Who's left holding the woman?

Practice issues facing hospital social workers working with women who have infants removed at birth by NSW Department of Community Services

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Over the past three years, there has been a significant change in the focus of hospital social work intervention with pregnant women – from supportive counselling relating to motherhood, to systems advocacy within the child protection context.

Hospital social workers in this field have frequently been faced with the inevitable conflicting interests of supporting parents and protecting infants. However, the recent changes have thrown up various ethical questions, and issues of integrity and advocacy, in what is a complex area of practice.

This paper seeks to examine some of the current practice issues for social workers in this area. By examining the current context and literature, several practice themes will be considered and explored. In examining this issue at both the micro level of current hospital social work practice and the macro level of legislative and systemic issues, several best practice suggestions are considered within the context of the author's current workplace.

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Over the past three years, there has been a significant change in the focus of hospital social work intervention with pregnant women – from supportive counselling relating to motherhood, to systems advocacy within the child protection context.

The development of public policy to support the changing ethos in relation to child protection responsibility within the community could be considered a catalyst for this. Mandatory reporting and early intervention programs are examples of two key policies that have impacted on this area of practice. However, there has also been a marked increase in the number of newborn babies removed from parental care at birth by the New South Wales Department of Community Services (DoCS), which is directly linked to Amendment 106a of the Children and Young Persons (Care and Protection) Act 1998 (see Note 1).

Hospital social workers have dealt with the removal of infants as part of their work for many years. However, the role of social work has arguably changed. Rather than acting as a passive facilitator of DoCS processes, hospital social work is now actively involved in this process – from identification of risk of harm through to supporting parents after the removal of their infant. Given this shift, an exploration of social work practice from an ethical, evidence-based perspective is essential.

CONTEXTUAL ISSUES

Psychosocial screening and early intervention with pregnant women has been significantly enhanced over the past decade with the NSW Government recognising the area as a key priority. As a result, practice has also evolved, and services working with these families have encountered new challenges and the need for adjustments to their practice.

A key component of early intervention with pregnant women involves the NSW Health initiative of screening all women for psychosocial vulnerabilities. This screening routinely takes place at first antenatal visits and again post delivery. Sections of the psychosocial screening include questions about adverse childhood experiences, previous contact with DoCS, current or past substance misuse and

domestic violence. As key indicators of child protection risk factors, positive screening on these questions prompts referrals to multidisciplinary support services.

Hospital social workers frequently receive referrals for women who have been identified via screening to have current or past DoCS involvement, including previous children removed by DoCS or with current Departmental involvement due to risk factors. Part of the intervention with these women includes liaison with DoCS to determine case plans or outcomes from risk of harm assessments. At the extreme end of the intervention continuum, DoCS may assess that an unborn baby is at unacceptably high risk and needs to be 'assumed' into DoCS' care at birth. (The terms 'assumed' and 'removed' are used interchangeably in this paper, although the distinction of assumption, which is specific to hospital settings, is detailed in Note 2.)

At the John Hunter Hospital (JHH) in Newcastle, NSW, the practice of DoCS removing newborn infants at birth due to high risk parenting factors has markedly increased in the past ten years. In 2007, twenty-one newborns were removed, compared to just six cases in 2000. In 2008 and 2009, the numbers have continued to climb. In 2000 at the JHH, the removals of newborns occurred usually after a protracted postnatal stay in hospital. They were predominantly cases in which DoCS had used the postnatal stay and assessments undertaken during that time to gain enough evidence to take the matter to the Children's Court. In 2007, however, practice began to change and DoCS began assuming care of babies immediately after birth. The need for ongoing assessment and evidence building was no longer pressed as an issue. This practice change was linked to Amendment 106a of the Children and Young Persons (Care and Protection) Act 1998.

Amendment 106a was invoked in late 2006 in the context of ongoing public scrutiny of DoCS in relation to detecting children at risk of harm. The NSW Ombudsman releases an annual report into the reviewable deaths of children, and this has consistently indicated an increasing trend in the number of children who have died, and/or their siblings, who were already known to the child protection system. Almost 30% of children who died in 2005 had siblings who had previously been reported to DoCS, and 15% of parents had had previous children removed from their care (NSW Ombudsman 2007). The report into Statutory Child Protection in NSW (DoCS 2006) released by the Minister for Community Services in 2006 suggested that DoCS should find a more consistent way of identifying children who were known to be 'at risk' by association to parents or carers from whom children had previously been removed.

The parliamentary debate about Amendment 106a was contentious. However, there was little community consultation or discussion prior to the Amendment being applied in practice (Parliament of NSW 2006). Under Amendment 106a, DoCS can assume care of infants born to mothers who have already had children removed by DoCS or siblings who have died in reviewable circumstances (see Note 1). The evidence previously submitted to the Children's Court is considered prima facie – to be considered as accurate and valid without any evidence to the contrary.

This change in practice has consequently raised both process concerns and ethical dilemmas for hospital social workers involved with these cases, and has been an area of new contentions and challenges. Social workers within the health system are presented with the contradiction of becoming better skilled at identifying women with 'at risk' infants, whilst at the same time often initiating adversarial outcomes as a result of intervention. The aim of social work in identifying at risk infants and mothers is to apply early intervention practice with the hope of lowering risk and making positive change before the birth of the baby. However, often the consequence is that these mothers are made more visible to the DoCS system and therefore subject to Amendment 106a.

Whilst the interests of the child remain paramount, the notion of 'least harm' to parents is being overlooked.

Social workers have long grappled with the issue of competing interests in child protection work. The issue of acting as an advocate for parents whilst trying to ensure the safety of the child has been well recognised as a difficult and complex area of practice. However, the current practice concerns being raised by social workers about the implementation of Amendment 106a are not about contesting the child protection risks or the integrity of DoCS assessments, rather they concern the process being applied.

As advocates for parents within child protection work, the inception of practice that involves infants being removed from parental care at birth due to the circumstances surrounding a previous matter, raises questions of justice and morality for hospital social workers. Whilst the interests of the child remain paramount, the notion of 'least harm' to parents is being overlooked. In the vast majority of cases, parents are informed neither of the legislation nor of the involvement of DoCS, and they are therefore not able to prepare counter evidence or to secure legal advice prior to the birth. They are also significantly traumatised at a period of extreme vulnerability in their life, and are often left without supports.

The evidence building from this practice has prompted a review of processes and the need for them to be consistent

and more ethically informed. There is no literature regarding the implementation of Amendment 106a and a paucity of literature around the practice of removing infants from their mothers at birth due to child protection factors. There are, however, several themes in both Australian and UK literature that look at the broader issues of parental participation in child protection practice and the outcomes for parents with children in the child protection system.

WHAT DOES THE LITERATURE SAY?

There is limited Australian research on outcomes for parents who have children removed by child protection services at birth. None of the studies located isolated the age of the child at removal or focused on the issue of removals in a hospital setting. There are, however, several key themes reflected in the available literature and paralleled across adoption research that are relevant for consideration.

The central theme running through the literature is the experience of grief and loss for these parents. There are profound grief issues that are often overlooked or perceived as inappropriate emotions such as anger or withdrawal.

Several authors make reference to the complexity of this grief, outlining in particular the issues of the irresolvable nature of the loss, given that the child is alive, just not with them. This can be further complicated by the responsibility for this loss being attributed to them directly, leading to wider experiences of guilt and shame (Burgheim 2005; O'Neill 2005; Thomson & Thorpe 2003, 2004; Thorpe 2008).

> These parents have not only had their children taken by the state, but the responsibility for the removal, as well as for being the cause of harm to their children, has been largely attributed to them personally, rather than any part of it to their environment (O'Neill 2005, p.14).

This grief is often not acknowledged by family, friends or workers due to shame or societal stigma. There are also parallels to the outcomes for mothers who lost children to early adoption practices or through the Stolen Generations. The impacts of loss of identity, loss of motherhood role and, particularly, the protracted negative outcomes from this loss, provide pertinent lessons from which practitioners appear to have learnt little.

> ... un-resolvable grief following loss of a child ... can develop over the years into post-traumatic stress disorders with major long-term distressing and dysfunctional sequelae (Thomson & Thorpe 2003, p.27).

Burgheim (2005) reflects on her years of practice with birth parents engaged with non-government child protection services and concludes that not only are the issues of grief for these families misunderstood, they are rarely identified as issues requiring referral or support.

> A basic need for anyone who is grieving is to have someone who is willing to enter into how the experience is for them, whether these feelings seem justified or not, and who will give them permission to express these feelings in a way that is right for them (p.3).

The second key theme reflected in much of the literature is that of parental experiences of powerlessness within the child protection system. The issue of parents feeling left out, unheard or not consulted is reflected in many studies in this area, particularly those that reviewed data obtained from interviewing parents who had had children removed from their care (Ferdananz 1996, cited in Panozzo, Osborn, & Bromfield 2007; MacKinnon 1998; O'Neill 2005).

The role of parental participation in child protection has been long debated and shown at best to be restricted, given the legislative power of child protection services. However, the literature suggests that the issues parents face are beyond being part of the consultation and decision-making for the immediate care of the children; they extend to include issues such as contact visits, court issues and effective communication.

> Research ... details the impact of child protection investigations on families – the institutional power of the child protection system; feelings of fear and vulnerability; a lack of clarity about the social work role; the seeming impossibility of renegotiation once decisions are made; the selectiveness of evidence cited in legal proceedings; and the lack of information about the children once they have left the home (Diorio 1992 & Ryburn 1994, cited in O'Neill 2000, p.7).

Further to parental experiences of powerlessness within the system, the literature clearly identifies that, as a general characteristic, this group of parents are marginalised, disempowered and predominantly suffering from social and economic deprivation (Fernandez 1996; MacKinnon 1998; Thomson & Thorpe 2003).

> Parents who come into contact with government organisations on protective grounds are, not surprisingly, more likely to report life stresses, depression, loneliness and weaker informal supports than those from similar backgrounds who have not had this contact (Gaudin et al. 1993, cited in O'Neill 2005, p.12).

It is therefore extremely unlikely that these parents will have access to adequate resources with which to access the information or support necessary to engage in opposition with government organisations. The legal discourse surrounding court proceedings and care applications is daunting to most who are unfamiliar with the legal system. To couple this with the inability to afford legal representation places parents in a disadvantaged position from the start.

Whilst court work is everyday business for child protection workers, parents are predominantly in crisis from the removal of their children and trying to negotiate how to

regain care of their children, whilst still dealing with psychosocial issues such as domestic violence, drug and alcohol abuse or mental health concerns.

The complexity of the families who are most likely to have children removed by child protection services is outlined in the literature as a key issue for service providers. Parents often have multiple and complex needs that require intensive or multi-agency intervention. However, the nature of the child protection system is crisis-driven and parents are given very little time (often in comparison to the child protection services) to prepare themselves for court and to be assessed as parents.

Inherently, there is also the contradiction that occurs when the support person most available to parents is from the same service that removed the child. It is therefore understandable that these parents do not readily accept the offer of support.

> It is hardly surprising that they behave irrationally, even violently, and are unable to accept the reality of what has happened, or that they are not willing to enter a 'good' relationship with the people to whom their children have been given (Burgheim 2005, p.2).

Whilst parents are unlikely to feel they can trust the same system to provide them with support, the workers must also grapple with the many issues of both the child and the parent.

> Many feel that they lack the skills, particularly if parents have other problems ... outside the field of expertise of child protection. In addition, it is extraordinarily difficult for workers to balance the needs and wishes of both children and parents, even dis-empowered parents ... (Mendes 1999, cited in Thomson & Thorpe 2004, p.48).

Dodson (1999) makes important reference to the disturbing over-representation of children in care from indigenous Australian families. However, this paper cannot provide an exploration of the issues specific to indigenous families except to highlight this as an alarming concern.

The literature reviewed also identifies significant factors that led to better parental experiences of the child protection system and workers. Not surprisingly, the main issues identified were a greater sense of participation and consultation in the process, and information about what they needed to do in order to regain care of their children (Dumbrill 2006; MacKinnon 1998; O'Neill 2005; Scott & Honner 2004). As Panozzo, Osborn and Bromfield (2007) comment:

> Methods that engage, encourage and empower parents may assist them to maintain contact with their children and work towards personal change and family reunification (p.7).

In addition to greater participation, parents identified that they would like to have been treated with respect and in a non-judgemental manner (Ryburn 1994, cited in O'Neill 2005, p.12). Several articles make reference to the importance of considering power dynamics in this area. Dumbrill (2006) makes particular reference to the notion of power 'with' parents rather than power 'over' parents as a useful strategy for engaging parents and making them active participants in the process.

Whilst participation and involvement of key stakeholders in decision-making is a critical aspect of good social work practice, in the area of child protection there is a key link between engaging parents and sustained positive contact for children in care. Parents who are able to be engaged in the child protection process are more likely to participate in ongoing contact visits and case meetings involving their child. In some cases, this may lead to family reunification, as indicated by Thomson and Thorpe (2003):

> Contact has a positive impact on the wellbeing of children, whether or not restoration is the goal (Thomson & Thorpe 2003, p.27).

In summation, there is currently no literature on the impact of Amendment 106a to the 1998 Children and Young Person (Care and Protection) Act as this legislation is a 'world first' and relatively new in its application. The literature examined elicits important and pertinent issues for birth parents such as grief and loss, lack of participation and difficulties in negotiating systems and accessing services. These concerns are only exacerbated by the trauma of the removal happening within hours of giving birth and, in many cases, with no knowledge of the plan.

THEME ANALYSIS

Current practice at the John Hunter Hospital in the area of removal of newborns is varied and inconsistent. This appears to be an issue from the perspective of both DoCS and the health workers involved. There is marked variation in what supports parents can access and the level of intervention by DoCS prior to, and after, the removal of their infant. This experience is echoed across other hospitals within the Hunter New England Area Health Service (HNEAS). At the John Hunter Hospital, the Social Work Service has been collecting data on the removal of newborns for the past three years. The following are key issues of practice concern.

SYSTEMS ABUSE

One of the causes for the variation in DoCS' intervention is that unborn babies receive little or no priority in the DoCS system – reporting on risk of harm to an unborn baby is not mandatory. In rare cases, a worker will be allocated to an unborn baby, but in the majority of cases it is not considered a priority until the baby is born. This practice clearly undermines the intention and possibility of early intervention – that is, to avoid risks translating into harm by early work with families. There is also inconsistent practice between

DoCS offices and workers around the issues of attending case meetings during pregnancy, despite these meetings being supported by policies such as NSW Health's *Interagency Guidelines for Child Protection Interventions* (NSW Department of Health 2006) and NSW Health's *Neonatal Abstinence Syndrome Guidelines* (NSW Department of Health 2005).

LEGAL INJUSTICE

Under Amendment 106a, DoCS are able to rely heavily on past evidence in their legal case. Parents are often left reeling from the loss of their newborn baby whilst also being required to appear in the Children's Court on the next day the court sits – and in that short time, build their legal defence. It seems unreasonable and unjust that those on one side of the legal battle have considerably more time and resources than the other. In many situations, parents fail to attend court as they have no support, transport, money or the confidence to attend. It is not feasible to expect clients who are dealing with daily issues of violence or drugs to be able to disentangle the chaos of their lives instantly and without well-structured support systems in place.

Pregnancy and birth are already well recognised as the biggest risk period for women's mental health without the added trauma of having had that child removed from their care ...

PARENTAL PARTICIPATION

Parental knowledge of child protection intervention prior to birth is often raised as an issue of contention between services. In cases where there are risk factors such as severe mental ill-health or a history of itinerancy, DoCS will often rely on these reasons as an indication for not engaging parents prior to birth. This phenomenon, however, is only valid in a small number of cases, and in all cases involving Amendment 106a, families have already had prior involvement with DoCS. Often this historical involvement creates a strong fear for parents and they are apprehensive about 'what will happen this time'. One could argue that this creates an opportunity for early engagement with families in the child protection system, as well as a chance to prevent the trauma of unnecessary family separation.

For many parents with children who are already in care, the window of opportunity for engaging with DoCS in a supportive way is very narrow and, if this is overlooked or missed by workers, the possibility of a working relationship or active parental participation in the child protection process is very limited.

In situations in which DoCS do engage families, the process becomes far more transparent and parents can choose to participate in planning and strategies that can lower the risk of harm to their child. However, in some cases, there will be limits to this choice – for example, participating in urine sampling to prove current drug status, or accepting specific referrals for parenting services. However, as the literature clearly indicates, the lack of any participation in the child protection process is a major issue for parents and a key concern in terms of poor outcomes for both the parent and the child (Dumbrill 2006; O'Neill 2005; Panozzo, Osborn & Bromfield 2007; Scott & Honner 2004; Thorpe 2008).

ISOLATION

Another key practice concern is the lack of support and follow up available for parents after the removal of their baby. They are often unable to access supports due to being in acute crisis, or are prevented from accessing services because the child is no longer in their care. Some parenting services have a brief to work only with families where a child is living in the family. Other programs, such as drug and alcohol services, often prioritise referrals if DoCS completes a specialised referral form. However, frequently a referral is not made because the child has already been removed. The outcome is that women usually disengage from all services and do not receive the support, medical follow up and counselling necessary to deal with the impacts of this experience. The resulting grief reactions of parents are not dealt with professionally and opportunities for family reunification can also be reduced.

GRIEF AND TRAUMA CONTINUUM

As the literature clearly defines, the grief and trauma caused by the removal of children is a key issue for both parents and impacts heavily on maternal mental health (Burgheim 2005; O'Neill 2005; Thomson & Thorpe 2003, 2004; Thorpe 2008). This is often overlooked in the crisis of having DoCS involved and Court to attend. Services which work with these women, including health services and DoCS, need to develop a more comprehensive understanding of the mental health implications of trauma for these mothers. Long-term implications such as depression or post traumatic stress disorder are often undetected as women frequently move between services or localities with no one person advocating for the importance of their follow up. Pregnancy and birth are already well recognised as the biggest risk period for women's mental health without the added trauma of having had that child removed from their care (NSW Department of Health 2008).

PRACTICE CONSIDERATIONS

In teasing out the practice issues and contemplating possible areas for change, it has been difficult not to focus on practice suggestions predominantly aimed at DoCS systems. This is associated with the difficulties in adapting and reflecting on practice that is heavily influenced by another agency's core business.

In light of this issue, the social work service at John Hunter Hospital has engaged with the local DoCS management to develop a joint protocol entitled *John Hunter Hospital Assumption of Newborns Pathway* (Wickham & Dimmock 2007). This protocol is aimed at making practice more consistent and predictable. A key practice standard is the engagement of families early in their pregnancy when Amendment 106a could apply. This engagement commonly involves a case meeting with multiple services providers, DoCS and the family. The purpose of the meeting is to begin planning for the birth of the baby and any areas of concern that families need to address in order to provide adequate care for their child. This initial contact allows families to be participants in the process and involves parents in the decision-making.

This joint protocol has been utilised in training with the Department of Health and DoCS workers to enable a clearer understanding of the process issues from both services. The protocol has been in place for two years and is now being used as a template to establish similar processes across the Hunter New England Area Health Service (HNEAS). Within the HNEAS, each hospital has noted an increase in the removal of infants at birth over the past two years. The inherent distress for staff and families is also a key issue of concern. Having a joint protocol to guide practice has resulted in a smoother process for staff. For families, the protocol has also provided a clearer basis for planning for the involvement of DoCS in their lives. In some cases at JHH, the protocol has led to successful reunifications or avoided the separation of parents and their infants. In most cases in which the infant is removed at birth, families will have already been aware of this likelihood, as well as the expectations DoCS had of them prior to the birth.

At JHH, the Social Work Service has also worked in conjunction with the Maternity Service to develop clearer discharge plans for women at risk of having their infants removed at birth. By linking in the relevant services for this client group, it is hoped that there will be better engagement of women and fewer situations of service withdrawal. Local mental health, parenting support and counselling services have been approached with regard to their availability to work with women, irrespective of whether the child is in their care. A single page pamphlet has been developed for clients, articulating which services are available to them and how to make contact. The pamphlet also includes information on common feelings and emotions that clients may face, the importance of understanding the Children's Court process, and early engagement with legal support.

CONCLUDING THOUGHTS

In examining the possibilities for practice change in this area, it is vital to reconsider the core values of the social work profession. These include advocacy, the pursuit of social justice, integrity, and the ethical responsibility to work with people to achieve the best possible state of wellbeing (AASW 1999).

Current practice developments at JHH have been introduced in the hope of reducing parents' experiences of powerlessness, and to advocate more widely through evidence-based research to break down the current barriers that preclude effective engagement of families in the child protection system. There is potential for these practice changes to influence the wider practice of child protection authorities. By actively advocating for better processes, and developing further research in this area, the voices of parents with children in the child protection system may be more valued. The impact that the Amendment 106a legislation will have on the parents, workers and larger systems involved in this work is an area yet to be fully explored. But, as Tomison (2002) aptly remarks:

> ... substantial changes to policy and practice in child protection systems have often been implemented without careful, evidence based consideration of the effectiveness of existing systems, of proof that the new initiative will have a significant, positive impact (p.6).

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NOTES

NOTE 1: DEFINITION OF 'AMENDMENT 106A'

106A Admissibility of certain other evidence

(1) The Children's Court must admit in proceedings before it any evidence adduced that a parent or primary care-giver of a child or young person the subject of a care application:

(a) is a person:

(i) from whose care and protection a child or young person was previously removed by a court under this Act or the *Children (Care and Protection) Act 1987*, or by a court of another jurisdiction under an Act of that jurisdiction, and

(ii) to whose care and protection the child or young person has not been restored, or

(b) is a person who has been named or otherwise identified by the coroner or a police officer (whether by use of the term 'person of interest' or otherwise) as a

person who may have been involved in causing a reviewable death of a child or young person.

(2) Evidence adduced under subsection (1) is prima facie evidence that the child or young person the subject of the care application is in need of care and protection.

(3) A parent or primary care-giver in respect of whom evidence referred to in subsection (1) has been adduced may rebut the prima facie evidence referred to in subsection (2) by satisfying the Children's Court that, on the balance of probabilities:

(a) the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist, or

(b) the parent or primary care-giver concerned was not involved in causing the relevant reviewable death of the child or young person, as the case may require.

(4) This section has effect despite section 93 and despite anything to the contrary in the *Evidence Act 1995* .

(5) In this section, 'reviewable death of a child or young person' means a death of a child or young person that is reviewable by the Ombudsman under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* .

NOTE 2: DEFINITION OF 'ASSUMED'

44 Director-General may assume care responsibility of child or young person in hospital or other premises.

(1) If the Director-General:

(a) suspects on reasonable grounds that a child or young person is at risk of serious harm, and

(b) is satisfied that it is not in the best interests of the child or young person that the child or young person be removed from the premises in which he or she is currently located,

the Director-General may, instead of removing the child or young person from the premises under a power of removal conferred by or under this Act, assume the care responsibility of the child or young person by means of an order in writing, signed by the Director-General and served on the person (whether or not a parent of the child or young person) who appears to the Director-General to be in charge of the premises.

(2) An order under this section does not cease to have effect merely because the child or young person to whom it relates is transferred to different premises.

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