.1	Number of unique children subject to all applications for a case.
consolidated_child_count	int	0.0	Number of children who have been consolidated from another case.
case_adult_count	int	0.3	Number of unique adults party to all applications for a case.
has_case_mother	int	0.1	Indicator if any parties are the birth mother to at least one child.

Table A.1: Transformed data tables and variables sourced and derived from the Cafcass ECMS for use in Element A (continued).

Table name Variable name	Type	Percent missing	Description
has_case_father	int	0.1	Indicator if any parties are the birth father to at least one child.
has_new_child	int	0.1	Indicator if for any child it is their first case.
age_youngest_child	decimal	0.1	Derived from child's dob and first_app_date.
case_child			
case_file_id	int	0.0	System ID for case.
child_id	int	0.0	System ID for child.
gender	text	0.0	Male or female.
dob	date	0.0	Date of birth.
ethnicity	text	74.6	ONS ethnicity group.
has_case_relationship	int	0.0	Indicator if an adult party to the case has a family-relation to this child.
has_case_mother	int	0.0	Child has birth mother party to the case.
has_case_stepmother	int	0.0	Child has step mother party to the case.
has_case_father	int	0.0	Child has birth father party to the case.
has_case_stepfather	int	0.0	Child has step father party to the case.
case_start_age	decimal	0.0	Age of child at start of case.
case_closed_age	decimal	4.2	Age of child when case is closed.
has_app_s31_care	int	0.0	Child is subject to an application for a care order.
has_app_s31_supervision	int	0.0	Child is subject to an application for a supervision order.
has_final_outcome	int	0.0	Child has a final legal outcome for this case.
final_outcomes	text	8.6	Concatenated string of all final outcomes received.
has_consolidated_outcome	int	8.6	Is final outcome 'consolidated'
case_adult			
case_file_id	int	0.0	System ID for case.
adult_id	int	0.0	System ID for adult
gender	text	0.6	Male or female.
dob	date	15.6	Date of birth.
ethnicity	text	78.4	ONS ethnicity group.
has_case_relationship	int	0.0	Indicator if an adult party to the case has a family-relation to this child.
is_case_mother	int	0.0	Adult is birth mother to a child on the case.
is_case_stepmother	int	0.0	Adult is step mother to a child on the case.
is_case_father	int	0.0	Adult is birth father to a child on the case.
is_case_stepfather	int	0.0	Adult is birth step father to a child on the case.
parent_child_count	int	20.1	Number of children in which adult is birth parent.
parent_consolidated_child_count	int	20.1	Number of children from consolidated case in which adult is birth parent.

Table A.1: Transformed data tables and variables sourced and derived from the Cafcass ECMS for use in Element A (continued).

Table name Variable name	Type	Percent missing	Description
is_parent_w_new_child	int	20.1	Adult is a parent appearing with a new child.
parent_new_child_count	int	20.1	Number of new children.
case_start_age	decimal	15.6	Age of adult at the start of the case.
case_closed_age	decimal	19.0	Age of adult at the end of the case.
is_on_consolidated_case	int	0.0	This case as been consolidated into another case.
case_adult_child			
case_file_id	int	0.0	System ID for case.
adult_id	int	0.0	System ID for adult.
child_id	int	0.0	System ID for child.
case_adult_role	text	29.1	Family-relational role of the adult to the child.

A.4.4 Data cleaning

There were three main tasks in processing the data beyond restructuring the tables as described above; (a) deriving time variables, such as fiscal years, ages and durations, (b) deriving all indicators, such as whether or not a birth father is present on a case, and (c) summarising the legal outputs. The first two are self-explanatory and the number of time variables and indicators can be seen in Table A.1, but the way in which we rationalised the legal order data requires some explanation. First, we checked the frequency of each legal output recorded by Cafcass, as well as the combinations of outcomes per child. From this, the following ranked groupings were created to reduce the amount of legal output information and to identify what we would consider to be the final legal output for the child:

Group 1: Order of No Order (ONO) / Order refused/ App dismissed / Application refused

Group 2: Supervision Order (SO) / Family Assistance Order (FAO)

Group 3: Special Guardianship (SG) / Residence Order (RO) / Child Arrangement Order (CAO)

Group 4: Care Order (CO) / Secure Accommodation Order (SAO)

Group 5: Placement Order (PO) / Adoption Order (AO)

Group 6: Consolidation

If the combinations of outcomes assigned to a child fall into a number of the groups, then we assigned the group which indicated the highest level of intervention given the outcomes. For example, if a child was recorded as having both a supervision order and placement order, this child would be recorded has a having a Group 5 outcome; 'Placement Order (PO) / Adoption Order (AO)'.

A.5 Element B: interviews with birth mothers

Qualitative research is particularly useful in exploring situations and phenomena about which little is known. Women's first person accounts were seen as critical to understanding the reasons why women returned to court and in particular, the window between proceedings. After proceedings women frequently disappear from the gaze of services until a further pregnancy is notified, hence women's first person accounts are essential to understanding women's experiences beyond court-ordered removal of their children, their self-help strategies and the role of informal networks in women's lives at this juncture. As Joan Hunt (2010) described from a comprehensive review of the literature, there are "glaring gaps" in research on parental perspectives on the family justice system, and very little data on the experiences of parents in public law cases after proceedings have ended. The research team was also interested in women's accounts of pregnancy, whether or not they were planned and how child removal impacted on subsequent pregnancies. Published studies suggest that male coercion can play a part in repeat pregnancy, so we wanted to hear from women how intimate relationships were described and whether coercion or other factors played a part in repeat appearances in the family court. A proportion of the women that were interviewed had brought about significant positive change and some were now caring full time for one or more children. We anticipated that women's first person accounts would help us to better understand the critical ingredients in positive change in women's lives.

A.5.1 Recruitment

The main study was preceded by a pilot study funded by one local authority in 2015 in which 26 women were interviewed. Following the confirmation of our Nuffield funded study an additional 46 women were interviewed from 6 other Local Authority sites. The additional six sites were selected on the basis of their varied demographic profiles, with the aim of achieving 'maximum variation' in the population recruited (Ritchie and J. Lewis, 2003). All 7 Local Authorities who participated in the study played a vital role in engaging birth mothers in the research. Both the 26 interviews undertaken in the pilot phase and the 46 women in the main phase of the study were included for final analysis giving a total sample of 72.

A.5.2 Sampling

A flexible target was set for sample size, with the overall aim of achieving thematic saturation (Guest et al., 2006). Following interviews with 26 mothers in the Midlands, a further 36 women were interviewed in London and the North West. This number exceeded the original target of 50 women, but the decision was taken that women would not be turned away if they volunteered for the study. Thus, the final sample size makes this one of largest qualitative studies of birth mothers in care proceedings (Hunt, 2010).

Mothers were recruited across age groups, from different ethnic groups and with different service histories (see Table 6.1). Summary demographics and service profiles are presented to make any bias in the sample transparent.

Element C provided a way of appraising the final sample achieved, through comparison with the profile of mothers captured as part of the court case file reading. A purposive approach to sampling was taken based on the following inclusion criteria: the mother had experienced two or more sets of care proceedings (or one consolidated set of proceedings involving 2 or more children).

A total sample of 72 women were interviewed. Whilst all the women had experienced the removal of their children through court-order, it came to light in interview that some had additional children placed out of their care through formal or informal arrangements with kin, through s.20 agreements and through private proceedings which did not start with care proceedings. Bainham (2013) claimed

that conceptualizing public and private law cases as distinct is problematic. In profiling women's pathways to 'repeat removals', although children were predominantly through court-order in public law proceedings, women's lived experience of multiple losses of children was more complex than indicated in the CAFCASS dataset.

A.5.3 Support for participation, consent, and incentives

Women were initially identified and approached via a known and trusted professional (most often a professional from children's social care services) who, using their own records, identified birth mothers who met the inclusion criteria. Subsequently the professional made contact, shared information regarding the project and gained initial consent for participation. Participation was underpinned by principles of voluntarism (British Sociological Association, 2017) and prior to interview protocols pertaining to confidentiality, anonymity and data protection were fully explained. The mother's signed consent was sought to allow the researchers to audio record the interviews using an encrypted audio device.

All interviews were conducted in a private room in either a local authority or partner organisation's premises. The venue was negotiated with the mother in advance to ensure that her wishes were taken into account. Transport to and from the interview was provided by a family support worker or where this was not required all transport costs incurred were reimbursed at the interview. In addition every woman was offered a £20 high street voucher as recognition of the time given up to take part in the interview.

A.5.4 Semi-structured interviews

The interviews were semi-structured around key topics (see Appendix A.5.7 for interview schedule). The loosely structured design of the interview aimed to capture the prominence that mothers gave to certain risk and protective factors or experiences, and to capture how mothers accounted for enduing difficulties and turning points over time. The interviews were seen as a process of "open ended inquiry" (Charmaz, 2006) and allowed the mothers to have control over the telling of their stories. The interviewer aimed to use questions which prompted the mother's own reflection on her journey into, through and beyond Children's Services and the Family Court. Thus the researcher aimed to allow the space for the interviewee to tell their story without preconceiving the content, rather taking the role as "empathetic witness" to the mothers telling of her story (Priya, 2010). As a result, some mothers inevitably gave more information than others and made choices about how much they felt able to disclose. Whilst the interviews varied in length (12 to 177 minutes), they were typically in the region of 90 minutes. Permission was sought to audio-record interviews and all interviews were transcribed verbatim and uploaded to the software package NVivo for secure data storage and analysis. On completion of each interview the interviewer made field notes. The notes included both an overview of the content but also the interviewees' reflections and impressions. A summary overview document was also created for each interview. The summary, field notes and transcripts were also uploaded to the software package NVivo. In two cases the quality of the recording resulted in full transcription being impossible and therefore field notes were relied upon for coding.

A.5.5 Questionnaire

Following the interview, a questionnaire was administered to all women verbally by the researcher and the answers recorded in a pre-built Access database. The purpose being to ensure that details regarding certain key experiences were consistently captured. The addition of a questionnaire was felt to minimise the possibility of under-reporting of presenting issues. To ensure unnecessary duplication, where the

interview had already clearly covered the question then the researcher omitted it from the questionnaire. The questionnaire data was securely stored and analysed separately.

A.5.6 Data analysis

Following transcription and de-identification, all transcripts were uploaded to the software package NVivo v10, and later v11, for analysis (QSR International Pty Ltd, 2015). Attribution codes were assigned to allow for differentiation between sites.

Following several readings of the transcripts a thematic analysis was undertaken. Whilst part of a broader mixed methods study, in analysing the interviews the team wanted to ensure that an inductive approach was taken to and that any new insights into the issue was constructed from the interview data rather than a preconceived deductive hypothesis being applied Charmaz (2006). This approach enabled the team to make analytic sense of the women's accounts of their journeys into and out of services and in particular to shine a light into the hitherto unexplored space between proceedings. Coding and data collection occurred simultaneously with each interview initially coded as soon as possible following the interview. Following several readings of each transcript a first round of coding was undertaken and a series of descriptive codes applied which summarised key content. Simultaneous coding was also employed as deemed necessary. Analytic memos were kept on potential emerging themes and informed later analysis. Initial coding generated a large number of initial codes. These were compared and differences and similarities sought between them. A subsequent round of more focused coding was undertaken in which condensing and merging of initial codes led to the development of what was felt to be particularly salient themes.

In addition to the analysis of the transcriptions, the questionnaire data was also analysed quantitatively. The creation of a Microsoft Access database allowed frequency and cross-tabulations to be performed. Table 6.1 provides a summary of the findings regarding the profile of the women interviewed. This was used to inform the development of the data capture tool for the court case file reading (Element C). Following collection and analysis of Element C, significant differences in descriptive statistics between the two elements were at the 1% level. This was to determine whether those who participated in the interviews were typical or atypical when compared to those in Element C.

A.5.7 Semi-structured interview schedule

1. Could you tell me, from your perspective, what led to the Local Authority removing your first child from your care? (Probe history including childhood)
2. What services or support were you offered to help you prior to the decision to take care proceedings?
3. What was your experience of these services? Did they make a difference? If not, why not?
4. What was the impact of having your child removed from your care?
5. Did you seek or were you offered any support to help you cope with the loss of your child?
6. Can you tell me what happened leading up to your second / subsequent pregnancies?
7. How did you feel about being pregnant again?
8. What support or services did you access during this pregnancy?
9. At what point did CSC become involved?
10. What was your experience of the assessment process?
11. What services or support did you access following birth of your second/subsequent child(ren)?

12. Looking back now, do you think that there was anything missing in terms of support or services either before care proceedings or after care proceedings?
13. How do you envisage your future?
14. If been positive change probe key turning points.

A.6 Element C: case file study

This third element of the study involved an in-depth, retrospective review of court files. Time aim of this element of the study was to fill gaps in our understanding of the profile of mothers, based on a representative sample of court files. The scope of this element of the study was far reaching and ambitious in that the team aimed to gain information pertaining to:

- Maternal histories regarding childhood issues and key events.
- Maternal issues as index and first repeat proceedings.
- Concerns relating to the children.
- Outcomes for the children.

This case file study differed from leading research studies in the field that also offer profiling data (Hunt et al., 1999; Masson et al., 2008) in two distinct ways. Firstly the data tool was built around the mother rather than an index child and secondly we aimed to capture a dynamic perspective of maternal trajectories by linking maternal childhood and multiple sets of proceedings.

Court case files are a very good source of profiling data, as they contain a volume of records documenting local authority and court activity. Although there was considerable variation in the amount and level of detail available in each file (see limitations) given the broad scope of this study, the court file was deemed to be the best source for the range of information we required. Thus an application was made to HMCTS to access the court files pertaining to all proceedings linked to each mother within the identified sample across the five DfJ areas. An electronic data-capture tool was designed by the team which was used to record the detailed data.

A.6.1 Data capture tool

In order to aid in the collection of information from the case files, a database-powered data capture tool was built. Given the scope and complexity of the information being sought the tool was comprised three distinct recording levels relating to the mother; her background, her proceedings, and her children. Detailed information was collected within each level as outlined in Table A.2.

Table A.2: Summary of the type of information collected as part of the case file reading.

Level	Category	Subcategory
Mother's background		
	Childhood issues	
		Neglect
		Emotional abuse
		Physical abuse
		Sexual abuse
		Mental health
		Informal out-of-home care and Looked After
		Mother's parents issues
		Contact with services
		Medical diagnoses and disabilities
	Motherhood	
		Number of children removed
		Number of children never removed
		Number of children returned / rehabilitated
	Criminal history	
		Nature of the activity (violent, theft, child-related, drug-related)
		Prison term
		Schedule 1 offence
Mother's proceedings		
	Mother's presenting issues	
		Substance misuse
		Domestic abuse
		Mental health problems
	Mother's previous and/or current partner	
		Ethnicity and immigration status
		Currently considered a risk or protective factor.
		Father to at least one of mother's children
		Ever previously implicated in child harm or maltreatment
	Local authority concerns and triggers	
		16 mother-related issues (e.g. mental health, substance misuse, homeless)
		9 child-related issues (e.g. mental health, abuse, neglect)
		4 household-related issues (e.g. risky adults, substance misuse)
	Child outcomes	
		Legal status, from and to
		Placement type, from and to
		Level of contact with mother, from and to
		Placed with siblings
	s.20 breakdown	
		If case is escalating from a s.20 agreement what are the concerns and triggers for this
	Child's adverse experiences	
		Emotional abuse
		Physical abuse
		Sexual abuse
		Neglect

Table A.2: Summary of the type of information collected as part of the case file reading (Continued).

Level	Category	Subcategory
Mother's child		
	Issues at birth	
		Born pre-term
		Admitted to SCBU
		Affected by mother's substance misuse
	Diagnoses	
		Learning disability
		Physical disability
		Behavioural problems
		Mental health diagnosis

A.6.2 Sampling

The court files were located in five DFJ areas. We aimed to include applications from the 32 Local Authorities that fall within the boundaries of these areas.

We calculated that the case file review required the collection of information from the applications pertaining to the children of 430 recurrent birth mothers. The inclusion criterion was that one of these applications had to have been made in the fiscal year 2013/14. The rationale for this inclusion criterion was that the case was issued relatively recently, thus, maximizing our opportunity to look backwards across multiple proceedings and capture a dynamic perspective, but was not so recent that the proceedings might not yet have concluded.

In order to arrive at the target of 430, an initial calculation, based on the assumptions of a simple random sample, specifying a two-sided 95% confidence interval of a binomial proportion to have a precision of ±5%, a sample size of 385 would be needed. Factoring in, the assumption of a non-usability percentage of 10% of cases, this brought the total sample size to a target of 428, which rounded up gives 430.

In practice, on completion of the file study we achieved detailed review of repeat cases relating to 354 women sample, whose history of proceedings was found to involve a total of 52 local authorities.

A.6.3 Measuring childhood maltreatment and harm

As described, the data tool comprised three levels. The first of these levels was constructed in order to capture maternal childhood and adolescent maltreatment. Eight key categories of adversity were finally included within this level of the tool; four categories of abuse (sexual, emotional, physical and neglect), mental health problems, substance misuse, out-of-home care experiences, and parental experiences (mental health problems, substance misuse, domestic abuse). Each of these categories formed a separate tab on the data tool, within each tab followed a series of fields as detailed in Table A.2. The categories and fields detailed within each abuse tab were informed by from other key studies and frameworks, namely; Masson et al. (2008), Radford et al. (2011), and Johnson and Cotmore (2015).

Under each of the tabs, details pertaining to 'any mention' of specific harm and maltreatments were recorded. This included information pertaining to type of harm, the perpetrator, and the frequency information regarding the mother's looked after history and any other out-of-home care experiences, was also recorded.

A.6.4 Application-level issues and concerns

The second level of the data tool was built in order to collect information relating to the concerns and issues relating directly to proceedings. Concerns and issues were collected for each set of proceedings thus allowing the team to collect longitudinal data and for a dynamic perspective of concerns and issues to be identified. Concerns mentioned within application were categorized as either:

- 'Historic concern' – that is an issue that had been of concern in the past but was not currently occurring or present.
- 'Current concern' – the issue is present and a concern for the Local Authority at the time of issuing proceedings.
- 'Trigger' – an event or incident that acted as a 'tipping point' in escalating the Local Authority's concerns and led to the decision to issue proceedings.

Additional detail of mother-level issues and issues concerning intimate partners were also recorded.

Table A.3: A form from the Element C data capture tool which allowed the researchers to measure the concerns the local authority had for the safety of the child.

	Historic Concern	Current Concern	Trigger
Mother-related			
Mental health issues	☐	☐	☐
Learning disability	☐	☐	☐
Physical disability	☐	☐	☐
Criminal history	☐	☐	☐
Substance misuse	☐	☐	☐
Sex working	☐	☐	☐
Transience / lack of housing	☐	☐	☐
Victim of domestic abuse	☐	☐	☐
Separation or divorce	☐	☐	☐
Lack of support network	☐	☐	☐
Kinship care breakdown	☐	☐	☐
Service non-engagement	☐	☐	☐
Withdrawal of s.20 consent	☐	☐	☐
Further pregnancy	☐	☐	☐
Child-related			
Mental health issues	☐	☐	☐
Learning disability	☐	☐	☐
Physical disability	☐	☐	☐
Emotional abuse	☐	☐	☐
Physical abuse	☐	☐	☐
Sexual abuse	☐	☐	☐
Neglect	☐	☐	☐
Risky or violent behaviour	☐	☐	☐
Sexualised behaviour	☐	☐	☐
Household-related			
Household member incarcerated	☐	☐	☐
Low socio-economic status	☐	☐	☐
Substance misuse	☐	☐	☐
Risky adults	☐	☐	☐

A.6.5 Child-level data

The third and final level of the data collection tool was developed in order to gather information pertaining to each child subject to the proceedings. The following tabs were included within this level:

- Child demographic details.
- Outcomes at the end of proceedings; placement type, legal order, contact arrangements with mother.
- Details of concerns relating to the child as presented within the court proceedings documentation:
  - Type and details of any alleged abuse and neglect.
  - Details of pregnancy and issues at birth (where relevant).

A.6.6 Data collection

Following the initial construction, the tool was piloted on three separate occasions by the research team initially, using cases accessed remotely via the Cafcass ECMS system, with further amendments being made. After which the team met for one day of training to ensure that everyone was confident in how to use the tool. A final pilot phase took place in one jurisdiction, in which researchers compared and discussed their coding decisions. A spreadsheet was constructed listing all court case references to be accessed for each site on encrypted laptops. Each researcher used this to record when files had been accessed and read, along with a brief de-identified summary of the case. The research team convened regular teleconferences throughout the file reading period to discuss any coding issues and to check for consistency of interpretation and discuss any technical difficulties with the tool.

In terms of accessing the court case files, following HMCTS clearance, the research team liaised with the file manager in each of the identified DFJ areas. Lists of the required case files were sent in advance to allow for files to be located.

A.6.7 Methodological limitations

There are a number of limitations to using court case files as source of information:

- The ability to capture the information depended on the completeness of the court files. This varied greatly within the sample, some files having multiple copies of key documents whilst there being obvious gaps in others.
- The level of organization of the documents within the files was generally poor. Whilst there were some notable exceptions, in general, documentation was haphazardly included. Difficulties were encountered in locating some files due changes in the coding systems and the relocation of some files following recent reforms of the family court structure.
- Given our reliance on professional statements and court reports as sources of information were only able to measure issues in terms of 'any mention of'. We can therefore only speak in terms of 'at least' for any given measure included in this element of the study. No mention of a specific issue or incident in the file, does not necessarily mean that it did not occur only that it was not recorded in any of the documents.
- There was a huge variation in the depth and detail of information included in the documentation. This was particularly the case for information pertaining to the mother's own childhood. If the mother had been subject to psychological assessment.In some cases there was no detail pertaining to the mother's history at all. These cases were removed from the sample prior to analysis.

- The court case files accessed were necessarily centred around the child(ren) subject to the proceedings and therefore the documents served a particular professional purpose. The information was largely deficit focused with very little mention of strengths or resilience factors.

A.6.8 Data cleaning and analysis

As part of the data cleaning, particular categories were removed from the study as the level of missing data within these was deemed too high. Additionally, cases were removed from the analysis, as we were unable to obtain information on the mother's childhood from the court case files.

Analysis began be generating descriptive statistics reporting on the prevalence of the different categories, as well as the detail provided by the sub-categories, at three levels; mother's background, mother's proceedings, and mother's children, After which associations between the different levels and the different categories were tested using different statistical methods (hypothesis testing and modelling). All data manipulation and analysis was performed in the statistical computing and graphics environment, R (R Core Team, 2017).

A.6.9 Second stage analysis

In order to further develop our analysis of the data pertaining to mother's childhood, we drew upon the formal analytic framework of ACE as developed by Felitti et al. (1998), which has since been checked for validity and interrelatedness (Dube et al., 2003; Dong et al., 2004; Ford et al., 2014), and used for summarising childhood experiences in a number of studies which have compared ACEs with adulthood mental and physical health outcomes (Dube et al., 2001; Anda et al., 2002; Hillis et al., 2001). However, there are some limitations to this, given that our data was collected from case file reviews, rather than self-report as it typical in the ACE studies cited. Nevertheless, we argue that the framework is still useful in helping to understand the significance of the data.

Firstly, the mother's childhood abuse tabs and fields were mapped across to the ACE study shown in Table A.5. ACE categories mapped almost directly onto our own data capture fields, with two exceptions. The ACE studies collected household challenges based on all members of the household, while, in contrast, our tool focused specifically on information regarding mothers' own parents and as previously discussed, this information was also often scant. Secondly, whilst ACE measures whether or not there has been parental separation, our tool captured significant loss, which was a much broader category.

Table A.4: Types of adverse childhood experiences (ACEs) and their subcategories.

Adverse Childhood Experience Any mentioned of...
Emotional abuse
Embarrassed or humiliated
Shouted or screamed at
Threat of physical harm
Threat of being sent away or removed
Sworn at
Witnessed domestic violence
Trafficked
Physical abuse
Hit hard with an implement
Hit or kicked hard
Shaken
Beaten
Sexual abuse
Non-contact (solicitation, exposure)
Contact (touching, kissing)
Forced intercourse
Child sexual exploitation
Emotional neglect
Interaction
Sensitivity
Timely responses

Adverse Childhood Experience Any mentioned of...
Physical neglect
Nutritional (quality, quantity of food)
Housing (maintenance, decor, facilities)
Clothing (insulation, fitting)
Hygiene (hair, skin, nails, teeth)
Health (health checks, immunisation, illness)
Safety and supervision (awareness, care)
Substance misuse
Alcohol
Cannabis
Stimulants[1]
Hallucinogens[2]
Depressants[3]
Parent(s) mental health issues
Anxiety
Depression
Bipolar
Schizophrenia
Personality disorder
Experienced significant loss
Death of attachment figure / caregiver.
Parents separated.
Parent(s) have been incarcerated

[1] Cocaine, crack-cocaine, ecstasy, methamphetamine amphetamines, heroin, steroids
[2] LSD, ketamine, mushrooms
[3] Methadone, tranquillisers

Table A.5: Mapping of ACE measures and case file study issues.

ACE category / item	Recurrent Mother item
Childhood abuse:	
Emotional abuse	Any emotional abuse in childhood
Physical abuse	Any physical abuse in childhood
Sexual abuse	Any sexual abuse in childhood
Childhood neglect:	
Emotional neglect	Any mention of emotion neglect
Physical neglect	Any mention of physical neglect*
Household challenges:	
Substance misuse	Parent(s) substance misuse
mental illness	Parent(s) has mental health issues
Violent treatment of a mother or stepmother	Domestic abuse towards a parent
Parental separation or divorce	Experienced significant loss
Household member go to prison	Parent(s) have been incarcerated

*(nutritional, housing, clothing, hygiene, health, and safety)

A.7 Integration of Elements B and C

To determine how appropriate it is to use findings from Element B in order to explain the patterns and associations seen in Element C, the distributions within each of the following variables were compared across the two elements:

- Ethnicity.
- Motherhood (age at first birth, number of children).
- Adulthood experiences (domestic abuse, mental health, substance misuse, transience, social support).
- Childhood experiences (looked after, abuse, significant loss).
- Mother's parents issues (substance misuse, mental health, cognitive dysfunction).

In all instances chi-square tests were used to determine if the distributions for each summary significantly differ at the 1% level between samples B and C. The 1% level was chosen as opposed to the typical 5% level because of the multiple tests being carried out.

Table A.6 contains the results for each of the tests; chi-square test statistic, degrees of freedom, and p-value, with asterisks indicate significant values at the 1% level. The results show that the samples do not differ significantly across the 12 of the 16 variables. The exceptions were mental health in adulthood, age at first birth, and cognitive dysfunction. The differences were that mothers interviewed as part of Element B were more likely to have mental health issues in adulthood, experience significant loss in childhood, enter motherhood at a younger age, and were more likely to have at least one parent with a cognitive dysfunction. We would argue that these differences can be partially explained by the differences in methodology between Element B and C, and that the interview techniques of Element B would be better at determining the presence of these issues in the mothers.

Table A.6: Chi-squared test results comparing distributions across demographics, adulthood and childhood experiences, motherhood and mother's parents' issues for the women in samples B and C. Due to multiple testing, p-values were identified as significant if they are below 1%.

Variable	Test statistic	DF	p-value	
Demographics				
Ethnicity	0.83	2	0.6614	
Adulthood experiences				
Domestic abuse	3.61	1	0.0574	
Mental health	16.48	1	< 0.0001	*
Substance misuse	0.15	1	0.6972	
Transience	5.60	1	0.0179	
Lack of social support	1.45	1	0.2291	
Childhood experiences				
Looked after	0.52	1	0.4697	
Domestic abuse	0.00	1	> 0.9999	
Sexual abuse	0.61	1	0.4343	
Physical abuse	1.53	1	0.2163	
Significant loss	16.26	1	0.0001	*
Motherhood				
Age at first birth	12.60	3	0.0056	*
Number of children	1.71	3	0.6347	
Mother's parents				
Substance misuse	0.18	1	0.6681	
Mental health	5.10	1	0.0239	
Cognitive dysfunction	29.54	1	< 0.0001	*

Appendix B. Annual profile of s.31 care proceedings

Tables B.1 and B.2 provide counts and percentages, respectively, of the annual administrative summaries of s.31 care proceedings recorded by Cafcass for each year ending March 31st from 2008 through to 2016.

Table B.1: Annual counts of administrative summaries of s.31 care proceedings recorded by Cafcass for each year ending March 31st from 2008 through to 2016. Counts have been rounded to nearest 10.

Count	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	6,540	6,640	8,940	9,160	10,140	11,030	10,650	11,190	12,820
s.31 app type									
Care	6,130	6,340	8,500	8,750	9,680	10,540	10,110	10,500	11,880
Supervision	260	160	240	230	260	270	290	320	380
Both	160	140	200	180	200	220	250	370	560
Number of adults									
0/Missing	40	30	50	50	20	20	30	50	70
1	880	840	1,000	2,070	2,440	2,660	2,350	2,510	3,060
2	4,200	4,200	5,740	5,890	6,460	6,990	6,850	7,150	8,070
3+	1,430	1,570	2,140	1,150	1,220	1,360	1,420	1,480	1,620
Birth mother recorded									
No	1,580	760	600	560	390	480	390	960	1,040
Yes	4,960	5,880	8,340	8,590	9,750	10,550	10,260	10,230	11,780
Mother 5-year status									
First time	–	–	–	–	–	8,360	8,000	8,100	9,440
Repeat same child	–	–	–	–	–	410	480	550	650
Repeat new child	–	–	–	–	–	1,780	1,780	1,590	1,710
Birth father recorded									
No	2,460	1,800	1,860	2,880	3,210	3,470	3,020	3,440	4,190
Yes	4,080	4,840	7,080	6,280	6,930	7,560	7,630	7,750	8,640
Number of children									
1	3,960	4,020	5,240	5,360	6,160	6,810	6,460	6,700	7,780
2	1,340	1,340	1,950	1,990	2,050	2,220	2,220	2,320	2,630
3+	1,250	1,280	1,750	1,810	1,930	2,000	1,970	2,170	2,420
Age of youngest child									
Under 4 weeks	1,850	1,880	2,290	2,400	2,780	3,120	2,880	2,620	2,880
4 wks to 1 year	1,500	1,580	2,080	2,020	2,250	2,350	2,180	2,440	2,440
1 to 4	1,730	1,790	2,520	2,700	2,910	3,080	2,980	3,160	3,530
5 to 9	900	830	1,170	1,210	1,310	1,440	1,460	1,700	2,100
10 to 15	540	540	850	800	860	1,000	1,090	1,190	1,760
16 and above	20	30	30	20	40	40	60	80	120
Case duration									
Under 26 weeks	890	870	990	850	1,340	3,700	5,540	5,820	6,400
26 to 38 weeks	1,650	1,280	1,510	1,750	2,740	3,500	2,860	3,180	2,500
39 to 51 weeks	1,240	1,330	1,770	2,080	2,530	2,070	1,310	1,260	660
52 or more weeks	2,740	3,140	4,660	4,470	3,540	1,740	920	760	160
Open	20	20	0	0	0	0	20	170	3,110

Table B.2: Annual percentages of administrative summaries of s.31 care proceedings recorded by Cafcass for each year ending March 31st from 2008 through to 2016. Due to rounding, column percentages may not add up to 100.

Percent	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
s.31 app type									
Care	93.6	95.4	95.1	95.5	95.4	95.6	95.0	93.8	92.6
Supervision	4.0	2.4	2.7	2.5	2.6	2.4	2.7	2.9	3.0
Both	2.4	2.2	2.2	2.0	2.0	2.0	2.3	3.3	4.4
Number of adults									
Missing	0.6	0.4	0.6	0.5	0.2	0.2	0.3	0.4	0.5
1	13.4	12.7	11.2	22.6	24.1	24.1	22.0	22.4	23.9
2	64.2	63.2	64.3	64.3	63.6	63.3	64.3	63.9	62.9
3+	21.8	23.7	23.9	12.6	12.0	12.4	13.3	13.3	12.6
Birth mother recorded									
No	24.1	11.5	6.7	6.2	3.9	4.4	3.7	8.6	8.1
Yes	75.9	88.5	93.3	93.8	96.1	95.6	96.3	91.4	91.9
Mother 5-year status									
First time	–	–	–	–	–	79.2	77.9	79.1	80.0
Repeat same child	–	–	–	–	–	3.9	4.7	5.4	5.5
Repeat new child	–	–	–	–	–	16.9	17.4	15.5	14.5
Birth father recorded									
No	37.7	27.1	20.8	31.4	31.7	31.5	28.4	30.7	32.6
Yes	62.3	72.9	79.2	68.6	68.3	68.5	71.6	69.3	67.4
Number of children									
1	60.5	60.5	58.7	58.6	60.7	61.7	60.6	59.9	60.6
2	20.4	20.3	21.8	21.7	20.2	20.2	20.8	20.7	20.5
3+	19.0	19.3	19.5	19.7	19.1	18.1	18.5	19.4	18.8
Age of youngest child									
Under 4 weeks	28.3	28.3	25.6	26.2	27.4	28.3	27.1	23.4	22.4
4 wks to 1 year	22.9	23.8	23.2	22.1	22.2	21.3	20.5	21.8	19.0
1 to 4	26.4	27.0	28.2	29.5	28.7	27.9	28.0	28.2	27.5
5 to 9	13.7	12.4	13.1	13.2	12.9	13.1	13.7	15.2	16.3
10 to 15	8.3	8.1	9.5	8.8	8.5	9.1	10.2	10.6	13.7
16 and above	0.3	0.4	0.4	0.3	0.3	0.3	0.5	0.7	0.9
Case duration									
Under 26 weeks	13.7	13.2	11.1	9.3	13.2	33.6	52.0	52.0	–
26 to 38 weeks	25.2	19.3	16.9	19.1	27.0	31.8	26.9	28.5	–
39 to 51 weeks	18.9	20.0	19.8	22.7	25.0	18.8	12.3	11.3	–
52 or more weeks	41.9	47.3	52.2	48.9	34.9	15.8	8.7	6.8	–
Open	0.3	0.2	0.0	0.0	0.0	0.0	0.2	1.5	–

Bibliography

Anda, R., Whitfield, C., Felitti, V., Chapman, D., Edwards, V., Dube, S., and Williamson, D. (2002). "Adverse Childhood Experiences, Alcoholic Parents, and Later Risk of Alcoholism and Depression". In: *Psychiatric Services* 53.8, pp. 1001–1009.

Arai, L. (2003). "Low expectations, sexual attitudes and knowledge: Explaining teenage pregnancy and fertility in English communities. Insights from qualitative research". In: *Sociological Review* 51.2, pp. 199–217+299.

Armstrong, D. and Hutti, M. (1998). "Pregnancy after perinatal loss: The relationship between anxiety and prenatal attachment". In: *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 27.2, pp. 183–189.

Bainham, A. (2013). "Private and Public Children Law: An under-Explored Relationship". In: *Child and Family Law Quarterly* 25.

Black, K. I., Stephens, C., Haber, P. S., and Lintzeris, N. (2012). "Unplanned pregnancy and contraceptive use in women attending drug treatment services". In: *Australian and New Zealand Journal of Obstetrics and Gynaecology* 52.2, pp. 146–150.

Black, S. E., Devereux, P. J., and Salvanes, K. G. (2016). "Does Grief Transfer across Generations? Bereavements during Pregnancy and Child Outcomes". In: *American Economic Journal: Applied Economics* 8.1, pp. 193–223.

Bonanno, G. A. and Mancini, A. D. (2008). "The Human Capacity to Thrive in the Face of Potential Trauma". In: *Pediatrics* 121.2.

Brandon, M. (2009). "Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07". In: *Department for Children, Schools and Families*, p. 156.

Bransford, C. and Blizard, R. (2016). "Viewing Psychopathology Through a Trauma Lens: Pitfalls and Possibilities". In: *Social Work in Mental Health* 15.1, null–null.

Briere, J. and Elliott, D. M. (2003). "Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women". In: *Child Abuse & Neglect* 27.10, pp. 1205–1222.

Briere, J., Kaltman, S., and Green, B. (2008). "Accumulated childhood trauma and symptom complexity". In: *Journal of Traumatic Stress* 21.2, pp. 223–226.

British Sociological Association (2017). *BSA Statement of Ethical Practice*.

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., Mason, C., and Kershaw, S. (2015a). "Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England". In: *British Journal of Social Work* 45.8, pp. 2241–2260.

Broadhurst, K. and Bedston, S. (2017). "Women in recurrent care proceedings in England (2007-2016): Continuity and change in care demand over time". In: *Family Law* 47, pp. 412–415.

Broadhurst, K. and Mason, C. (2014). "Recurrent care proceedings: Part 3: birth mothers - against the odds - turning points for women who have lost children to public care". In: *Family Law* 44, pp. 1572–1576.

Broadhurst, K. and Mason, C. (2017). "Birth Parents and the Collateral Consequences of Court-ordered Child Removal: Towards a Comprehensive Framework". In: *International Journal of Law, Policy and the Family* 31.1, pp. 41–59.

Broadhurst, K., Mason, C., and Webb, S. (2018). "Birth mothers returning to court: can a developmental trauma lens inform practice with women at risk of repeat removal of infants and children". In: *Justice for children and families: a developmental approach*. Ed. by M. Shaw. Cambridge: Cambridge University Press.

Broadhurst, K., Shaw, M., Kershaw, S., Harwin, J., Alrouh, B., Mason, C., and Pilling, M. (2015b). "Vulnerable birth mothers and repeat losses of infants to public care: Is targeted reproductive health care ethically defensible?" In: *Journal of Social Welfare and Family Law* 37.1, pp. 84–98.

Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis*. Vol. 10. London: SAGE, p. 208.

Clark, T., Bradburn, M., Love, S., and Altman, D. (2003). "Survival analysis part I: basic concepts and first analyses." In: *British journal of cancer* 89.2, pp. 232–8.

Collett, D. (2015). *Modelling Survival Data in Medical Research, Third Edition*. Vol. 46. 2, p. 548.

Collins, L. and Lanza, S. (2013). *Latent class and latent transition analysis : with applications in the social, behavioral, and health sciences*. Wiley.

Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., and Maughan, B. (2007). "Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample". In: *Child Abuse & Neglect* 31.3, pp. 211–229.

Connery, H. S., Albright, B. B., and Rodolico, J. M. (2014). "Adolescent substance use and unplanned pregnancy: strategies for risk reduction." In: *Obstetrics and gynecology clinics of North America* 41.2, pp. 191–203.

Cook, A. et al. (2005). "Complex Trauma in Children and Adolescents". In: *Psychiatric Annals* 35.5, pp. 390–398.

Cossar, J. and Neil, E. (2010). "Supporting the birth relatives of adopted children: How accessible are services?" In: *British Journal of Social Work* 40.5, pp. 1368–1386.

Cox, P. (2012). "Marginalized Mothers, Reproductive Autonomy, and Repeat Losses To Care". In: *Journal of Law and Society* 39.4, pp. 541–561.

Cox, P., Barratt, C., Blumenfeld, F., Rahemtulla, Z., Taggart, D., and Turton, J. (2017). "Reducing recurrent care proceedings: initial evidence from new interventions". In: *Journal of Social Welfare and Family Law* 39.3, pp. 332–349.

Craine, N., Midgley, C., Zou, L., Evans, H., Whitaker, R., and Lyons, M. (2014). "Elevated teenage conception risk amongst looked after children; a national audit". In: *Public Health* 128.7, pp. 668–670.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., and Kolk, B. A. van der (2012). "Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis". In: *American Journal of Orthopsychiatry* 82.2, pp. 187–200.

Dong, M., Anda, R., Felitti, V., Dube, S., Williamson, D., Thompson, T., Loo, C., and Giles, W. (2004). "The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction". In: *Child Abuse & Neglect* 28.7, pp. 771–784.

Dube, S., Anda, R., Felitti, V., Chapman, D., Williamson, D., and Giles, W. (2001). "Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study." In: *JAMA* 286.24, pp. 3089–96.

Dube, S., Felitti, V., Dong, M., Giles, W., and Anda, R. (2003). "The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900." In: *Preventive medicine* 37.3, pp. 268–77.

Estok, P. and Lehman, A. (1983). "Perinatal Death: Grief Support for Families". In: *Birth* 10.1, pp. 17–28.

Fallon, D., Broadhurst, K., and Ross, E. (2015). *Preventing unplanned pregnancy and improving preparation for parenthood for care-experienced young people*. Tech. rep. October, p. 44.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. P., and Marks, J. (1998). "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults". In: *American Journal of Preventive Medicine* 14.4, pp. 245–258.

Fergusson, D. M. and Lynskey, M. T. (1997). "Physical punishment/maltreatment during childhood and adjustment in young adulthood". In: *Child Abuse & Neglect* 21.7, pp. 617–630.

Finer, L. B. and Henshaw, S. K. (2006). "Disparities in rates of unintended pregnancy in the United States, 1994 and 2001". In: *Perspectives on sexual and reproductive health* 38.2, pp. 90–96.

Finkelhor, D., Ormrod, R., Turner, H., and Holt, M. (2009). "Pathways to Poly-Victimization". In: *Child Maltreatment* 14.4, pp. 316–329.

Ford, D., Merrick, M., Parks, S., Breiding, M., Gilbert, L., Edwards, V., Dhingra, S., Barile, J., and Thompson, W. W. (2014). "Examination of the factorial structure of adverse childhood experiences and recommendations for three subscale scores." In: *Psychology of Violence* 4.4, pp. 432–444.

Freeman, P. and Hunt, J. (1998). *Parental Perspectives on Care Proceedings*. Tech. rep. London: TSO.

Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N., and Wilson, D. (2011). "Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not". In: *Children and Youth Services Review* 33.11, pp. 2176–2185.

Hall, K. S., Kusunoki, Y., Gatny, H., and Barber, J. (2014). "The risk of unintended pregnancy among young women with mental health symptoms". In: *Social Science & Medicine* 100, pp. 62–71.

Harden, A., Brunton, G., Fletcher, A., and Oakley, A. (2009). "Teenage pregnancy and social disadvantage: systematic review integrating controlled trials and qualitative studies." In: *BMJ (Clinical research ed.)* 339.7731, b4254.

Harwin, J., Alrouh, B., Ryan, M., and Tunnard, J. (2013). "Strengthening prospects for safe and lasting family reunification: can a Family Drug and Alcohol Court make a contribution?" In: *Journal of Social Welfare & Family Law* 35.4, pp. 459–474.

Harwin, J., Broadhurst, K., Kershaw, S., Shaw, M., Alrouh, B., and Mason, C. (2014). "Recurrent care proceedings: Part 2: young motherhood and the role of the court". In: *Family Law* 44.10, pp. 1439–1443.

Harwin, J., Ryan, M., Tunnard, J., Pokhrel, S., Alrouh, B., Matias, C., and Momenian-Schneider (2011). *The Family Drug and Alcohol Court (FDAC) Evaluation Project Final Report*. Tech. rep. London: The Nuffield Foundation.

Hastie, T., Tibshirani, R., and Friedman, J. (2011). *The Elements of Statistical Learning: Data Mining, Inference, and Prediction*. Second Edi. Springer.

Hillis, S., Anda, R., Felitti, V., and Marchbanks, P. (2001). "Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study." In: *Family planning perspectives* 33.5, pp. 206–11.

Horowitz, M. J., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., and Stinson, C. H. (1997). "Diagnostic Criteria for Complicated Grief Disorder". In: *Am J Psychiatry* 1547.

Howe, D., Sawbridge, P., and Hinings, D. (1992). *Half a Million Women. Mothers Who Lose Their Children by Adoption*. London: Penguin.

Humphrey, J. A. and White, J. W. (2000). "Women's vulnerability to sexual assault from adolescence to young adulthood". In: *Journal of Adolescent Health* 27.6, pp. 419–424.

Hunt, J. (2010). *Parental Perspectives on the Family Justice System in England and Wales: a review of research*. Tech. rep. University of Oxford, p. 167.

Hunt, J., Macleod, A., and Thomas, C. (1999). *The last resort : child protection, the courts and the 1989 Children Act*. Tech. rep. London: Stationery Office.

Jackson, E. &. and Day-Sclater, S. (2009). "Introduction: Autonomy and Private Life". In: *Regulating Autonomy, Sex Reproduction and the Family*. Ed. by S. Day-Sclater, E. Ebtehaj F., E. Jackson, and M. Richards. Oxford and Portland Oregan: Hart Publishing, pp. 1–16.

Johnson, R. and Cotmore, R. (2015). *National evaluation of the Graded Care Profile*. London.

Kaufman, J., Cook, A., Arny, L., Jones, B., and Pittinsky, T. (1994). *Problems defining resiliency: Illustrations from the study of maltreated children*.

Lamb, E. H. (2002). "The impact of previous perinatal loss on subsequent pregnancy and parenting." In: *The Journal of perinatal education* 11.2, pp. 33–40.

Laub, J. H. and Sampson, R. J. (1993). *Crime in the making: Pathways and turning points throughout life*. Vol. 31. 3, pp. 301–325.

Layne, L. L. (2002). *Motherhood lost : a feminist account of pregnancy loss in America*, p. 354.

Layne, L. L. (2003). "Unhappy endings: A feminist reappraisal of the women's health movement from the vantage of pregnancy loss". In: *Social Science and Medicine*. Vol. 56. 9, pp. 1881–1891.

Lewis, T., McElroy, E., Harlaar, N., and Runyan, D. (2016). "Does the impact of child sexual abuse differ from maltreated but non-sexually abused children? A prospective examination of the impact of child sexual abuse on internalizing and externalizing behavior problems". In: *Child Abuse & Neglect* 51, pp. 31–40.

Lindley, B. (1994). *On the Receiving End: Families' Experiences of the Court Process in Care and Supervision Proceedings Under the {C}hildren {A}ct 1989*. Tech. rep. Family Rights Group London.

Logan, J. (1996). "Birth Mothers and their Mental Health: Uncharted Territory". In: *British Journal of Social Work* 26.5, pp. 609–625.

Lucke, J. C. and Hall, W. D. (2012). "Under what conditions is it ethical to offer incentives to encourage drug-using women to use long-acting forms of contraception?" In: *Addiction* 107.6, pp. 1036–1041.

Luthar, S. S. ((2003). *Resilience and Vulnerability - Adaption in the Context of Childhood Adversities*, p. 574.

Luthar, S. S., Cicchetti, D., and Becker, B. (2000). *The construct of resilience: A critical evaluation and guidelines for future work*.

Masson, J. and Dickens, J. (2015). "Protecting unborn and newborn babies". In: *Child Abuse Review* 24.2, pp. 107–119.

Masson, J., Pearce, J., Bader, K., Bader, K., Marsden, J., and Westlake, D. (2008). *Care profiling study*. Tech. rep. March. University of Bristol, pp. 1–3.

Masten, A. S. (2001). "Ordinary magic: Resilience processes in development". In: *American Psychologist* 56.3, pp. 227–238.

McCracken, K., Priest, S., FitzSimons, A., Bracewell, K., Torchia, K., Parry, W., and Stanley, N. (2017). *Evaluation of Pause: Research report*. Tech. rep., p. 85.

Meltzer, H., Ford, T., Bebbington, P., and Vostanis, P. (2012). "Children who run away from home: Risks for suicidal behavior and substance misuse". In: *Journal of Adolescent Health* 51.5, pp. 415–421.

Messman-Moore, T. L. and Long, P. J. (2003). "The role of childhood sexual abuse sequelae in the sexual revictimization of women". In: *Clinical Psychology Review* 23.4, pp. 537–571.

Meystre, S., Ferrández, Ó., Friedlin, F. J., South, B., Shen, S., and Samore, M. (2014). "Text de-identification for privacy protection: A study of its impact on clinical text information content". In: *Journal of Biomedical Informatics* 50, pp. 142–150.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., and Silverman, J. G. (2010). "Pregnancy coercion, intimate partner violence and unintended pregnancy". In: *Contraception* 81.4, pp. 316–322.

Millham, S., Bullock, R., Hosie, K., and Haak, M. (1986). *Lost in care : the problems of maintaining links between children in care and their families*. Gower Pub. Co, p. 258.

Munby, S. J. (2016). *View from the President of the Family Division (15): Care Cases - The Looming Crisis*. Tech. rep.

Mundt-Leach, R. (2014). "Contraception needs of women attending drug and alcohol treatment centres". In: *Mental Health Practice* 17.6, pp. 29–34.

Murphy, K., Anderson-Moore, K., Redd, Z., and Malm, K. (2017). "Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative". In: *Children and Youth Services Review* 75, pp. 23–34.

Neil, E. (2003). "Accepting the Reality of Adoption: Birth Relatives' Experiences of Face-to-Face Contact". In: *Adoption & Fostering* 27.2, pp. 32–43.

Neil, E. (2007). "Coming to terms with the loss of a child: The feelings of birth parents and grandparents about adoption and post-adoption contact." In: *Adoption Quarterly* 10.1, pp. 1–23.

NSS (2017). *The separation principle*. (Visited on 08/08/2017).

Nylund, K., Asparouhov, T., and Muthén, B. (2007). "Deciding on the Number of Classes in Latent Class Analysis and Growth Mixture Modeling: A Monte Carlo Simulation Study". In: *Structural Equation Modeling: A Multidisciplinary Journal* 14.4, pp. 535–569.

ONS (2016a). *Birth characteristics in England and Wales: 2015*. Tech. rep. Office of National Statsitics.

ONS (2016b). *Births by parents' characteristics in England and Wales: 2015*. Tech. rep. Office for National Statistics.

ONS (2016c). *Childbearing for Women Born in Different Years, England and Wales: 2015*. Tech. rep. Office for National Statistics.

Priya, K. R. (2010). "The Research Relationship as a Facilitator of Remoralization and Self-Growth: Postearthquake Suffering and Healing". In: *Qualitative Health Research* 20.4, pp. 479–495.

QSR International Pty Ltd (2015). *NVivo qualitative data analysis Software v11*.

R Core Team (2017). *R: A Language and Environment for Statistical Computing*. Vienna, Austria.

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., and Collishaw, S. (2011). *Child abuse and neglect in the UK today*. Tech. rep. NSPCC.

Ritchie, J. and Lewis, J. (2003). *Qualitative research practice: a guide for social science students and researchers*. Sage Publications, p. 336.

Robertson, P. A. and Kavanaugh, K. (1998). "Supporting parents during and after a pregnancy subsequent to a perinatal loss." In: *Journal of Perinatal and Neonatal Nursing* 12.2, pp. 63–71.

Ross, C. E. (1993). "Fear of victimization and health". In: *Journal of Quantitative Criminology* 9.2, pp. 159–175.

Rutter, M. (1985). "Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder." In: *The British Journal of Psychiatry* 147.6.

Rutter, M. (2006). "The Promotion of Resilience in the Face of Adversity". In: *The Promotion of Resilience in the Face of Adversity*. Ed. by A. Clarke-Stewart and J. Dunn. Cambridge University Press, pp. 26–52.

Rutter, M. (2012). "Resilience as a dynamic concept". In: *Development and Psychopathology* 24.2, pp. 335–344.

Ryan, J. P., Choi, S., Hong, J. S., Hernandez, P., and Larrison, C. R. (2008). "Recovery coaches and substance exposed births: An experiment in child welfare". In: *Child Abuse and Neglect* 32.11, pp. 1072–1079.

Sampson, R. J. and Laub, J. H. (2003). "Life-course desisters? Trajectories of crime among delinquent boys followed to age 70". In: *Criminology* 41.3, pp. 555–592.

Scheidt, C. E., Hasenburg, A., Kunze, M., Waller, E., Pfeifer, R., Zimmermann, P., Hartmann, A., and Waller, N. (2012). "Are individual differences of attachment predicting bereavement outcome after perinatal loss? A prospective cohort study". In: *Journal of Psychosomatic Research* 73.5, pp. 375–382.

Schofield, G., Moldestad, B., Hojer, I., Ward, E., Skilbred, D., Young, J., and Havik, T. (2011a). "Managing Loss and a Threatened Identity: Experiences of Parents of Children Growing Up in Foster Care, the Perspectives of their Social Workers and Implications for Practice". In: *British Journal of Social Work* 41.1, pp. 74–92.

Schofield, G. (2002). "The significance of a secure base: a psychosocial model of long-term foster care". In: *Child & Family Social Work* 7.4, pp. 259–272.

Schofield, G. and Beek, M. (2009). "Growing up in foster care: Providing a secure base through adolescence". In: *Child and Family Social Work* 14.3, pp. 255–266.

Schofield, G., Beek, M., Ward, E., and Sellick, C. (2011b). *Care Planning for Permanence in Foster Care*. Tech. rep. University of East Anglia.

Selwyn, J. (2004). "Placing Older Children in New Families:Changing Patterns of Contact". In: *Contact in Adoption and Permanent Foster Care, Research Theory and Practice*. London: BAAF Adoption and Fostering, pp. 144–164.

Shaw, M., Broadhurst, K., Harwin, J., Alrouh, B., Kershaw, S., and Mason, C. (2014). "Recurrent care proceedings: Part 1: Progress in research and practice since the Family Justice Council 6th Annual Debate". In: *Family Law* 44.9, pp. 1284–1287.

Stevens-Simon, C., Kelly, L., Singer, D., and Nelligan, D. (1998). "Reasons for first teen pregnancies predict the rate of subsequent teen conceptions." In: *Pediatrics* 101.1, E8.

Tabberer, S., Hall, C., Prendergast, S., and Webster, A. (2000). *Teenage pregnancy and choice Abortion or motherhood: influences on the decision*. Tech. rep. Joseph Rowntree Foundation.

Taussig, H. N. (2002). "Risk behaviors in maltreated youth placed in foster care: a longitudinal study of protective and vulnerability factors". In: *Child Abuse & Neglect* 26.11, pp. 1179–1199.

Thoits, P. a. (1991). "On Merging Identity Theory and Stress Research". In: *Social Psychology Quarterly* 54.2, p. 101.

Thrane, L. E. and Chen, X. (2012). "Impact of running away on girls' pregnancy". In: *Journal of Adolescence* 35.2, pp. 443–449.

Tucker, J. S., Edelen, M. O., Ellickson, P. L., and Klein, D. J. (2011). "Running Away From Home: A Longitudinal Study of Adolescent Risk Factors and Young Adult Outcomes". In: *Journal of Youth and Adolescence* 40.5, pp. 507–518.

Wellings, K. et al. (2013). "The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)". In: *The Lancet* 382.9907, pp. 1807–1816.

Wells, S. (1994). *Within me, without me : adoption: an open and shut case?* Scarlet Press, p. 205.

Winkler, R. and Van Keppel, M. (1984). *Relinquishing Mothers in Adoption Their long-term adjustment*. Tech. rep. Melbourne: Institute of Family Studies.

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