

Cover Page

Title: Vulnerable birth mothers and repeat losses of infants to public care:
is targeted reproductive health care ethically defensible?

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Abstract

This article aims to advance debate about the ethics of targeted reproductive health care for birth mothers who have experienced recurrent care proceedings. Making reference to new research evidence that reports the scale of the problem of repeat care proceedings in England, the article considers the role that enhanced reproductive health care might play in helping mothers exit a cycle of care proceedings. Emerging practice initiatives are introduced which are all stretching the boundaries of statutory intervention, by working intensively with mothers *following* removal of children to public care. The central argument of this paper is that a positive interpretation of rights provides a warrant for providing enhanced access to contraception, but this must be part and parcel of a holistic, recovery focused approach to intervention.

Caution is also raised in respect of the reasons that may lie behind a pattern of rapid repeat pregnancy for this particular group of women. Issues of loss and grief are clear complicating factors in reproductive decision-making where an infant or child has been removed to public care, the magnitude of which must be firmly acknowledged. Charting novel theoretical ground, discussion draws on a conceptual vocabulary from the literature on other forms of perinatal loss, suggesting that the notion of ‘replacement baby’ may help to explain why some mothers are caught in this negative cycle. Although this article is prompted by escalating concerns about the human and economic costs of repeat care proceedings in England, discussion will be relevant to a number of international contexts such as the U.S.A. Canada and Australia where cognate systems of child protection give rise to similar patterns.

Birth mothers and repeat losses of infants to public care: Is targeted reproductive health care ethically defensible?

Introduction

The following short case history sets the scene for this theoretical article in which we aim to debate the ethics of targeted reproductive health care for vulnerable birth mothers caught in a cycle of repeat pregnancy and repeat state removal of their children:

At the age of 18 Becky gave birth to her first child who was subsequently removed from her care at ten months old on account of Becky's drug misuse and entrapment in a violent relationship. During legal proceedings, Becky became pregnant again, and following protracted care and adoption proceedings, both infants were placed together with adoptive parents. Some 12 months after the conclusion of proceedings, the local authority received a further notification that Becky was pregnant again and her case was opened to the local children's social work team. This time Becky stated that she was keen to separate from her partner and wanted help to overcome her addiction. However, at six months pregnant upon notification, Becky was left with little time to evidence change and thus, the local children's social work team progressed a plan for removal at birth but with a high level of supervised contact between Becky and her third child. Becky's commitment to contact with her new baby was very good, however, hair strand testing revealed that she was once again using heroin. In addition, the police reported that they had been called to her address on a number of occasions due to reports from neighbours of domestic violence. Children's services swiftly made an application to the family court for a care order, seeking early resolution of the case based on a plan for adoption. Becky requested more time and pleaded with the court to give her another chance. However, the weight of recent evidence counted against Becky and her request for further assessment was rejected. In discussion with researchers, Becky has said that she had not planned any of her pregnancies and that she understood that her second pregnancy was particularly

mistimed. However, in relation to her third child, Becky described the local authority as “cruel and impatient” – with time and the right kind of help she believed she could have turned her life around.

The issue of unplanned pregnancy has been extensively discussed in the international literature in relation to socially disadvantaged women (Finer and Henshaw, 2006; Ryan et al., 2008; Lucke and Hall, 2011). Equally the health risks of short-interval pregnancies are evidenced (Zhu, 2005; Wendt et al., 2012). However, for mothers like Becky, short interval consecutive pregnancies have profound consequences because an infant born shortly after older sibling(s) have been removed to public care is at significant risk of following the same path (Broadhurst et al., 2014). Where pregnancies follow in short succession, birth mothers have little time to engage with their own rehabilitation such that they can evidence change. Our recent research, funded by the Nuffield Foundation, has found that the population of birth mothers caught up in *recurrent* care proceedings is a sizeable, but hitherto, neglected population. Providing a first estimate of national prevalence, we have established that between 2007 and 2013, some 7143 birth mothers appeared and re-appeared before the family court, with the majority, losing their children to public care or adoption (Broadhurst et al., 2014). The topic of birth mothers and repeat care proceedings is now of national concern in England, evidenced by extensive media coverage of this issue (e.g. BBC Today Programme, 23rd, June 2014; The Guardian 23rd June 2014; The Independent, 23rd June 2013).

In this paper we turn our attention to a range of new pilot initiatives that are emerging in the UK, stimulated by networks of concerned professionals who consider that something must be done to help this population of vulnerable birth mothers, their children and informal networks. Specifically, we address the following question: *what ethical issues are raised where new projects seek to interrupt a pattern of repeat pregnancy and repeat removal?* As part of a multi-professional recovery focused approach, new projects

explicitly steer women towards temporary or longer-term prevention of pregnancy. This is premised on an understanding that the burden of a further pregnancy and legal proceedings may undermine women's engagement with their own rehabilitation. Whilst these developments are clearly a very welcome step forward in beginning to address the needs of this hidden population, they also raise ethical questions that require clarification. Birth control can be an adjunct to women's freedom but can also be used in oppressive or discriminatory ways when targeted at social groups for political reasons, rather than women's best interests (Clarke, 1998; Hardon, 2006).

Although this population of mothers share much in common with other women vulnerable to unplanned pregnancy, the loss of infants and children to the state in this way, brings particular complications that warrant *separate* discussion. For example, the urgency to 'replace' a child lost to the public care system is a clear complicating factor for professionals who aim to shape reproductive decision-making (Grant et al., 2011). In a proportion of cases mothers will have experienced removal of an infant at birth, which is a particular form of loss that is poorly understood. Our specific focus on birth mothers within public law proceedings is not to dismiss the experience of birth fathers; rather it is based on an understanding that reproductive decisions are particularly implicative for women, because they invest their bodies in pregnancy and childbirth in a different way from men.

This article is divided into three sections. Given the dearth of literature on the topic in question, the first two sections of the paper provide relevant background context. New empirical findings are initially presented that indicate the scale of recurrent care proceedings in England, drawing on recent research (Broadhurst et al., 2014). In the second section, the imperative for a prevention agenda is outlined, with a case made for

continuity of care for women who have lost children to public care and adoption. Turning to the substantive focus of the paper, the final sections provide a detailed discussion of the ethical issues raised where intervention aims to steer women towards temporary or longer-term prevention of pregnancy. Novel theoretical ground is charted by, *inter alia*, linking research on perinatal loss and child death, to loss of infants to public care. Although our discussion is focused on England, conclusions drawn will, no doubt, be of broader international relevance. In the U.S.A, Canada and Australia child protection systems lead to similar patterns of compulsory intervention and state removal of children (Grant et al., 2011; Taplin and Mattick, 2014)

Birth mothers and *recurrent* public law proceedings: What is the scale of the problem?

The local authority issues care proceedings under s.31 of the Children Act 1989 in England, when concerns about children's safety and wellbeing are so great that compulsory intervention is deemed necessary. In the majority of cases, where an interim or final care order is made, the child (children) will be removed from birth parents' care (Masson et al., 2008). During the fiscal year 2008-2009, the number of care applications made by local authorities rose sharply in England and although there are signs that this increase is slowing, national concerns continue about the high volume of care proceedings. Between April 2013 and March 2014, the Child and Family court Advisory Service recorded some 10, 609 care applications, compared to 6,465 for the same period 2008-2009 (Cafcass, 2014). In this context, new ways of working with families are being sought to reduce the need for public law proceedings. Birth mothers caught in *recurrent* care proceedings are now of national concern, with both practitioners and policy

makers raising questions about why some mothers appear ‘stuck’ in a cycle of repeat pregnancy and repeat legal intervention. The impact of maternal exposure to recurrent litigation is deeply concerning and, in addition, recurrent proceedings impact greatly on the lives of siblings who may or may not be placed together in substitute care (Wulczyn and Zimmerman, 2005). Extended family networks and intimate partners can be equally bereaved through multiple losses of infants and children to public care. Thus, this is a problem of utmost moral urgency.

Supported by a grant from the Nuffield Foundation and accessing data through the administrative datasets of Cafcass, we have been able to restructure administrative data to provide the first national estimate of prevalence of *recurrent* care proceedings in England (see Broadhurst et al., 2014 for a fuller discussion). Although the observational window for this study was restricted to the period 2007-2013 because older records cannot provide the level of accuracy or detail needed for research purposes, this window was sufficient to capture cases where a birth mother was linked to successive care proceedings, concerning different children. Recurrent legal episodes often follow in swift succession, frequently precipitated by the birth of a new baby. Of the total population of birth mothers appearing before the courts during this period (n=46,094), ‘recurrent mothers’ constituted 15.5% (n=7143) and were linked to 15, 645 care applications (approximately 29% of all care applications). Of course birth mothers are commonly linked to more than one child at each application making the population of children involved in recurrent care proceedings during this window significantly higher (22,790). Birth mothers in the sample were young or very young, with 50% aged 24 years or less and 19% aged between 14 – 19 years of age. The study found recurrent birth mothers were linked to between 2 and 5 sets of consecutive care proceedings. Findings confirm that birth mothers are caught in a cycle of short interval pregnancies

and short interval proceedings which leaves women with little time to make or evidence changes to their lives. The median interval between a first and second care episode was only 75 weeks. Moreover, in 42% of cases, we found that the local authority made a care application at, or very close, to an infant's birth. In only a minority of cases (9%) was a supervision order recorded, suggesting that very few children were reunited with their birth mothers.

In this study, we chose to examine recurrence through a focus on *care proceedings*, because national records provide access to reliable data on public law proceedings. However, this focus does not capture the *total* volume of state removals of infants and children. An unknown population of infants and children are placed with kin on account of child protection concerns, through *private law proceedings* only. Under English child protection legislation, it has not been uncommon for an older child to be placed with a grandparent on a residence order (private law option), whilst an infant born subsequently is placed for adoption through public law proceedings. In addition, many infants and children enter care on a voluntary base under s.20 of the Children Act 1989. This complexity is not readily captured in any centralised datasets – it can only be revealed through the reading of individual case records. However, the statistics we present on care proceedings alone, indicate that the proportion of birth mothers caught up in recurrent public law proceedings is sizeable, and warrants a co-ordinated policy response.

New Initiatives: embracing continuity of care

Where mothers lack mental capacity, misuse substances or are homeless, they may struggle to exercise informed reproductive choice leading to unplanned pregnancies (D'

Souza and Garcia, 2004; Hepburn, 2004; Downe, et al., 2008). That teenagers are at greater risk of unplanned pregnancy is also a very well established finding (Ryan et al., 2008; Harden et al., 2009). Many of these risk factors are present for mothers caught up in care proceedings in England (Mason et al., 2008; Harwin et al., 2014). However, birth mothers, whatever their age or vulnerability, will tend to fall outside mainstream children's services once care and adoption proceedings conclude. Whilst the 2002 Adoption and Children Act raised the profile of birth parents by specifying the need for a specialist post-adoption service, these services are variable (Neil et al., 2010) and there is no national requirement for post-adoption agencies to address mothers' complex rehabilitative needs. In addition, it is only a small percentage of children who become subject to adoption proceedings; the vast majority of children are placed in long-term foster care or within kin networks (Care Inquiry, 2013). Where children are placed in long-term foster care or with kin, contact may be restricted but there is no national statutory mandate to provide *post removal support* for parents in these circumstances. The urgency of a post proceedings service is suggested by emerging qualitative evidence that mothers can experience a serious downturn in functioning following the removal of an infant or child (e.g. increased drug and alcohol use), which among other serious health concerns, exacerbates the risks for unplanned pregnancy (Mason and Broadhurst, forthcoming, 2014). Although this issue has not yet been systematically examined in the UK beyond our pilot study (n=26 birth mothers), finding based on larger samples in the U.S.A. resonate with this observation (Ryan et al., 2008, n=931; Grant et al., 2011; n=458). For all these reasons the birth mothers in question are likely to continue to be caught in a pattern of repeat pregnancy and repeat legal intervention, where this negative cycle continues unchecked.

In England, pockets of innovative practice are addressing the needs of this neglected population. Although it has previously been the case that following care proceedings, birth mothers have been largely offered a *reduced* level of intervention from children's services once children are removed from their care, new projects stand in sharp contrast because they offer an intensive rehabilitative response to mothers following removal. Placing *women's needs* at the centre of practice, projects such as Salford City Council's "Strengthening Families" (Warrington and Siddall, 2014); Suffolk County Council's "Positive Choices" (Suffolk CYPS, 2010) and the Tri Borough's "Support for Change" (Tri Borough, 2013), all offer comprehensive services to mothers who have had children removed before. Common across projects is the allocation of a key worker, who works closely with mothers to devise an individually tailored plan of intervention, based on detailed assessment of mother's history and presenting needs. Although each new initiative brings its own distinctive ingredients (for example, Salford Strengthening Families project works with mothers pre-conception and during pregnancy), the importance of engaging and re-engaging mothers where they withdraw is central to an assertive outreach approach. Responding to the full range of needs presented by mothers, the key worker creates a 'team around the birth mother' with the aim of maximising chances of recovery. Mothers are explicitly encouraged to consider the reasons why a child has been removed from their care previously and to focus on what needs to change, should mothers wish to care for a child in the future. Projects can also impact positively on mother's contact with their existing children, where children remain within kin networks or are in foster care. Preconception care also affords the opportunity of improving maternal *and* foetal health in a subsequent pregnancy. Although new pilot initiatives are at an early stage of development in respect of available evaluative evidence, initial indications are that a proactive approach which aims to assist women to exercise control over many aspects of their lives, can help

mothers exit a cycle of repeat pregnancy and repeat legal proceedings (Warrington and Siddall, 2014). Programme attrition has also been reported by each of these projects because problems of homelessness and serious drug misuse can make consistent engagement with professional services very difficult (Warrington and Siddall, 2013). Where women do become pregnant again, services ensure an intensive pre-birth assessment and support service.

In order for initiatives to progress further, it will be important to generate robust evidence about how they are working and the critical ingredients of success. At present there is dearth of both empirical and theoretical evidence. In the sections that follow we aim to make a modest contribution to theory development through a focused discussion of the ethical issues raised, where projects seek to delay a subsequent pregnancy.

Supporting reproductive autonomy?

Providing access to information about contraceptive technologies, sexual health and family planning is normatively valued across the globe. From a rights-based perspective, women should have sufficient opportunity to determine both the number of, and spacing between pregnancies (WHO, 2012). However, to move beyond the universal provision of reproductive health services towards the *targeting* of specific social groups or individuals with the intent of preventing pregnancy is more controversial. Although in Western nation states we have become accustomed to public health strategies that seek to prevent teenage conception (Baird and Porter, 2011), political projects that have sought to curb reproduction in perceived ‘deviant mothers’ such as those addicted to drugs and alcohol, are much more contested (Morgan, 2004; Flavin et al., 2010). The

emergence of Project Prevention, a US-based initiative that aims to reduce the number of infants subject to illicit drug use by incentivising contraceptive uptake/sterilisation through financial rewards, has been subject to fierce opposition. Critics have argued that to offer of a sizeable and immediate financial incentive to individuals dependent on drugs is coercive (Lucke and Hall, 2011). Project prevent exploits the addict's vulnerability to short-term gratification, and does little to foster longer-term goals in respect of rehabilitation. In addition, the project disregards basic ethical tenets by rushing individuals to agree to *inter alia*, sterilisation, without properly assessing capacity to give informed consent.

Concerns about intrusive state intervention for mothers caught up in recurrent care proceedings must, however, must be counterbalanced against state *abandonment* of a clearly, very vulnerable population (Cox, 2012; Broadhurst and Mason, 2013). To suggest that all intervention to enhance reproductive autonomy for our group of mothers is *a priori* an interference with self-determination is as woefully neglectful of human rights as the strategies of Project Prevention. Here it is useful to adopt the distinction that Janssens et al. (2004) draw between freedom *from* and freedom *to* – the authors argue that a negative conception of rights (freedom from) that simply sets limits for others in terms of intervention, has limited relevance for health and social care practice. In order for women to exercise their reproductive rights, it may be necessary to provide enhanced support to ensure equitable access to health care services.

Emphasis on support to enable autonomous choice is outlined in the work of Jackson and Day Slater (2009) who provide an excellent critique of a neo-liberal conception of autonomy. The authors reason that 'protecting autonomy may not involve simply an *absence* of state interference, but could require the positive provision of resources' (2009, p.2). In common with others critics (e.g. Raz, 1986; Tronto, 1994) they take issue with

neo-liberal concepts of self-hood and agency where they are overly individualistic. Women do not equally and freely make informed choices; rather reproductive decision-making can be constrained by a range of intersecting social and economic factors. For the population of birth mothers whose children become subject to care proceedings, their lives are marked by heightened risks for compulsory child protection intervention, but equally, heightened risks for unplanned pregnancy as described above. This is a *double jeopardy* which has to-date been insufficiently acknowledged. In addition, mothers caught up in recurrent care proceedings have frequently experienced maltreatment and neglect in their own childhoods which, as Jackson and Day-Sclater describe, can lead to a ‘systematic chipping away at the qualities we need - such as self-worth and self-trust’ undermining the capacity to exercise autonomous choice (2009, p.7). Maltreatment in childhood is often compounded in adult relationships where intimate partner violence is common. For example, studies have highlighted a clear association between intimate partner abuse and unintended pregnancy. Miller et al. (2010) surveyed young women aged 16-29 in five family planning clinics in the US and found a high prevalence of partner violence linked to pregnancy coercion and birth control sabotage. Recent population surveys in the UK indicate that only 54.8% of pregnancies are consciously planned (Wellings et al., 2013), but the figure may be a lot higher for the birth mothers in question. Personal social history matters and decision-making is embedded within a network of relationships which impact on our ability to make choices for better or worse.

Privacy is often invoked as the defence against state intervention in family life.

However, privacy also has a dark side, where women are vulnerable to domestic abuse and exploitation. An uncritical valorisation of privacy neglects the power relations

within the domestic world particularly where women lack the means or capacity to exercise choice (Allen, 1998). For mothers caught up in recurrent public law proceedings, the state misses an opportunity to provide women with a more meaningful set of options, where fear of intrusion in private worlds stifles policy and practice innovation. Thus, we arrive at a dynamic concept of autonomy premised on an understanding that women's capacity for reproductive autonomy may shift and change in relation to the social context of their lives and the extent to which they are empowered to make choices through information, targeted advice giving and the removal of barriers to reproductive health care services.

Persuasion as moral requirement: ethically defensible or a step too far?

New initiatives not only offer services targeted at mothers who have had children removed from their care, but, in addition, add *persuasion* into a mix of targeted advice giving and empowerment because women are given a clear 'nudge' in favour of long-acting reversible contraception (LARC). Salford City Council's "Strengthening Families" programme encourages mothers to engage in a flexible period of rehabilitation having previously had a child removed from their care, before becoming pregnant again. LARC is seen to offer the best protection against unplanned pregnancy because this form of contraception minimises the risks of user failure. For our population in question, there is clearly a best interests argument in favour of delaying a subsequent pregnancy, but do explicit attempts to persuade breach ethical boundaries in respect of (engineering) reproductive choices? As Cohen (2013, p.3) writes, some of the toughest dilemmas encountered by health and social care practitioners turn on a conflict between 'the fundamental values of respect for autonomy' and the '(paternalistic)

promotion of well-being?.

To address this dilemma, it is useful to think critically about persuasion in health and social care practice, and in particular the question of whether we sacrifice too much at the 'alter of autonomy' if we see all forms of persuasion as unethical or coercive (Barilan and Weintraub, 2001, p.14). Fostering autonomy has typically led practitioners to shy away from conversations with patients or service users that might be seen as coercive in terms of steering patients towards normatively valued health outcomes. The concern is that an explicit attempt to determine patients' health decisions implies that the patient is an incompetent decision-maker. A preferred model is to provide information about a range of choices but respect the patient's wish to self-determination. However as Rubinella (2013) writes, this rests on an entirely negative interpretation of persuasion that jumps too quickly from persuasion to manipulation. There is no doubt that persuasion is an unsettling term in health and social care practice, but this should not dissuade practitioner from seeking to shape patient or service user choice in favour of well-being. Arguably, it is the *intended outcomes* that determine whether 'nudging' in this way is ethically defensible.

Individuals using health and social care services, like everybody else, exhibit a wide range of decision-making biases (Redelmeier et al. 1993). When such biases are successfully offset by a nudge, then persuasion can be autonomy enhancing. Thaler and Sustein (2008) describe this as a *rationality-promoting* effect. Here it is useful to provide a further example from our pilot work. The case concerned Katie (aged 18) and her two sons, born in swift succession and both later adopted. During public law proceedings concerning her first-born son and prior to the final hearing, Katie notified the local authority that she was pregnant again. The researcher asked Katie why she had not

chosen to delay her second pregnancy, given that assessments before the court indicated that she was not able to parent at this point. In response to this question, Katie offered a very troubling explanation that clearly illustrates how uninformed decision-making can lead to tragic outcomes. Katie told the researcher that she had become pregnant because she thought that she might be able to ‘trade’ her second born son, with her first born Jamie – the latter child subject to a plan for adoption. She stated that she understood the local authority had adoption targets, so they could take her second born son instead to meet these targets, and release Jamie back to her care. A consistent finding from studies of parents within care proceedings, is that parents struggle to understand the local authorities concerns and frequently do not know what changes they are required to make such that they can be reunified with their children (Lindley, 1994; Hunt, 2010). Katie’s account is a very clear example of such misunderstandings. This case illustrates the importance of an active approach to steering service user choice in favour of best interest outcomes, which is surely a moral requirement providing that *all options* remain open.

So, how might the boundary between ethical persuasion and manipulation be managed in practice? Arguably, the mothers in question are at risk of the latter for all the reasons we have described. In the section above, we highlighted issues of power in the domestic world, but it would be hugely blinkered to ignore the possibility of unethical conduct in the professional-service user relationship. Public law proceedings and the provision of substitute care for children are both costly enterprises and in this context, it might be tempting to coerce mothers into delaying/ceasing further pregnancies on the grounds that the state can ill afford the costs of providing care for more children. We start from a premise, that an ethical approach to steering healthy reproductive choices must be a *responsibility* shared by health care providers with the mothers in question, based on

honest and informative but also challenging conversations. As Janssen et al (2004) write, ethical persuasion is defined by its departure from any tactics that are deceptive or dishonestly manipulative. Although there are no value-free presentation of facts, the negative health and psychological consequences of multiple short interval pregnancies for our care mothers are well evidenced and these risks needs to be shared with birth mothers. In addition, the implications of being caught up in recurrent care proceedings are clear. Following the closure of care proceedings, a period of intense children's services scrutiny is followed by withdrawal of services, leaving women to deal with the anguish of losing children without the requisite help. Information and support is however, critical at this juncture to include advice about 'best interest' reproductive decisions. This potentially enables mothers to build their self-care and problem solving skills and make more informed choices about the timing of a next pregnancy, such that they have a better chance of parenting a child in the future. For some mothers, it may also be that they choose not to have further children.

Where projects may run into difficulty, is where service eligibility is *conditional* on pregnancy cessation for a prescribed period. The difference between persuasion and conditionality is subtle, but important. Conditionality implies that if a woman becomes pregnant, then the service is withdrawn – our standpoint on conditionality is that this is a step too far. Women should not be required to leave services if they become pregnant within a planned treatment period – rather enhanced help and support must continue for this vulnerable group. Given that many women who have experienced compulsory removal of children will have experienced childhoods of loss and abandonment, agencies should not replicate this through adhering to rigid policies of conditionality. It is far better to use techniques of motivational interviewing for example, to help mothers recognise and unlock barriers that stand in the way of taking control of their lives. For

this group of women the road to recovery will undoubtedly be uneven; the challenge for agencies is to try provide mothers with a firm steer but also a secure base from which to effect change.

Grief and loss as complicating factors in reproductive decision-making

For mothers who have lost children to public care and adoption, loss is a key issue that must be considered in respect of subsequent reproductive decisions. It may be that the most natural response to the loss of an infant is to seek to replace that infant through a further pregnancy. This is certainly the thesis of Grant et al., (2011) in the U.S. who argue that compulsory removal of an infant from a mother increases the likelihood of a subsequent short interval birth. Grant and colleagues followed up 458 substance misusing mothers participating in an evidence based programme designed to help mothers retain care of their children. Results indicated that mothers who remained in the 3-year programme and retained custody of their children were less likely to record a subsequent birth during this period. In the UK, mothers who lose their children to adoptive parents will most likely have indirect contact only, commonly termed 'letterbox' contact. Letterbox contact involves the exchange of letters and photographs, but face-to-face contact is not permitted. For mothers whose children are placed with long-term foster carers or with kin, the picture is more complicated but contact is frequently restricted and may also be supervised. Although these varied permanency outcomes will impact differently on parenting identity and the experience of loss, separation of mother and child in this way is undoubtedly a complicating factor in respect of subsequent reproductive decisions.

In the absence of any substantive evidence base concerning loss *and* subsequent reproductive decisions for our birth mothers in question, it is necessary to turn to related literatures. Arguably, research on the topics of perinatal loss and child death are relevant, where studies have examined the impact of loss on subsequent pregnancy decisions. Hitherto, this connection has not been made, but we anticipate that readers might follow our logic in thinking that mothers who are separated from an infant at birth might be compared to 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 (Armstrong and Hutti, 1998; Estok and Lehman 1985; Robertson and Kavanagh, 1998; Lamb 2002; Scheidt et al., 2012). Cuisinier et al. (1996) examined the impact of a subsequent birth on grief for 221 mothers who had experienced a pregnancy loss and concluded that a subsequent birth significantly *lessened* mothers' sense of grief. The notion of 'replacement child syndrome' has a long history within the literature on perinatal loss and child death with studies again confirming that subsequent pregnancy is a way of coping (Cain and Cain, 1964; Poznanski, 1972; Davis et al. 1989). Thus, this body of literature offers a *different perspective* on mothers caught in a cycle of rapid repeat pregnancy and compulsory removal who might otherwise appear self-defeating or unreasonable. Where mothers lose older children to care or kin networks, loss will no doubt be experienced differently but we should not assume that they are not equally, if differently, bereaved.

Where projects seek to intercept a further pregnancy, practitioners will need to be mindful of how 'replacement' drives can be managed. Salford City Council's "Strengthening Families" project aims to offer what might be considered as a period of extended preconception care to women over a 3-year period. Replacement drives are

‘managed’ through an intensive programme that incrementally helps mothers to prepare for a future pregnancy. Hope of regaining parenting capacity and a sense of progress, helps mothers to accept the need for delaying pregnancy in the short-term (Warrington, and Siddall, 2014). Coping with loss depends on a range of social and cultural resources, such as strong kin networks and access to professional help (Layne, 2006). Whereas women experiencing miscarriage or stillbirth are offered a range of service options in the form of face-to-face and web-based support groups or counselling, in the context of stigmatised losses to care, it is far harder to access appropriate help. Post-adoption services do offer support, but this is of variable quality and evidence of uptake indicates a significant proportion of birth parents do not access this service (Neil et al., 2010). New innovative programmes that aim to foster recovery in mothers who have lost children to public care and adoption must place an understanding of the magnitude of loss at the centre of practice, and foster methods of coping.

What kind of contraception? LARC

Our discussion would be incomplete without a consideration of methods of birth control, in particular, long acting reversible contraception (LARC). Although LARC, has been described as empowering for women on account of effectiveness in preventing pregnancy, LARC has also given rise to significant controversy because implants and contraceptive injections *reduce* user control. The oral contraceptive pill is the mainstay of GP prescribing, but for high-risk groups such as teenagers, LARC is both the recommended and preferred option (Russo et al., 2013; Baldwin and Edelman, 2013). The umbrella term LARC refers to long-acting reversible contraception most commonly in the form of Depo-Provera injection or the contraceptive implant. Issues in respect of user control arise because once injected, effects last for 8-12 weeks and the procedure is non-reversible during that period. In the case of contraceptive implants,

effects may last for three years but they can be withdrawn upon request. Ethical frameworks have been developed to regulate prescription and management of LARC (NICE, 2005) but there is a history of controversy that split the women's movement in relation to whether or not LARC is *prima facie* positive or empowering for women (Ginsburg and Rapp, 1991).

Critics have argued that contraceptive technologies are far from benign – rather they are ‘inscribed during their development with cultural values and ideas about their future use’ (Hardon, 2006, p.615). The legacy of Norplant in particular, has prompted searching questions about the targeting of ‘welfare mothers’ with contraceptive technologies that are tantamount to temporary sterilisation. Early development of Norplant saw particular populations of women subject to unscrupulous drug testing. Hardon (2006) provides an excellent summary of the issues making reference to the early global programme of clinical trials that were initiated in 44 developing countries. Led by the New York based Population Council, trials were widely reported as breaching standards of informed consent in the recruitment of women because adverse side-effects were not made clear to participants. In the leading text: *Norplant: Under Her Skin* (Mintzes et al., 1993), the actual physical difficulties of rods breaking during removal and practitioner reluctance to remove implants where women requested this, were clearly documented. Lawsuits brought in UK and US led to such reputational damage that the drug was withdrawn in these countries.

Despite early controversy, a distinct shift is now discernible within the extant literature. Increased acceptability of LARC has been achieved through new improved implants with fewer side effects underpinned by robust clinical trials. Thus, controversy that raged about Norplant has given way to more mainstream medical concerns with

effectiveness and uptake of contraception (Stoddard et al., 2011; Baldwin and Edelman, 2013., Russo et al., 2013). Consensus in medical opinion is that the risks of rapid repeat pregnancy need to be balanced with and mostly outweigh risks associated with the prescription of LARC (Baldwin and Edelman, 2013). In the UK, following introduction of NICE guidelines, there has been a sharp increase in the uptake of implants. This is not to suggest, that as with any form of contraception, side effects are nil; questions continue about the impact on bone density where LARC is prescribed for adolescents. However, meta-syntheses of findings from clinical trials suggest that new drugs are generally well tolerated (less than 10% of patients reported side effects). In respect of mothers at risk of rapid repeat pregnancy, the imperative to explain honestly and openly both the range of contraceptive options and implications of LARC must not be set aside, because of fears of user failure with oral methods. A proactive outreach approach is suggested to encourage uptake of contraception given the well documented barriers to health care that arise where mothers are homeless or misuse drugs. However, outreach support must extend to monitoring tolerance to LARC in this vulnerable population who may not seek help should problems of tolerance arise. The clear advantage of LARC lies in the fact that its long acting nature provides women with an extended inter-natal window, in which they can focus on their own recovery. Thus, where LARC is combined with a holistic programme of support that aims to steer women towards better life chances, then risks are most likely outweighed by the advantages of interrupting a cycle of repeat pregnancy and repeat legal proceedings.

Conclusion

Returning to the central question we posed at the start of this paper: *what ethical issues are raised where new projects seek to intercept a pattern of repeat pregnancy and repeat removal?* - it is

now possible to draw some conclusions. First, a proactive approach to reproductive health care is suggested for this population of birth mothers. Given the evidence we have presented regarding the short intervals between repeat pregnancies and repeat legal proceedings, it is difficult to envisage how birth mothers can exit this cycle, unless this pattern is interrupted. Providing enhanced access to contraception and preconception care is based on a *positive* understanding of women's rights and an acknowledgement of the multiple factors that most likely increase the chances of unplanned pregnancies for this group of women. Standing back for fear of excessive intrusion into women's intimate lives is an *unethical* position, because the evidence is that mothers may experience multiple losses of infants and children to the care system, where they are 'left alone' (Broadhurst et al., 2014). Second, providing enhanced access to reproductive health care must be part of a *holistic programme* of intervention for the birth mothers in question – the provision of contraception alone will not help mothers to recover their wellbeing. In particular, services should be far more mindful of treatments recommendations made by social workers and other experts within care proceedings, and ensure appropriate access to support services does not stop following the conclusion of legal proceedings. In contrast to standard statutory practice where women are left to their own fate once children are removed from their care, our recommendation is that clear advice is needed at this juncture, so that mothers (and their partners/informal networks) understand what needs to change and understand realistic timeframes for recovery. Third and finally, the impact of loss on mothers' subsequent pregnancy decisions must be carefully considered. The notion of 'replacement baby' has been much discussed in relation to other pregnancy losses, such as miscarriage and stillbirth, but this thesis may also help to explain why vulnerable birth mothers become caught in a cycle of short interval pregnancies which otherwise appear self-defeating. It is vital that services fully acknowledge and work with loss and

grief associated with state removal of children. Finally, it is critical that agencies make progress towards achieving *continuity of care* for this population of women. Where mothers are abandoned to their fate following the conclusion of legal proceedings, we do little to enhance their welfare or that of their unborn children. Indeed, a downturn in functioning following legal proceedings will most likely heighten the risk of a further unplanned pregnancy.

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