

BREAKING THE CYCLE

Supporting Tasmanian parents to
prevent recurrent child removals

TERESA HINTON



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You are only just keeping your head above water and they are coming down on you and pushing you under. That's how it goes. They sit on you and you drown. If that history wasn't there they would not have taken my son. They would not be applying for an 18 year child protection order. It's all because of history. That should not define a person. Is it really that hard to believe that someone can endure what I've endured and still come out the other end? They are not praising me for how well I've done. They are putting me down for my history. You can't possibly be a parent, look at your history. It's no wonder people don't make it out the other end.

MARY

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But overwhelmingly the author is grateful to the parents who agreed to become involved in the research and overcame their grief and anger to talk about their experiences. Without them the research would not have been possible.

The names used in this report have been changed to protect the privacy of research participants.

The research findings, conclusions and recommendations of this report are those of Anglicare and should not be attributed to any members of the Research Reference Group. Any errors in the report are the responsibility of the author alone.

Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AVREC	Anglicare Victoria Research Ethics Committee
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Service
CHaPs	Child Health and Parenting Service
CPIS	Child Protection Information System
CPNMDS	Child Protection National Minimum Data Set
CPO	Child Protection Order
CSO	Community Service Organisation
CSS	Child Safety Services
CSW	Child Safety Worker
CYS	Children and Youth Services
DPM	Department of Psychiatric Medicine
DSS	Department of Social Services
FDAC	Family Drug and Alcohol Court
FIN	Family Inclusion Network
HMHB	Healthy Mothers, Healthy Babies Project
IFES	Intensive Family Engagement Services
IFSS	Integrated Family Support Services
NSW	New South Wales
OOHC	Out-of-home care
PTSD	Post Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SARC	Social Action and Research Centre, Anglicare Tasmania
TAC	Tasmanian Aboriginal Corporation
UBA	Unborn Baby Alert
UK	United Kingdom
VLA	Victorian Legal Aid
WA	Western Australia

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Executive Summary

This report documents the prevalence and experiences of Tasmanian parents who have children recurrently removed by Child Safety Services, and the experiences of the services that support them. Recurrent removal is when removal of a child is followed by a subsequent pregnancy, further court proceedings and another removal at or shortly after birth or during infancy. This tragic cycle can be repeated a number of times with children being 'born into care'. Through interviews with 15 parents and over 80 service providers, the research documents the experience of removal and its consequences for parents, examines the current service network and its capacity to support them and reviews interventions which are being deployed in other jurisdictions, both nationally and internationally, to break this cycle.

The key findings of the research are:

- One-fifth of birth mothers (20.5%) who have children removed by Child Safety Services in Tasmania will experience further removals, typically of babies and infants. Younger mothers are most at risk. Short intervals between repeat proceedings reduce opportunities for mothers to make the necessary changes to avoid a further removal. This is a highly vulnerable group of mothers. They often have histories in the OOHC system, high rates of mental health and substance use issues and experience of family violence, poverty and insecure housing.
- Parents and services report a range of 'collateral consequences' when a child is removed. They include removal processes which are traumatic for both parents and children, an overwhelming grief and loss, reductions in income and threats to housing stability. At the same time parents are required to deal with legal processes, maintain positive access to their children and meet any conditions imposed by Child Safety Services and court orders to address safety concerns. These consequences can exacerbate existing difficulties, impose system-induced trauma on already vulnerable parents and result in another pregnancy. This has been described as a 'perfect storm'.
- Unless parents are on a reunification path there is little support available to them to assist in dealing with removal and its consequences. Although there is a complex network of programs and services working with families across the state, few are targeted to their specific needs and no one has the mandate to actively support them. This means contact with services is sporadic and engagement is problematic as parents try to access services which are often inappropriate to their needs. Parents who embark on another pregnancy face high levels of stress and anxiety about whether their unborn child will be removed, at a time when typically their material and emotional circumstances

are deteriorating. However, the needs of vulnerable pregnant women and their histories become risks to the unborn child rather than eliciting support and parents describe being neglected and abused by the Child Safety System.

- Removal and subsequent pregnancy present key opportunities to intervene and work with parents to promote insight into safety concerns, improve parenting capacity and circumstances, address underlying problems and break the cycle. Both parents and services want to see intensive case-managed support available during pregnancy and after removal to assist in dealing with the collateral consequences, address safety concerns and provide a firmer base for the parenting of any future children. This support must be trauma-informed, relationship-based and delivered at arms-length from the Child Safety System to promote engagement.
- The majority of birth families continue to see themselves as parents with an important role to play in their children's lives, whether or not reunification is a possibility. Yet maintaining contact can be fraught with difficulty and gradually diminish as long term orders are applied and children settle into new lives. However, with over 50% of adolescents estimated to either self-place back with their birth families or return to them once they exit out-of-home care at 18, there is a strong case for assisting parents to sustain positive relationships with their children, address the underlying issues which led to removal and improve their future parenting capacity.
- Other jurisdictions are now beginning to recognise this cohort of parents and develop interventions tailored to their needs and to reduce entry into out-of-home care. Although interventions differ in terms of design, cost and intensity, they share key characteristics. These characteristics are intensive holistic support post-removal, tailored to individual need, and delivered by skilled, well-resourced professionals who can walk alongside parents and refer into specialist services which can appropriately meet their needs.
- This research, and the research and policy literature more generally, highlights the human and financial costs of successively removing children from their birth parents. It identifies a policy gap where the focus of Child Safety on the needs of the child obscures and de-prioritises the needs of vulnerable parents. It identifies a growing concern that there is both a moral and practical imperative to support parents who experience removal to prevent recurrent removal, reduce entry into out-of-home care, sustain the parent/child bond and build a more solid foundation for parenting any future children.

The findings from this research should be considered alongside a partner project, *In Limbo*, which examines in detail the material consequences of child removal for families and how to prevent these consequences from forming an obstacle to successful reunification (Fidler 2018).

Recommendations

LEGISLATIVE AND POLICY FRAMEWORK

- **RECOMMENDATION 1:** That the Department of Communities develop a policy framework to clarify where the duty of care for parents lies and how their needs should be met.
- **RECOMMENDATION 2:** That the Department of Justice and Children and Youth Services review current court processes and access to legal advice and representation for parents involved in the Child Safety System
- **RECOMMENDATION 3:** That the Department of Communities ensure that parents with children in out-of-home care are proactively assisted to maintain the parent/child relationship and improve parenting capacity whether or not children are returned.

ENGAGING AND SUPPORTING PARENTS

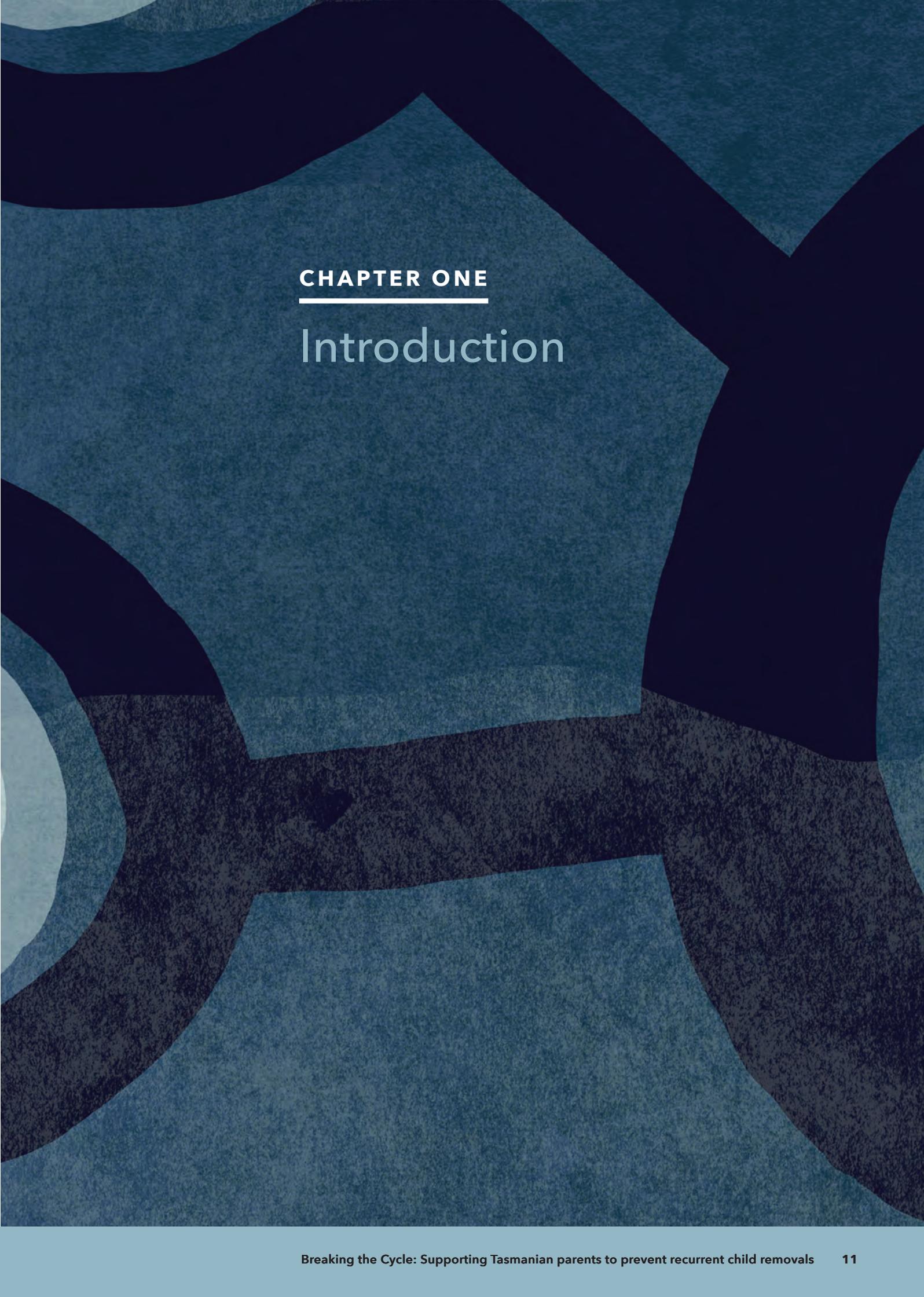
- **RECOMMENDATION 4:** That Children and Youth Services develop a clear framework to respond to and support those in out-of-home care and care leavers through early pregnancy and parenthood.
- **RECOMMENDATION 5:** That the Department of Communities and the Department of Health ensure that intensive support is available during pregnancy to proactively engage vulnerable women and assist them to prevent removal.
- **RECOMMENDATION 6:** That the Department of Communities ensure that skilled post-removal support be available to all parents who experience removal of their children.

ADDRESSING TRAUMA

- **RECOMMENDATION 7:** That the State Government ensure that trauma-informed practice becomes the norm across sectors working with vulnerable parents who have had their children removed.
- **RECOMMENDATION 8:** That the Department of Health and the Department of Communities ensure that parents have access to intensive therapeutic support which can address the underlying causes of the challenges parents face in parenting their children.
- **RECOMMENDATION 9:** That Children and Youth Services ensure full implementation of the Signs of Safety Framework across the Child Safety System.
- **RECOMMENDATION 10:** That the Department of Communities develop good practice guidelines for the removal of children and specifically for the removal of babies at or shortly after birth.

MONITORING AND REVIEW

- **RECOMMENDATION 11:** That the Department of Communities develop the capacity to collect data about the incidence and characteristics of recurrent removal, including trends over time.



CHAPTER ONE

Introduction

This research provides a picture of the prevalence and characteristics of recurrent removals of children from their birth mothers in Tasmania. Recurrent removal is when removal of a child by Child Safety Services¹ (CSS) is followed by a subsequent pregnancy, further court proceedings and another removal at or shortly after birth or during infancy. For some parents this tragic cycle can be repeated a number of times with children being ‘born into care’.

Across Australia and internationally there is an increasing recognition of these issues (Broadhurst et al. 2015). This is leading a number of jurisdictions to explore models of intervention which can support parents to break the cycle, address any safety concerns and assist them to parent effectively. Yet there is currently little information about the scale of repeat removals in Tasmania, about the characteristics and support needs of these parents and about how best to intervene to break the cycle. This research quantifies the issue in Tasmania, explores its size and shape, examines the experiences of birth parents subject to recurrent removal and the services that support them, and reviews programs being implemented elsewhere which aim to intervene in this cycle.

Too much time can be spent thinking about what is not working well rather than what needs to happen to solve a problem. Given the current invisibility of this population of birth parents, this research provides an opportunity for those caught in this cycle to influence legislation, policy, practice and services through describing the lived experience and identifying what kind of support they feel would be most beneficial to them and their children. The research provides a platform to consider how best to address these issues in the Tasmanian environment and reduce the entry of children into OOHC.

A partner project, *In Limbo*, examines in detail how to prevent the material consequences of child removal from forming an obstacle to successful reunification (Fidler 2018).

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1 The redesign process in Tasmania has led to Child Protection Services being renamed Child Safety Services in recognition of the central focus on child safety and wellbeing.

1.1 Background to the research

In 2013 the Social Action and Research Centre (SARC) explored the experiences of parents in the Tasmanian child protection system (Hinton 2013). A number of those involved in the research had experienced repeat² removals of babies and infants. Although court proceedings can result in a recommendation of support for birth parents to overcome their difficulties and to promote a reunification pathway for the family, a number of Tasmanian parents described traumatic removal practices and an absence of support post-removal to assist them to make the changes necessary to promote reunification and/or to improve their parenting capacity. 'Going feral' was a common response; for example parents described increasing their alcohol or drug use to dull the pain. At the same time parents in the 2013 study highlighted that the time immediately after removal represented an important opportunity for intensive support to assist them to come to terms with what had happened and to instigate change.

More recently, anecdotal evidence from community services working with parents has highlighted the short timeframes to achieve any change stipulated in interim orders post-removal; the sparsity of support services, particularly therapeutic interventions; and the fact that parents often do not meet the thresholds for access to the intervention and support that is available, for example adult mental health services. The lack of service capacity to work intensively with families to mitigate or resolve CSS concerns limits the ability of parents to follow any court recommendations and benefit from them.

A lack of support after removal can have severe consequences for parents and for any subsequent children they may have both in the short term and the longer term (see Hinton 1999, 2013; Novac et al. 2006; Broadhurst & Mason 2017b). Broadhurst has identified these as the 'collateral consequences' of court-ordered removal. For parents they can include unresolved grief, anger and emotional damage, a deterioration in mental health and in material circumstances, a negative impact on relationships within the family and a high risk of rapid repeat pregnancy and further removal.

Recent pioneering work in the UK which analysed court care proceedings to quantify the population of birth mothers experiencing repeat removal found that 24% of women who had a child removed were likely to experience repeat episodes of care proceedings (Broadhurst et al. 2017a). The 16-19 year age group were most at risk, with removal rates for any subsequent birth increasing to one in three women. The research raised questions about what happens in the gap between removal and subsequent court proceedings, where unaddressed problems compound histories of trauma and undermine future life chances (Broadhurst &

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2 The terms 'recurrent' and 'repeat' are used interchangeably to refer to the serial removal of children from their birth parents.

Mason 2017b). The research concluded that there is an urgent need to rethink parents' needs post-removal and how to meet them.

Parents who reappear in the courts are unlikely to generate much public sympathy. Yet the likely scale of the problem and the tragic cycle it represents indicate that a coordinated and effective response is required to break the cycle. In the longer term there is a need to examine more closely the consequences of removal and how to prevent a lifelong negative impact on parents that results in them becoming clients of other services like homelessness, mental health and alcohol and drugs services.

1.2 Policy and service environment

There are a number of initiatives at both a federal and state level which impact on the support available to parents post-removal and at risk of or experiencing recurrent removals.

The National Framework for Protecting Australia's Children 2009-2020 aims to reduce levels of child abuse and neglect through a series of three-year action plans and six supporting outcomes (DSS 2009). These include that 'children and families access adequate support to promote safety and intervene early'. The Framework is promoting the establishment of targeted intensive family support services to reduce the number of children entering OOHC, particularly Aboriginal and Torres Strait Islander children.

Within the National Framework there is also a current focus on achieving consistency between jurisdictions about permanency planning, which aims to achieve stable long-term care arrangements for all those in OOHC and prevent 'drift' in care (DSS 2015). This is leading to changes in legislation in a number of Australian jurisdictions to make speedier permanency decisions and mandate shorter timeframes in temporary care. For example, Victoria has imposed a strict time limit of 12 months for parents who have had a child removed to demonstrate parenting capacity, after which the State will apply for a long-term care order. This can be extended to two years in exceptional circumstances. Concerns have been raised about how this push for permanency can impact on the quality of decision-making, especially in an environment where there is little support for parents to address complex problems and meet the requirements identified by CSS within short timeframes.

At a state level Tasmania is currently reviewing its permanency planning arrangements and the CSS is being redesigned to tackle rising notification rates, increased complexities and growing numbers in OOHC (DHHS 2016a, b). At the core of the redesign is the goal of creating an integrated system which can more effectively support families prior to reaching crisis point and reduce the numbers of children and young people entering OOHC. This is leading to changes in managing the 'front door' and how families access the services they need, as well

as establishing a mechanism for families reaching crisis point to access assertive support through the development of Intensive Family Engagement Services (IFESs). Four pilot IFESs are currently being established, working with approximately 50 families across the state who are on the cusp of removal. In addition, greater flexibility in the timeframes for child protection orders (CPOs) is being introduced and it is now possible to better tailor them to the individual circumstances of families to address changes they are required to make in relation to safety concerns.

Underpinning the redesign is the Common Approach Framework³. This is being promoted across the service system to ensure a holistic focus for professionals to secure child wellbeing. It works alongside a state-wide risk assessment and planning framework which will assist children and families to receive services better targeted to their needs. In addition, the redesign also entails fully embedding the Signs of Safety framework⁴ across the CSS. It is anticipated that this will promote a better engagement of families in identifying and addressing safety concerns and ensure a more standardised approach in working with families across individual child safety workers (CSWs).

Recurrent removal typically involves the removal of a baby or infant. Across Australia there is a move towards earlier intervention through pre-natal reporting and a number of Australia jurisdictions have legislated for the reporting of unborn children to statutory authorities. The 'unborn baby alert' (UBA) has become a key plank in monitoring and accessing support for pregnant women who pose a risk to their unborn child from issues like domestic violence, unmanaged mental illness and substance use. Tasmania is alone in mandating prenatal reporting (CFCA 2017a). This means that prescribed persons must inform CSS of their belief that a child, once born, is reasonably likely to suffer abuse or neglect or require medical treatment. Although pre-natal reporting provides a window of opportunity to counter identified risks pre-birth, it also raises concerns about negative consequences such as disengagement from or avoidance of health services by pregnant women and later presentations at ante-natal care. These consequences can effectively shorten the window in which pregnant women can access help and demonstrate any changes that CSS require to assess them as safe to care for their newborns.

Tasmania has a network of services that vulnerable parents can access during pregnancy, birth and the early years to support them to parent and reduce any

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- 3 Developed by the Australian Research Alliance for Children and Youth (ARACY), this provides a flexible framework to help professionals have a quality conversation with a child, young person or family about all aspects of their wellbeing.
- 4 Signs of Safety is a risk assessment, risk management and case planning framework designed to be used at all stages of the child protection process. Developed in Western Australia, it is now being used around the world to promote the engagement of families and family-inclusive practice while keeping the safety and wellbeing of the child at the centre of the work.

risks to the wellbeing of babies and children. Universal services for all parents are provided through the Child Health and Parenting Service (CHaPS), which offers some 'enhanced services' for more vulnerable parents. There are also a range of community-based services to support families and those experiencing alcohol and drug issues, mental health or family violence. Yet few can specifically support those who have experienced removal or repeat removal unless they are considered to be reunification ready and on a reunification pathway.

Despite both a national and state-based focus on reducing the numbers entering the OOHC system and improving the outcomes for those who do, little thought appears to have been given to how to better support parents post-removal in order to contribute to these goals. This research provides a timely opportunity to consider how the Tasmanian CSS redesign process will impact on this cohort of birth parents and forms a basis for more strategic thinking about how best to meet their pre and post removal support needs and reduce the numbers of children entering the OOHC system.

1.3 Through the lens of trauma

Parents who experience recurrent removal have often been exposed to traumatic life events. It is now recognised that exposure to adverse and traumatic life events like childhood neglect and abuse can have negative effects in childhood, adolescence and adulthood. These negative effects include mental and physical ill health, social and relational difficulties and poor academic and employment outcomes. Of course individual responses to traumatic events vary widely and it is the individual response to adverse experiences which determines whether it is considered traumatic or not (SAMHSA 2014). But trauma is now recognised as an important concept for human service delivery, with trauma-informed practice being acknowledged as an emerging field (Wall et al. 2016).

Exposure to trauma means that parents can present to CSS and other services with a complex range of symptoms and behaviours related to past trauma. However, as Wall et al. (2016) identify, neither they nor those working with them have necessarily linked these behaviours to previous trauma exposure. As a result they may face an uninformed response that is potentially re-traumatising and adds a layer of 'system-induced' trauma to their experiences. Responses to trauma can affect a parent's ability to engage with services and be a barrier to the development of productive working relationships with CSS to address safety concerns and avert removal.

In addition parents can experience 'moral injury'. This refers to the lasting psychological, spiritual and social harm caused by one's own or another's actions that transgress deeply held moral beliefs and expectations about right and wrong

(Haight 2017a). Parents in contact with CSS can experience moral injury due to the harm inflicted by themselves or others on their children, their failure to protect or to provide basic necessities and when social systems which should be helping them are instead harmful. The mismatch between core beliefs and actions can lead to a breakdown in an individual's sense of integrity and persistent emotional distress, and contribute to feelings of guilt, shame, rage, depression and loss of trust in themselves or others. Practitioners can also suffer from moral injury (Haight 2017b) as a result of under-resourced systems, high caseloads and policies which they see as unfair or abusive to parents.

This research uses the lens of trauma to better understand the experiences of parents who have their children removed by CSS. It is a language which resonated with parents who participated in the research, who commonly described themselves as 'injured' and requiring 'time and help to heal' from traumatic life events.

1.4 Research aims

This research quantifies and explores the experiences of Tasmanian birth parents who have suffered, or are at risk of suffering, recurrent removals of children. It examines interventions that are being used in other jurisdictions to break this destructive cycle and how applicable they might be in Tasmania.

In particular the research:

- establishes the prevalence of repeat removal in Tasmania and the characteristics of parents who experience it;
- examines the lived experience of removal, the support available pre- and post-removal and what might inhibit or increase the risk of repeat removal;
- explores what interventions are effective in providing pre- and post-removal support, breaking the cycle of repeat removal and reducing the negative longer-term consequences of removal; and
- makes recommendations for reducing repeat removal rates and entry to the OOH system in Tasmania.

The research provides a focus for the voices of both families and the services that work most closely with them to identify the challenges parents face and ways of supporting them to overcome those challenges. It takes into account the likely over-representation of the Aboriginal population, young parents and parents with disabilities who may require a diverse range of interventions and solutions.

1.5 Research methods

The research involved:

- **reviewing research, policy and practice literature** including good practice models and interventions nationally and internationally designed to reduce repeat removal and provide post-removal support. The review proceeded via internet searches and ‘snowballing’⁵ to identify key informants to explore interventions and service models in more detail, including any evaluative material.
- **quantifying repeat removals** in Tasmania. This entailed interrogating the Child Protection Information Database (CPIS) to establish the prevalence of recurrent removal and the characteristics of parents who experience it.
- **mapping current service initiatives** to support parents pre- and post-removal through semi-structured interviews with:
 - **key informants in government and non-government services** about policy and service initiatives in this area;
 - **birth parents** to collate the lived experience of those subject to repeat removal. Community services were asked to identify a sample of parents who were then approached to participate in the research. Fifteen parents (from 13 different households) were interviewed, including two birth fathers. Between them they had 54 children who had been subject to care proceedings and removed from their care. Parents had a lot to say and interviews were lengthy – up to two and a half hours. They were recorded and transcribed and all parents were reimbursed for their participation to cover any costs they incurred; and
 - **front line services** about their experiences of working with and supporting birth parents. This proceeded through a mix of email questionnaires, telephone interviews and face-to-face meetings. Over 80 service providers were involved in one-to-one and group interviews across the state. This included informants based in Community Service Organisations (CSOs), in health and family support services, legal services and in CSS.

Ethical approval for the involvement of birth parents in the research was given by Anglicare Victoria Research Ethics Committee (AVREC).

The research was guided and advised by a reference group with representatives from Children and Youth Services, CSOs and parents involved with CSS. The Tasmanian Aboriginal Corporation was also consulted during the research and about the final report and recommendations. The reference group met three times during the course of the research.

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5 A sampling technique where existing research participants are used to recruit future subjects.

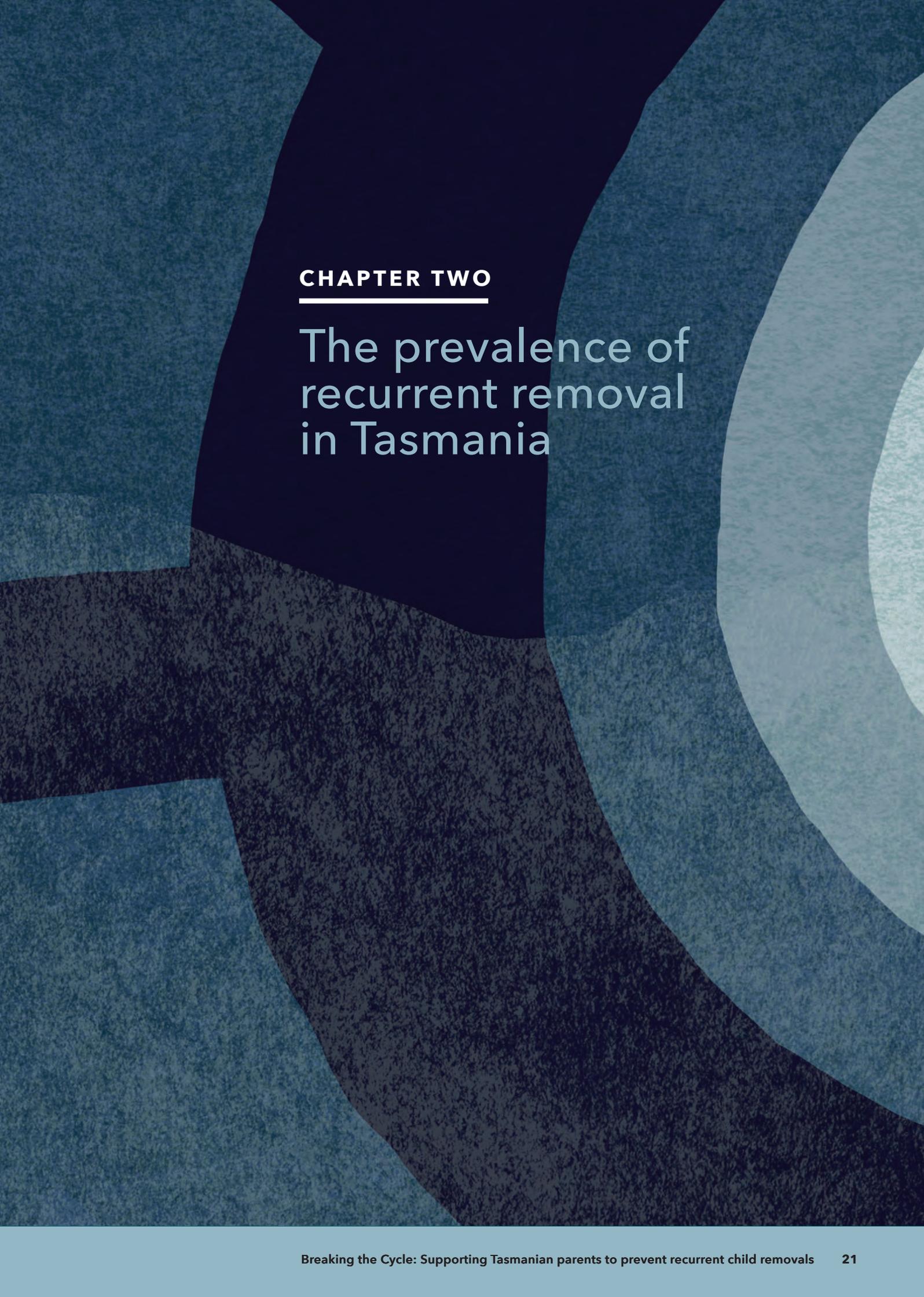
1.6 Limitations of the research

The research was limited by three main factors. Firstly, birth parents who have had their children removed can be hard to access. Difficult past experiences, especially for those experiencing recurrent removal, may limit their willingness to become visible and have contact with services. The research considered at length how best to attract parents to participate in the research. Most were recruited through a range of services provided by CSOs, with attempts to recruit those with less contact with services through the network of Neighbourhood Houses across the state. Two parents were recruited to the research through word of mouth. This means that most of those interviewed were already in touch with support services and their pathway therefore is likely to have been smoother than those not engaged with services. However, a number of parents who participated had experienced periods where they had survived outside the service network. This allows some reflection upon what it means to experience removal with little support. In addition, the research was able to draw on second-hand data from the experiences of services in witnessing the struggles of their clients. Although small, the interview sample provided good representation across the spectrum of characteristics and circumstances birth parents find themselves in.

Secondly, although most services working in this area are aware of and work with parents experiencing recurrent removal, it is only recently that the service environment has identified them as a cohort with needs that may require a particular service response. This means that most current interventions have only recently been implemented and lack the longer term evaluative work required to assess how effective differing responses are in breaking the cycle over a period of years. As a consequence there is not necessarily a fully evaluated model which can easily be slotted into the Tasmanian environment.

Lastly, although the research refers to birth parents, most of our interviewees and much of the work in this area focuses on birth mothers. Significant numbers of families experiencing recurrent removal also involve a number of fathers rather than just one. This has meant that the birth mother was used as the unit of analysis for estimating prevalence. This is not to disregard the experiences of birth fathers who have children recurrently removed. However, for the purposes of this study, it is the birth mother who inevitably became the central focus of the work.





CHAPTER TWO

The prevalence of
recurrent removal
in Tasmania

How many parents experience recurrent removal in Tasmania and what are their characteristics? Answering this question is a crucial starting point for considering any interventions designed to break the cycle of recurrent removal.

Data was extracted from the Child Protection Information System (CPIS) about birth mothers experiencing recurrent removal during the observational window January 2000 to May 2018. Data extraction was based on templates used in international work (see Broadhurst et al. 2017a) so that comparisons in prevalence rates could be drawn between different jurisdictions. Comparisons were also made between birth mothers experiencing recurrent removal and all birth mothers to establish any particular characteristics which might increase the risk of recurrent removal.

2.1 Prevalence rate

Over a period of 18 years during the observational window January 2000 to May 2018, a total of 1,629 birth mothers in Tasmania had experienced the removal of 2,820 children. Of these 331 had experienced two or more removals (572 children were involved in the subsequent removals for these mothers). This represents 20.5% or one-fifth of birth mothers who have their children removed. It is likely to be an underestimate as there will be those towards the end of the observational window who will progress to further removals in the future.

This figure compares to that found in a seminal UK study of recurrent removal (Broadhurst et al. 2017b) where rates of recurrent removal were lower, with 17.2% of birth mothers who had their children removed experiencing at least a second removal.

2.2 Characteristics of birth mothers

There is a strong link between recurrent removal and maternal age, with younger women and those who become mothers in adolescence having a higher rate of recurrent removal.

Generally, those experiencing child removal and particularly recurrent removal became mothers considerably younger than the general population, where the median age for a first birth is now 28.9 years (AIHW 2017b). Whilst one-third (34%) of birth mothers experiencing one removal had first become mothers in adolescence, over half (55%) of those experiencing repeat removal had been teen mothers.

As well as becoming first time mothers at a younger age, those experiencing recurrent removal also experience their first removal at a younger age than women experiencing only one removal. Of those with one removal, 9% were teenagers and 27% were under 25 years when their children were removed. This compares with 19% of those with recurrent removal being teenagers at the time of their first removal and 48% being under 25 years. Overall, those experiencing recurrent removal were twice as likely to be teenagers at the time of removal than other birth mothers. As Broadhurst et al. have identified (2017 b), this is concerning given the difficulties in meeting birth mothers' own developmental needs as adolescents while they are struggling to deal with motherhood and parenting.

TABLE 1: Birth mothers experiencing removal by age of youngest child removed, UBA notification and number of children removed

Child Profile	One removal %	Two removals %	Three removals %	Four + removals %
Newborn (under 4 weeks)	6	26	38	62
Infant (under 12 months)	22	24	33	14
1-9 years	47	37	23	0
10+ years	25	13	7	10
Subject to UBA	16	42	60	71
Involving one child only	61	77	86	62
Total removed under 12 months	28	50	71	76

How old are the children being removed? Table 1 highlights a striking increase in the percentage of children removed as newborns as repeat interventions occur. Recurrent removals are increasingly likely to only involve one child and for that child to be a newborn or infant.

Table 1 also shows that recurrent removals are more likely to be subject to a UBA during pregnancy. The UBA can instigate support work with mothers to establish safety planning before and after the birth in hope of averting the need for removal. The figures in the table suggest women with more repeat removals are more likely to have a pregnancy identified as at-risk and monitored by CSS. They cannot, however, tell us what kind of support interventions, if any, were provided.

Beyond age, the CPIS can provide only a limited amount of data about other characteristics of birth mothers and their children: their Aboriginal status; whether or not they have a disability; and whether they have a history of CSS intervention in their own childhoods. Concerns about the quality and comprehensiveness of this data mean that it has not been reported in detail in this research. However what data is available suggests higher rates of recurrent removal for children recorded as Aboriginal and slightly higher rates of disability among birth mothers experiencing recurrent removal. It also suggests that as the number of recurrent removal episodes increases so too do the associated risk factors of age, Aboriginal status and disability.

Many birth mothers involved in the Child Safety System have a history of child safety intervention in their own childhoods. As Table 2 demonstrates, birth mothers experiencing recurrent removal were almost twice as likely to have had CSS involvement during their own childhoods than other birth mothers who had experienced removal.

TABLE 2: Birth mothers x childhood involvement with Child Safety Services

Nature of involvement	One removal %	Two+ removals %
Subject to a Child Safety notification	19	34
Entering out-of-home care	3	6

Data about fathers is limited. However, as removals reoccur, they are increasingly likely to involve families where children have been fathered by different men. Among birth families which experienced just one removal 8% had more than one father involved. This increased to 45% of those families who experienced recurrent removal. Like birth mothers, fathers experiencing recurrent removal were young, with 22% being teenagers at the time of the first birth.

2.3 Risk factors and safety concerns

There are over 60 possible risk factors listed by CSS which can contribute towards a decision about whether to remove a child or not. What is the prevalence of main risk factors like substance use, mental health issues, family violence, cognitive function, housing stability and non-engagement with services and how do these risk factors change over time with subsequent removals?

Without interrogating individual case files the data quality meant that it was not possible to answer these questions. The exception was family violence, where figures are available from 2009. Among birth mothers, family violence was recorded as a factor in 28% of initial removals. However, where there had been subsequent removals, domestic violence was a factor in over half of those cases (52%). Family violence was a factor in the records for individual children in well over half of initial and recurrent removals varying from 59% in initial removals to 57% in third removals.

The data did allow for some exploration of the type of abuse children had experienced – emotional abuse, neglect, physical abuse and sexual abuse – and to see whether type of abuse changed over the recurrent removal period. For all children experiencing removal neglect was the most commonly recorded risk factor (88%), closely followed by emotional abuse (81%). While emotional abuse declined over recurrent removal episodes, neglect increased. This might suggest that neglect is driven in part by the deterioration in material circumstances experienced by birth families post-removal. Both physical and sexual abuse declined but physical abuse was still a factor for over half of the children removed in third and fourth removals (at 52%). Sexual abuse however dropped from over a third to under a fifth of third and fourth removals.

2.4 Outcomes

Table 3 examines the outcomes for the children of birth mothers experiencing recurrent removal. As recurrent removals increase, the number of long term orders issued rises and children are less likely to be reunified with their birth families and more likely to be placed in foster care rather than kinship or non-reimbursed relative care.

TABLE 3: Outcomes - legal orders and placements

Final outcome	One removal %	Two removals %	Three removals %	Four + removals %
Legal				
Long term order	39	58	59	31
Interim, short term order**	12	16	19	52*
Placement				
Parents	44	24	16	10
Foster care	17	32	46	62
Kinship care	12	15	13	10
Relatives (not reimbursed)	4	2	2	3
Third party	6	13	14	7
Residential	4	4	3	3

*These figures reflect birth families at the end of the observational window who are more likely to be on interim orders without having progressed to longer term orders or guardianship.

**This excludes assessment orders.

Significant numbers of mothers are subject to continuous proceedings where proceedings are issued prior to a final hearing of an earlier set of proceedings. Table 4 shows that although over a quarter of second and third removals (30% and 26%) overlap with previous removals, this increases to almost half (48%) of fourth or more removals. Overall approximately three-quarters of subsequent removals occur within 12 months of a previous removal. The duration of proceedings also shortens substantially once the mother is known to CSS.

TABLE 4: Time since previous proceedings

Timing	Two removals %	Three removals %	Four removals %
Overlapping	30	26	48
Less than 1 year	47	49	24
1-2 years	6	9	19
2-3 years	4	4	10
3+ years	14	12	0

For the birth mother this suggests that she experiences multiple losses within a very short timeframe with little opportunity for dealing with the emotional challenge of removal, the range of collateral consequences, a new pregnancy and changing circumstances. This is especially the case when removals are related to recovery from or a deterioration in mental health or addiction issues. This rapid recurrence reduces the opportunity for birth mothers to seek support or to implement the necessary changes to avoid a subsequent pregnancy and further removal.

2.5 In summary

One-fifth (20.5%) of birth mothers experiencing removal in Tasmania experience recurrent removal. Since 2000 this accounts for 331 mothers who have had an additional 572 children removed in recurrent removal episodes.

Recurrent removal typically involves:

- larger families than among the general population;
- one child, usually a baby or an infant under 12 months;
- a link between maternal age and recurrence with younger mothers most at risk;
- a higher risk of CSS intervention during a birth mother's own childhood;
- repeat pregnancies which are subject to an Unborn Baby Alert and consequently to potential opportunities for intervention; and
- shorter intervals between removals which are likely to take place within one year of a previous removal.

Overall the data suggests a pattern of increasingly rapid recurrent removal from birth mothers who are commonly young and highly vulnerable at prevalence rates comparable to those in other jurisdictions.



CHAPTER THREE

The experience
of removal

This chapter explores the experiences of parents who have had children recurrently removed and what happened to them post-removal. It is based on interviews with fifteen parents from thirteen different households, including two birth fathers.

Between them they had been involved in 33 different removal episodes where a total of 58 children had been removed. Interviewees were asked to describe their own history and their history with CSS, their experience of removal and its impact on them and their family. Each story is of course complex and unique. Nevertheless there are striking commonalities and shared experiences among them which point to problems and challenges stretching from the individual to the systemic.

The chapter also uses data from interviews with over 80 service providers who work with or have contact with parents experiencing recurrent removal. Their testimonies about witnessing the challenges and struggles of parents validate these experiences and provide a mirror image of the stories told by parents.

3.1 Parent profile

This was a highly vulnerable population of birth parents. Although it is difficult to isolate the 'typical' birth parent experiencing recurrent removal, our sample did cover a spectrum where discernable patterns of behavior and circumstance were apparent and fitted with what we know about the characteristics of those experiencing recurrent removal in Tasmania.

The ages of birth mothers participating in the research ranged from 22 to 41 but they had all first become parents when they were young; in adolescence (8) or in their early twenties (5). They had large families with all except one having three or more children up to a maximum of seven and the majority fathered by two or more different men. At the time of interview five said they were living alone without a partner. Others were living with the father of their youngest children or had re-partnered, which in one case had meant taking on step-children. Half of the mothers (7) identified as Aboriginal. Nine parents were care experienced, meaning they had been in the care system themselves as children. Three identified with a mild intellectual disability which they said could mean difficulties in processing information and in understanding things.

Whilst the majority had experienced two removal episodes, five had experienced three or more. Subsequent removals were typically of newborns or infants (under 12 months), although in four cases the birth mother had re-partnered and established a new family by the time of the second removal. Children had been removed to foster care and to kinship care and most parents had contact with their children through supervised access visits. But the picture was complex, with multiple care arrangements and with some children subject to Orders living with their father or grandparents where there were unsupervised access arrangements. However, a number had not seen their children for lengthy periods and/or hours of contact were diminishing due to difficulties in dealing with both kinship and foster carers,

a reduction in access time as children moved to longer term Orders and children making their own decisions about how much contact they wanted. For some contact had reduced to Christmas and birthday cards and the occasional photograph. Two parents had older children who were self-restoring with their birth families or returning to them once they exited OOHC at 18.

Interviewees revealed a complex mix of issues and challenges that could be classified as a risk to their children's safety and for intervention by CSS:

- high rates of mental health issues. These included anxiety, depression and post-natal depression, PTSD and low self-esteem. Two said they were diagnosed with borderline personality disorder and several had been suicidal;
- health problems including diabetes, migraines, heart conditions and stress-related disorders like hair loss;
- contact with the criminal justice system. This applied to 6 parents including periods in prison and on probation;
- low levels of education and employment. Only one mother had completed year 12. Others had left mid-year in grades 10 and 11, often due to a pregnancy. One had left school in grade 8 and another in grade 9. Only one parent was currently in employment although several had a history of casual employment and of returning to study, training or volunteering;
- problematic drug and alcohol use. This applied to 7 parents and included addiction to prescription drugs like codeine;
- financial problems with histories of benefit sanctions, rent arrears, eviction and debt;
- experience of abusive relationships and domestic violence with a number of women reporting family violence across a series of relationships;
- insecure housing and homelessness with the majority of parents reporting periods of homelessness, living with family, couch surfing, living in cars and in temporary accommodation like shelters; and
- isolation due to fleeing domestic violence, rejection by family, few supportive relationships and difficulties in engaging with formal support services.

How far do the interviews reflect current CSS practice? Parents talked about experiences with CSS over a number of years, including their own childhoods. However most referred to what had been happening in the past five years and were still actively in contact with CSS, including two mothers who had only just given birth. This allowed the research to explore the spectrum of experiences from the recent removal of a newborn through to the long-term adjustments required to live life without children or to witness their own children having their children removed.

3.2 Pathways into Child Safety Services

Parents were asked to describe the circumstances which led up to their first contact with CSS and to the removal of their children. Firstly, there were those who had been in OOHC themselves and where CSS had been a part of their life throughout their own childhood. In three cases this was intergenerational where their own parents had also been in care. They described childhoods characterised by abuse, neglect and instability (Robinson 2017). Two mothers were in the OOHC system when they first became pregnant. Although they described varying levels of support when they were in OOHC, they experienced a withdrawal of that support when they reached 18:

I was on the child protection myself. I was only 17 when I had Wesley. That was part of the reason they took him because things weren't going so well and I never had enough support. That was a big part of it. I wasn't actually in foster care, I was living in the moving on program and I had my own unit through them. There weren't really enough supports there and they weren't really helping like they were meant to. There were some notifications put in that were false and he was taken at a month old. (Emily)

I was placed in care when I was six. Every time the authorities came in my mother would run away with me. My stepfather was interfering with me and asked me to keep it as our little secret. School got wind that I was being mistreated at home and the police came and I was taken to hospital and examined quite extensively. At 12 I fell pregnant to this stepfather. My mother picked me up and threw me through some double sliding doors and I miscarried at 22 weeks. He [the baby] died in my arms. I left. I worked out living on the streets of Hobart was safer, a sense of family without being family. Those three years on the street were the best times in my life. I fell pregnant at 17 but not long after Madison was born he [her grandfather] started abusing her. I ran with her and I got put in a shelter and welfare got involved. (Amy)

There's an intergenerational thing there. My mother was under an 18 year child protection order, I was under an 18 year order, all my siblings as well. All 6 of us have been removed. I was one of those children who went back and fro. I think I was reunified with my mum about 12 or 13 times. I was 16 when I had my first child so I was still under an order. They didn't even look at me as in removing my babies. I had nothing but positive feedback about my parenting. But I was in a really violent, aggressive relationship with the children's dad, very abusive. Over the 12 year relationship there must have been over 20 notifications put in to Child Safety about the violence. Child Safety tried for a long time to get me away from him and tried at one stage to get me a unit where he wasn't allowed but I wouldn't go. So they decided to support me

with him. They started paying for rent, paying me a youth allowance, provided all the support financially for a having baby. They bought the cot and change table, bought me new furniture and all that sort of stuff, paid for the expenses. I turned 18 in August and Layla was born in November and it was a complete cut off from child protection, nothing. All gone. Not once did they come and knock on my door, not once did I get a phone call to see if I needed anything.

(Mary)

Secondly, there were those who had approached CSS for help, advice and support. This had led to more proactive involvement from CSS and, from the parents' perspective, a punitive response rather than the support they were seeking. One mother, having realised that her 6 year old daughter had been sexually abused by her ex-partner, approached CSS for advice in how to deal with the situation. Another sought help because she knew she was harming her child but didn't know how to stop. A third was seeking respite to help her cope with the behaviours of her children affected by cumulative harm from a previous domestic violence situation.

I am a self-reporter because I wanted support and help. I was hurting my daughter for love. She was three. I have borderline personality disorder which is under control now. I was telling my IFSS worker⁶ and she got someone from Child Safety to come and have a meeting with me and her around it all. Pretty much he said don't do it again and if you do we will remove your child from your care. I told people because I wanted help because I knew it was wrong. I just didn't understand what was going on. (Abigail)

The two boys were really full on, extremely full on. They were 8 and 4 and they were go, go, go and then I discovered they had ADHD, bad ADHD. I was getting phone calls, school was coming to me and saying these are the issues, behaviours were explosive. They put in a referral to St Giles and I have never heard back to this day from St Giles⁷. Things just started to decline in the way that I was able to manage the children. Because they weren't on any medication they never slept, I could never get them to sleep, on the go all the time. I rang Child Safety in November and said look I'm struggling to manage their behaviour, I am struggling to get them in to see a pediatrician, I need some help. What I was after was respite, a break. They took the children and got me to sign for 5 days and said that they would do an assessment. After the 5 days they said no, you're fine, gave the kids back to me and left me on my own. I said but I want help and they said without an Order there is nothing we can do. (Mary)

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6 Integrated Family Support Services (IFSS) support families who are struggling to improve their capacity and reduce their chances of entering the CSS.

7 St Giles supports children and adults with developmental delays and disabilities.

Thirdly, there were those who had experienced a long history of contact with CSS prior to removal involving a series of notifications as families struggled to cope with a range of issues including substance use and mental health problems. One mother fleeing a domestic violence situation with her children described how, over a prolonged period, the violence then escalated through a series of broken restraint orders. Despite her efforts to remove herself and her children CSS made it clear that unless she was able to break off all contact with her ex-partner this continued to be a safety concern which would warrant removal.

It was when my daughter, Nora, was first born. I was on the drugs and I was drinking. They had a meeting after my daughter was born in the hospital to see if I was capable of taking the baby home. I was 22 when I had her. I ended up taking her home with mum. They kept ringing up saying they were getting notifications. This went on until my boy was born. They were saying it was my violence and how boisterous I was. I ended up putting her in mum's care so welfare would stay off my back. Evan (her son) got out of hand and I went and asked for help. Mum couldn't look after him anymore and he got me into trouble with welfare. They made out I was neglecting the kids. So I asked for help with Evan and they came and got the girls. (Jackie)

However some parents reported no contact at all with CSS and no offers of support until they faced the reality of removal. They were unaware that notifications had been made and the first they knew was a phone call or a visit from CSS threatening removal.

3.3 Removal

Removing a child from birth parents is a difficult and challenging situation for all concerned: the birth parent, the children, child safety workers, health service staff, the police and any other support services who are involved. Removals can be planned where parents are involved in deciding how the removal will take place; for example handing children over in a CSS office. Some are removed from school or a day care centre and parents do not find out what has happened until sometime later or when they are notified by a phone call. Others are forced removals without the cooperation of parents and conducted with a police presence. These can be particularly traumatic for both the parent and the children involved.

Respondents were asked to describe what had happened when their children had first been removed. They had no difficulties in recalling in vivid detail the date, the exact time and the events as they unfolded. Initial removal episodes involved between one and six children ranging in age from newborn to 8 years old. Half of the parents had newborns or infants (under 12 months) removed along with their older children. For Kaylee, while her newborn was removed from hospital within a few hours of birth, her five other children had been removed from school and from day care at the same time.

Removal could happen quickly with very little warning. Janine had been asked to appear in court to be told her children would be removed. By the time she returned home the police were already there to remove the children. In other cases CSS and the police just turned up at the front door:

We had to be in court around 2.30. I hadn't been to court before so it was a bit nerve wracking. We went to court and they said they were taking the children and we had to get home. Pretty much when we got there they were there. A police car was there and I got my two year old snatched out of my hands by the police because I wouldn't hand him over. It was very traumatising. All I remember is him crying mummy no, mummy no. The police had to put my hands behind my back, not handcuff me or anything but put my hands behind my back. I just had to watch the car go with my boy in it. It was terrible. I didn't understand why all of a sudden. I'd had my boy till he was 2 years old and if they were on my case I don't understand why they didn't do it earlier. (Janine)

It was a Sunday. I had a friend down from Queensland with her two children. There was a knock at the door and it was Child Safety with the police saying they were removing my children. I tried everything I could to not give them my children. We tried to sign them over to my friend but she didn't live in Tasmania so it wasn't practical. They called the paddy wagon for Logan because he almost kicked the car door hinges clean off. He became really aggressive and abusive to the police. I heard the lady on the phone asking for a doctor to come out to sedate him. He was eight. Ryan, they couldn't catch him. They asked me to do it and I said I am not going to help you take my children. But there was nothing I could do and I walked inside bawling my eyes out. My friend helped them when she realised there was no way out and they would only end up arresting me. She said why don't I put them in my car and drive them to wherever you want. That's what ended up happening. (Mary)

Services described removals like a military operation where CSWs would carry it out quickly and cleanly. Although there was no nice way to do it they considered that if a removal was well done parents found it easier to accept. However, removals were also described as traumatic and many services noted their speed and the lack of emotional or psychological support for parents during the process and with CSS being the only service available. Some parents had a relative, friend, or partner with them during the process. Others were alone with no support at all:

He was lactose intolerant and we were struggling a lot with feeding. They said well go see the doctor and we did that. I came out from that appointment and was on my way to go and see my mum, but child protection were there waiting. Dan [the Child Safety Worker], ended up picking me up and saying we are just going to make a quick stop into Woodhouse [CSS office] and I'll drop you off.

I never thought nothing of it so I walked into the office with Wesley. A worker called me an unfit mother to my face and said we're taking Wesley, you have five minutes to hand him over or we are going to ring the magistrate's court and get him that way. So I had no say in it and I had to sign him over. They said are you going to give him a hug and I said no because I was too upset. They didn't understand that and I had to leave. (Emily)

Abigail had her baby removed while living in supported accommodation. She described being served orders during the process of removal:

I was called downstairs. I messaged my dad and said I need you to come. Child Safety arrived. They sat me down and said that today we are removing your child from your care. That was just it for me and I started crying and crying and crying and crying. They are trying to explain things to me but I couldn't hear it because at the time I was too distressed. They asked me to go and pack a bag for Ava. I was full on crying trying to pack this bag while my dad is holding my daughter crying. I am hysterical. I went back downstairs with her bag. He kept trying to give me papers and I said just put them down next to me, I was holding Ava at the time. He said no we need to hand them to you. I took them and they were court orders to take Ava. She was two and a half. I remember the date and the time, 1.30 in the afternoon. They were going to take her out of my arms or they said do you want to put Ava in the car and I said I'll put her in the car. I gave her a big hug and a kiss and said you're going to go on a holiday and mum will see you soon. I didn't know what else to say. (Abigail)

One interviewee had gone on the run with her child:

They told my partner there and then that they had been to court, got an order and were going to take Stella. Their concerns were our drug use and our violence. Pete said I'm not handing her over you will have to come and find her. We took our daughter and we hid for four days at someone's house. Welfare raided everywhere that they thought we'd be. They finally found out where we actually was and they surrounded the house and come in and took Stella. You are surrounded by all these cops and you don't want to give your kid up. It's just an instinct I think, a mother will run with them. (Bianca)

Parents were asked whether they understood the safety concerns CSS had about their children. Although a minority said they did understand, more expressed a sense of confusion about why the children had been taken, especially so suddenly, and there was often no clear sense of what exactly they had done wrong.

Having nothing tangible just added to their loss and to their sense of confusion and helplessness:

At the time they didn't tell me why she got taken. I didn't understand why they took her. When she went into care they tried to say she had fleas and mites and all this and she was acting sexual and everything. She wasn't doing all of that in my care. (Shirley)

If they did understand the safety concerns they did not necessarily agree with them or feel that the concerns warranted removal. They felt that information had been taken out of context or misinterpreted or false information had been provided by others with ulterior motives, for example by relatives who wanted to gain custody of a child. They said that their difficulties had not been recognised and that their children were removed without any supportive intervention or a comprehensive understanding on the part of CSS of the difficulties they faced:

We were looking after her. We might have had drug abuse, but we weren't doing it in front of her. She was cared for, she was clean. They even tried allegations like I had no blankets for her when I had witnesses say yes she did, she had everything she ever wanted. But they don't take that. They get on their high horse, we have the allegations, we're going to stick by these whether they are true or false. I have enemies out there who are going to ring up and put allegations in. (Bianca)

I couldn't understand how it was being thrown back in my face after having sought help for those concerns. There were reports that I was being abusive which was inaccurate. I don't deny I was smacking my children on the backside, I don't deny restraining my children when they become physically abusive or were trying to punch holes in the walls. They weren't medicated. We were experimenting to try and help the kids to sleep, to calm down. I didn't get a chance for the medication to work. I admit I had no parenting skills, they were pretty limited but I was dealing with ADHD. (Mary)

When I became mentally ill they grabbed at that as a basis for the decision to remove. But the reason I deteriorated was because of them. I had post-natal depression and they think that meant I would hurt my child. I would never hurt my child but I had said 'I feel like I'm going to hurt the baby'. What I meant by this was I would accidentally make the bottle too hot, or not change the nappy when I should, not that I would deliberately hurt him. But they misinterpreted that. (Laura)

At this point the key question parents ask is "what do I need to do to get my children back?"

3.4 The collateral consequences of removal

The period immediately after removal was described as highly distressing and confusing by parents. It threw their lives into chaos as they tried to deal with the emotional trauma of the loss and witnessing the distress of their children, accessing legal advice and appearing in court whilst trying to manage what could be a dramatic loss of income and the threat to their housing this entailed. At the same time they were trying to negotiate access to and contact with their children and meet any conditions imposed by CSS to address safety concerns. This period has been described as the 'perfect storm'.

The research literature highlights the way in which child removal compounds what are often multiple and complex problems. This was true for many of the parents in our sample. Any challenges they might have been facing prior to removal escalated after removal including housing instability, interpersonal violence, mental health and substance use issues. In some cases removal followed a period of intense CSS intervention or scrutiny where they were 'everyone's client'. Once the children had gone they were abandoned and struggling to find support. This could create a deep sense of injustice and 'moral injury'.

3.4.1 LEGAL REPRESENTATION AND ADVOCACY

The first challenge for most parents post-removal is accessing legal aid and advice in a short time frame. This can be particularly problematic when a newborn has been removed and a birth mother is having to find legal help and attend court within days or sometimes hours of the birth.

Child Safety matters are heard in the Children's Division of the Magistrates Court. Removal means a warrant from the Court, legal processes, lengthy affidavits and custodial arrangements spread over a period of days and followed by what was often a long drawn out legal process full of adjournments and delays:

It was a couple of days after removal that we went to court. They rang me at 9 o'clock to say you need be in court by 10 and you have an hour to get a lawyer. So I went through legal aid but there was nothing they could do so they adjourned it for another week so the lawyer could look into it. But he just stuffed me around even more. They didn't tell me what I had to do to get him home, they didn't tell me anything and I lost him even more because of the lawyer I had. He was only basically there for the money. He wasn't putting what I needed saying across. (Emily)

I didn't have a lawyer because a lawyer wouldn't represent me. I went to two different lawyers. I went into legal aid and they gave me a list of people to call. I called and some didn't have spaces. Three of them weren't taking on any legal aid and the two I went to knocked me back because of my case. Because

I was harming my child they thought she's not going to get her kid back so why should we represent her. That's how I felt. They just said they couldn't get legal aid funding for me. It got adjourned for a Section 52⁸ and I had to find a lawyer. That got adjourned and adjourned again until March. I had to have a psychiatrist evaluation for that. So from removal to the Section 52 in March was four months. That then got adjourned until July. (Abigail)

They described a potluck situation where they did not know whether they were getting good legal advice and representation from a lawyer that was on their side. Although some were very happy with their lawyer and felt that without their help there would have been a much more negative outcome, others felt poorly represented. They described how the good work they had done to address any safety concerns leading up to removal or while their children were in OOHC had not been acknowledged or taken into account in the decisions made by the Court:

I tracked down a lawyer who I hated, she was useless. My first court appearance, I remember standing there waiting for her to come over and have a discussion with me about what to expect and what my response should be or how I should behave or anything. But instead I just remember listening to her having her conversation about what she did that night, what she was wearing, where she planned to go out partying. And they got their order. I finally managed to switch over to who I have now after they got their first order and for the second order managed to get a different lawyer. (Mary)

In order to be granted legal aid an applicant must pass three tests: an 'income and assets test', a 'merits test' based on the likelihood of success in the court and a 'priority client test'. The applicant must fit into the priority client list as defined by the Commonwealth. Bianca described having no legal representation at all. She had tried and failed to get legal aid, was too confused and emotional to pursue it and ended up representing herself:

We have been representing ourselves the whole way through it. We thought we could do it on our own. We couldn't pay for legal representation and we couldn't get legal aid. I tried to get it and gave up. I went and saw the lawyer and the reason I can't get it is because it's already been to court. She also said legal aid don't like representing clients that are dealing with welfare because 99% of the time the clients lose and welfare wins. So then they won't give you legal aid. That means you have to pay for a lawyer yourself and someone on Newstart allowance can't do that. (Bianca)

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8 A Section 52 is a court convened conference between parties in proceedings to determine what matters are in dispute or to resolve disputed matters. It is presided over by a Magistrate or officer of the court and includes the legal representatives of the parties.

Parents identified two key issues in dealing with the court system. Firstly they were concerned about the use of ‘expert’ opinion, for example reports from psychologists or psychiatrists about their parenting capacity. Secondly they were troubled about what they saw as the misinformation presented at court in affidavits. They felt their words had been twisted and misinterpreted and were often taken out of context.

They kept sending me to places for reports, it was constant. There were so many things open to interpretation. They were looking for evidence to justify what they were doing. And it got very clouded and misinterpreted. I was talking with one psychologist about one former partner who used amphetamines. He didn’t record that properly and he actually wrote down that I admitted to having used amphetamines. That is on paper and I then had a history of drug use. (Laura)

Some of the stuff that was said was true but it was taken very much out of context. Logan was kicking holes in my walls and stuff like that. They said I had a lock on their bedroom door on the outside and that I was locking them in their bedroom. In actual fact I was locking them out of their bedrooms. They would get in there and trash it and I couldn’t keep up with the housework. I was by myself and they would trash them both. So I restricted the mess to one room. Logan also had lots of fears around spiders and refused to go to the toilet because of them. He would actually open his walk in wardrobe and pee and poo inside it and then throw his clothes on the top. So I started putting a bucket in there and would empty it in the morning. But with the lock on the door it looked like I was locking them in. That was one of the reasons they took them. It’s not a criminal court where it has to be proved beyond reasonable doubt. In a civil court it’s probability and risk is such a very big thing. They only have to throw a couple of those words in there like abuse and us parents are screwed. (Mary)

3.4.2 FINANCE AND HOUSING

The removal of children can cause a dramatic loss of income as family tax benefits and parenting payments are removed. This can immediately create difficulties in maintaining accommodation⁹. Most public housing is provided on the basis of the number of occupants. This means that the removal of children combined with a loss of income immediately puts housing at risk due to under-occupancy and no longer being able to afford the rent. For those living in or moving into the private rental sector the loss of parenting payments and a move onto Newstart Allowance makes accessing a private rental property problematic. These difficulties can be exacerbated by a common oversight on the part of parents or CSS to notify Centrelink of the change in circumstances, resulting in acquiring substantial

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9 See Fidler (2018) for a full description of the financial and housing consequences of child removal.

Centrelink debts. For at least half of the parents in our sample it meant periods of time when they were homeless.

As well as rental payments parents described numerous difficulties in being able to afford enough food, pay for utilities and fund the costs involved in attending access visits with their children or meeting a range of conditions imposed by CSS.

The boys were taken, there were problems with access. I was constantly trying to negotiate with my real estate agent so that we could keep the house. In the end I just thought I can't keep up with this. I was getting \$400 a fortnight from Centrelink at the time but out of that I had to pay \$150 a week in rent as well as firewood, tank water, travel, food, dogs, power. I had to leave the house. I had to pack up all the stuff and put it into storage and went looking for a place to stay with my dogs. Initially I went to the North of the state with my two dogs and stayed in a caravan park. Basically I just took off and hit the road. (Laura)

They removed my children, my pay got cut off. I couldn't afford the rent and ended up falling very far behind so I had to get out very quickly. It took three months for my payments to be cut off but obviously that landed me with a \$6,000 Centrelink debt. I had to pack up and get out and I didn't have anywhere else to go. I literally lived in my car for a good two to three months and then couch surfed here and there. (Mary)

Parents' attempts to take up employment and training opportunities had met a number of obstacles. Many employers require a Tasmanian Working with Vulnerable People Card. Getting a card requires the disclosure of criminal convictions and any involvement with CSS or family violence. The card is now required for a range of types of employment including casual work in McDonalds or Subway:

A child protection history has affected my ability to get work through our gardening business, particularly getting a public contract for work. We have been knocked back with contracts because of child protection involvement. In 2016 I applied for the Working with Vulnerable People Card and was told to supply more information. I provided psychiatrist and psychologist reports, reports from the school. It took three months to get it. Now I am concerned about being knocked back because of Ryan's removal. (Mary)

I wanted to do a course and needed the Working with Vulnerable People Card. I looked up Cert 2 in community services. I can't do it because I have to work with vulnerable people, adults in nursing homes. I can't do anything like that. It has really stuffed us up and made it impossible. It rules your whole life, every waking moment. (Cheryl)

In addition, meeting the requirements of CPOs or maintaining access visits, which usually take place during working hours, also affect the ability to take on employment. As one father said:

Since child protection has been in my life it's been impossible to have employment. I tried to work the show one year but it went against me because I was missing access. You can't go to a job interview. How come you can't come to work, oh I've got access, I've got child protection in my life and that's the end of the job. I can't do access and it stops the kids from coming home. You're sick and it stops the kids from coming home. Now I don't sleep much because of the trauma and everything that's gone on in my life. It's made me feel like I'm not safe on a work site now. I'm too fatigued, too run down, too drained all the time. (Adam)

A continual source of frustration was the lack of awareness among CSWs about their situation, the financial and housing challenges they faced and the tough decisions they had to make to survive:

The first time my kids were removed I was without money for a long time from Centrelink. I waited six weeks. I explained to the worker that I had to pack everything up and give the house up and she said why. I explained about the money situation and named it up for her what things cost and what I was getting. She said well I used to work for Centrelink and other people manage. I didn't like that woman. The workers changed so now I'm on my second worker. She actually said to me I don't understand why you moved out of your house in the first place. The workers had no idea about what people are forced to do to survive. (Laura)

3.4.3 GRIEF, LOSS AND TRAUMA

Having a child removed is an extremely traumatic and stressful experience, particularly in the absence of any support. It was described as profoundly painful and the cause of substantial ongoing emotional trauma. Reactions described by parents include grief, loss, shame and guilt and an overwhelming anger which made it difficult to think clearly, to cope with the situation or to absorb any information:

I did go through a grieving process. I was in denial. I was angry. I was furious when I read the affidavit. There were different aspects. I was sad for the first couple of months. I had to get rid of my daughter's stuff, her cot, her clothes. I remember one day going through her clothes crying my eyes out. I had to get rid of her toys. I had to get rid of it all. I sold it because I couldn't look at it. Every morning I would wake up and turn around and look at her bed and burst into tears. (Abigail)

The impacts of having no support in the immediate aftermath are numerous. Parents described the impact on their mental health, particularly those with pre-existing conditions, and many said they had become suicidal. The distress could lead to a downward spiral into depression, substance use and self-destructive behaviours:

It's cruel. I just wanted to kill myself after they took my kids. I didn't want to be here anymore. I feels like a part of you has just been ripped out. You just collapse to the ground, it's so cruel. It's like being on a rollercoaster, up and down, up and down because you don't know what they're going to throw out at you next. (Bianca)

They went into care. I had support within the community, like the social worker. I was seeing my own psychiatrist, I was on anti-depressants and it was helping. But things got really, really bad, my personal situation and everything else. I didn't cope with them taking the boys, and the boys didn't cope with being taken. I went to DPM (Department of Psychiatric Medicine) because I just wasn't feeling right, I felt I wanted to die. I didn't know what to do and my whole world was falling apart. I stood to lose everything and I did lose everything. I lost the house, I lost everything. (Laura)

Bianca described not attending court, not engaging with any services and spiraling down into increased drug and alcohol use:

From then on I just got stuck into drugs real bad because I couldn't handle it. It broke me. I haven't seen her since that day. I was on my own to deal with it myself. I was in such a low place and didn't have support. I was quite young then. I didn't know what to do, didn't know where to go, who to turn to. I had to give up or that's how I felt anyway. I just missed it all at court because I thought Leah would be better off where she was. I just let it go. (Bianca)

The stress impacted on people's relationships. In some cases it escalated pre-existing domestic violence or led to breakdowns and separation:

It caused much of the domestic violence because he was so angry. He has never been physically abusive, just arguments and yelling. He would have outbursts and call Child Safety cunts. So the situation and the stress of it drove the domestic violence, yelling and arguing. It also drove him back to drink as a recovering alcoholic. (Carol)

There was no time for us. We were just existing. We were not a couple, we had no time together. If we wanted to do anything it was how is this going to affect child protection? We want a family, we don't want to be separated. We split up from the stress. They have made it very, very difficult for us to get through. (Cheryl)

3.4.4 NEGOTIATING ACCESS

After removal parents' lives are overshadowed by negotiating the custodial arrangements for their children. This is a major issue for parents. Arrangements vary according to the circumstances, age of the child and the relationship with parents, but typically for a child on an interim 12 month order parents are offered a weekly one hour supervised access visit. Arrangements are progressed by the CSS case manager and the process can be protracted, leaving the parent with little or no access initially. In some cases after removal parents do not know where their child is and have no contact with them for weeks. The situation for parents who are homeless can be particularly difficult:

I didn't get any calls with them, I didn't know where they were. I had no relationship with the carers. It was about a month and a half before I got a visit with them. They got split between two different carers. It was difficult but that's what I had to live for, just those visits. (Mary)

Once access arrangements are finalised parents may be coping with a range of practical difficulties. Most access, at least initially, is supervised and organised in contact centres, on CSS premises, in public spaces and in the birth parent's or carer's home. Supervised access means that a support worker is present to monitor the access visit. The role of the support worker varies from observation and collecting evidence about parenting capacity to more proactive parenting support. However CSS access teams are poorly resourced leaving little flexibility in dealing with staff turnover or illness. This means an environment where visits are routinely cancelled or fall through at the last minute, causing enormous distress to parents. The unavailability of support workers can mean that what should be a weekly or fortnightly visit can drift to monthly contact with visits not rescheduled or the time made up. Parents did not necessarily know how to negotiate when visits were not happening on a regular basis or even whether they had a right to negotiate and to request more access. Many faced a continual battle trying to negotiate access for special occasions like Christmas or for birthdays.

Parents reported feeling intimidated by the presence of support workers. One mother described 'feeling under the microscope' when access was supervised by a worker with a note pad. Difficult environments for access visits, particularly when they were held in CSS premises, did little to improve the situation. Parents felt that the success or otherwise of visits was used to reward or punish them by increasing or decreasing the amount of access they had:

I finally got access one hour a week supervised at St Johns Park [CSS premises]. It was horrible. You were confined to the house and you're being watched like you're some sick disgusting perpetrator that can't be trusted to be around your own children. Every little thing you say and do is being jotted down on a piece of paper. It can very easily be taken out of context, very easily misconstrued into something different. (Mary)

My worker increased my access from an hour and a half to two and a half hours. I was allowed to take her out and it didn't have to be at Woodhouse [CSS premises] which is very sterile. It feels like a hospital. I could go to the park with a support worker which I enjoyed more than Woodhouse. Then they allowed her to come to where I lived and then it went to Good Beginnings¹⁰ who supervised and the Child Safety Worker would come for an hour afterwards to supervise. So I was getting about six hours a fortnight. Then other workers said we are going to drop you down to an hour and a half a fortnight. It was because that was all they could allocate me. I kicked up a stink and said no. I have never ever missed an access of my own accord. But they cancel them. (Abigail)

The practical difficulties and the surveillance could add to the distress of dealing with the visit itself. This might involve managing tensions with carers, witnessing the distress of their children and managing their own emotional reactions so that they did not impact negatively on the visit. One contact centre said 'we leave 15 or 20 minutes between drop off and pick up times and parent attendance' in order to better support parents (and carers) to cope with the situation.

It is hard. My daughter has found it difficult at a few stages when she was younger. She used to cry and all that kind of stuff. Since she turned 3 she's settled a bit. I put her in the car and she won't cry, she'll say goodbye. Miles is more difficult and lately I've been struggling to get him in the car without him gripping hold of me or crying and getting very upset. So that's very traumatising for me meeting them. It's not like I can go back and fix them after I leave. (Janine)

Access arrangements with newborn babies can be especially fraught. When removed from hospital newborns, depending on their medical situation, may be placed initially in the hospital nursery with the mother having unlimited access prior to her discharge. When she is discharged or when the baby is removed to a carer, access can reduce to a minimum of one hour a week. This can be very painful for parents, who may find it easier to disengage. This then affects their chances of being assessed as reunification ready. However when newborns are involved the mother may be given access several times a week especially if she is continuing to express milk for the baby:

He went into nursery care. He was in there for three nights and then he got taken away to a foster carer, the one he is still with today. I stayed in the hospital longer than he did. I was allowed to go to the nursery any time I wanted. (Janine)

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10 Good Beginnings is a national charity which delivers early intervention programs to families with young children.

I started having access with him three times a week and I also had this excellent worker from Good Beginnings. She was brilliant and helped me keep my milk going. She was so encouraging. Because the access had to be supervised it was at home. The child protection worker would drop my baby off and the Good Beginnings worker would supervise. She was a child health nurse as well. She helped me with bonding and lots of different techniques and little tricks. (Laura)

3.4.5 WORKING WITH CHILD SAFETY SERVICES

When children are removed from their parents they are typically placed either on a 12 month interim Order where there is the possibility of reunification or a long term 18 year Order where a more permanent placement is found until the children reach adulthood. Interim Orders usually have conditions attached requiring parents to address the issues which brought them into CSS and compromised their child's safety. They may be asked to seek treatment for mental health and substance use issues, to address family violence or separate from a violent partner, to find stable housing or improve their parenting capacity and household management skills.

At a time when parents are still reeling from the collateral consequences of removal, making these changes can involve reducing their substance use, undergoing regular drug and alcohol screening, attending appointments for psychological, psychiatric and cognitive assessments and engaging in interventions to improve parenting capacity or anger management. They described entering 'muddy waters'. Hoping children will be returned is integral to the experience of removal. Yet so many parents enter a period when they are unclear about the possibilities for reunification and what they have to do to achieve it. They described their efforts to meet any conditions imposed by orders or by CSS as 'jumping through hoops':

They had a list of all the things they wanted me to do and I did it. It included seeing a forensic psychologist, having reports done. I had to engage with a trauma psychologist. I had to have regular drug testing. Prescription drug use was my big issue. I ended up developing a huge addiction to codeine. I had to come off it and to get reviews of my medication. I had to engage in parenting programs, at least one and I've done two now. Making sure I had a stable home. It was awesome because they were looking at reunifying eventually. But then as time went on they had these hoops for me to jump through and they put the hoop a little bit higher or they would move it a little bit further away. (Mary)

They don't want me to have any contact with my ex and to attend family violence counselling. They want me to attend my psychologist appointments which are fortnightly and to see my GP regularly. They want me to do

Doorways to Parenting¹¹. They want me to see a psychiatrist and that accesses go on as normal. Because I have shown them I want to improve my life that's when they said we'll pay for a psychologist. I had to show them through doing things off my own back and then they rewarded me with funding. I feel that should be given to anyone with mental health issues. I don't think it should get to the point where a child is removed to say hey she's got borderline personality disorder, let's help her, let's give her some money. That shouldn't happen. (Abigail)

A number of parents commented on the assessments and information gathering which did not necessarily lead to any help. CSS can fund therapeutic interventions for parents where there are possibilities of reunification. This is not necessarily available to other parents even when their mental health state has been assessed as requiring attention. One mother described how she was asked to undertake psychological assessments, not to find out if she needed help but to assess how well she was likely to parent given the trauma she had experienced. Assessments are also undertaken in the months after removal when parents can be defensive, frightened, angry and facing the permanent loss of children.

I had to have a lot of assessments done and I pretty much failed. They think I've got pretty limited ability. I was sent to some place to do further testing. I failed that as well. I was upset and hurt because they said even if I fail it, it doesn't matter as long as I gave it a try. But it was all a lie and they never are honest. They think my ability of learning is just too low. They reckon I haven't got the capability of looking after them. (Janine)

A child psychologist said they were worried about how I might be getting on and that care should be given to watch out for mum's mental health. But they didn't do anything. They just kept information gathering and sending me letters to chastise me because I had done something they didn't agree with in access. Maybe the kids said they want to come home and I said yes you can. Then I get into trouble for that. (Laura)

Overall parents described trying to work with CSS and meet any conditions imposed but with little clarity about goals or the possibilities for reunification.

We kept being told for the first six months he'd be home, he'd be home. They will be home by Christmas. You are doing everything right. We have done everything we could to get our kids back. We went to all the courses and appointments, the family conferences, accesses, back and forwards up and down three times a day. When we first started with child protection our

11 Doorways to Parenting is delivered statewide by the Salvation Army and supports families at risk of CSS intervention or subject to an Interim Order.

affidavits were that thick. Now we've got them right down. But they still refer back to it all the time. Please see affidavit 2016. We've done everything they asked for and we're still here now. I don't get it. (Cheryl)

3.4.6 ANOTHER PREGNANCY

Among the parents who participated in this research the majority typically reappeared in the CSS system with a newborn or infant within three years of the first removal. Five went on to experience a third or fourth removal with the same or different fathers and within a shortening timeframe. In some cases they were already pregnant whilst in the midst of court proceedings for a previous removal. This means that as well as coping with the range of collateral consequences from the first removal they were now also dealing with a new pregnancy.

Service providers commenting on subsequent pregnancy emphasised the part played by hope; that parents felt their child would not be taken because they hadn't done anything wrong. As one family support worker said, having never been parented themselves they were unable to acknowledge any parenting problems they had which stalled their ability to change. Alternatively they may have the insight but not enough genuine support to facilitate change:

Having a child fulfills a need for connection and intimacy and someone who loves them. Repeat pregnancy is about a deep longing for love and empathy to counter a history of trauma, grief, loss by having a baby. They may never have experienced a healthy family environment. A child is removed and four months later and with the despair and the fact they're not thinking straight they are pregnant again and Child Safety is thinking we have to monitor you, another removal. With second pregnancies they constantly feel I can do it better this time. But if they don't understand why the child was removed initially they can't address any necessary changes. We see people reappearing across the spectrum of our services where needs have remained unaddressed. This 'ripple effect' is often overlooked. (Counsellor)

As other research has demonstrated, having another child was driven by wanting someone to love or to love them and providing another opportunity to prove they could parent and to get their other children back. Parents were asked how decisions had been made about having subsequent children and proceeding with a pregnancy. This is a difficult question to answer and it is not always clear either to mothers themselves or those working with them whether a pregnancy is planned or unplanned. Some described the pregnancy as an 'accident' where the turmoil of the first removal had led to difficult circumstances and little attention being paid to reproductive health or contraception. Despite abortion being considered a decision was made to continue with the pregnancy:

They were planned pregnancies for me yes. I was being abused constantly by their father, bashed all the time, put down, I was nothing but a bad whack that came out of my mum, awful things. So I had all this love to give but nobody really to give it too or no one who really appreciated it. So a baby for me was that. I could give someone the love and the care that I had inside. (Mary)

He was a very big shock, put it that way. At the time everyone was upset because they thought you're going to get this child taken from you. But I lived in hope. We were happy about the pregnancy but we knew the consequences and I was nervous throughout the whole pregnancy. An abortion was on the list only because of what I was going to go through. It's hard to explain. I didn't know if I would be strong enough to go through it. But I went and saw my baby on the screen and thought I have to keep this baby, I'm going to do it. It was really hard for me because you can feel him kicking and buying all that baby stuff. But at the end of the day we really wanted a child. (Janine)

I let the child safety worker know that I believed I was pregnant. She said you have five children in care, why are you pregnant, are you sure you want to have the baby. I said yes. But she just kept hinting about my options. She almost convinced me. I went to family planning, I felt like I had to explore that option. I was thinking, come on toughen up, these kids were here first, deal with what's here first. But it was against my values. So basically I didn't go through with it. I went to the appointment and the whole time thinking they are going to kill my baby and I don't really want to do this, why am I here. It is my belief that you meet someone, you have children and you raise a family together. That is my life's purpose. It is what I know and what I am here for. It's just who I am. For me it was like I have purpose, it kept me going and with life comes hope too. The thought that with this one I can get my others back because I can prove myself. I can start afresh. (Laura)

3.5 Recurrent removal

When women reappear in court, typically with a new baby, it suggests that removal has not provided a solution to their problems or ameliorated the risks that these problems might pose to the safety of their children. Given the perfect storm generated by the collateral consequences of initial removal, a key question for this research was to explore what happens to parents between a first and a subsequent removal, between the conclusion of court proceedings for one removal episode and the start of proceedings for any subsequent children. If there are no interventions made to support parents after a removal and to address their concerns how far does this increase the risk of a subsequent pregnancy and further removal?

Services identified a number of characteristics among those experiencing recurrent removal:

- teenage pregnancy and motherhood;
- transgenerational disadvantage with a history in OOHC and trauma;
- a cycle of poverty;
- difficulties in acknowledging problems and/or having the ability to change; and
- a lack of adequate parenting skills including behaviour and attachment issues.

They described a spectrum. At one end there are those damaged by intergenerational disadvantage and trauma and longing for a family to 'make things better' and repair their histories. They may never have experienced a healthy family environment and face a long journey to be able to parent safely. At the other end of the spectrum are those who, given good legal representation and support at the right time, can parent effectively. In the middle are those families who are able to retain custody of their children if sustained support and case management is available:

Sometimes it's just they don't have the skills but no one has been there long enough. No one has created an atmosphere and a relationship so that person sees they have the ability to gain those skills. They might have the desire but they haven't made the right connection to be able to work through that and develop skills. Or the organisation hasn't had the flexibility or the funding to put what is really needed in place. (Support worker)

As parents demonstrated, initial removal had often exacerbated the problems they faced, led to a deterioration in their circumstances and overlaid their experiences with extreme psychological challenges as they dealt with the grief and loss and tried to maintain relationships with their children in OOHC.

Pregnancy provides a window of opportunity to identify and work to address any safety concerns and there are systems in place in hospitals to respond to this. These include identifying vulnerable pregnant women where there is a risk to the unborn baby, coordinating support through pre-birth inter-agency meetings to assess and make decisions about any safety concerns and provide support to the family. Decisions about removal will be made towards the end of the pregnancy. Parents were asked about any contact they had with CSS during their pregnancy and any support they had been offered. They reported a range of experiences. Some had proactively informed CSS about their pregnancy and been involved in pre-birth conferencing. Others had become aware that there was a UBA but had no contact during the pregnancy with CSS beyond what was required to facilitate access to their other children. But there were also those who were not aware of any UBA

and reported no contact with CSS. Both mothers and services working with them painted a picture of surveillance rather than support during their pregnancies:

I think they had a couple of baby alerts on me, I'm not quite sure. I actually found out the hospital puts them on you. So it was just contact about Alice [her daughter in OOHHC], nothing about my baby or nothing. They never brought it up throughout the pregnancy. They notify welfare if I'm doing anything wrong or if I don't turn up to appointments but I went to all my appointments. I didn't seem to have a reason to be worried, they had no reason to take him off me. I was doing everything right. (Shirley)

We didn't even know there was an unborn baby alert on her. Until she was born we knew nothing. I even went and bought things because they told me she was coming home. I went and got everything to prepare and it was a waste of money because she wasn't coming home. They didn't give me the time of day. They were only telling me part stories of what to do, not everything so they were trying to make me fail which they did. It was horrible. All they said was half stories, do this, do that but they weren't telling me everything. She was in hospital for a week and they took her from the hospital. They sent me home 24 hours after she was born. (Emily)

The first thing I did was not tell them I was pregnant, I wasn't honest. I wish I had of been but I was scared at the time. I didn't want to lie to them and wanted to do the right thing and have a chance with my son. They pretty much told me there was a very high risk that he would be taken and they did take him. They kept promising me that I could probably have a chance through my whole pregnancy. They didn't exactly say I could have a chance but I was pretty much getting my hopes up and that's what I did throughout the pregnancy, get my hopes up. When I was pregnant I was proving myself. I let them see everything that I bought him and they said I'd done an amazing job. I had a C section with him and my partner gets a phone call saying we can keep the child. Then they take us up to the maternity ward and they [CSS] were there. (Janine)

Many mothers described a lack of clarity about their risk of removal which could last right up to the hours after birth. They described constant reassurance during the pregnancy only to have their newborn removed within a few hours or days of birth. Others had given birth expecting the baby would be removed to find that they were then allowed to take the baby home. Parents described the fear, anxiety and stress of not knowing whether they would be able to keep the baby. Services described the levels of stress and anxiety of parents as 'extraordinary'. One woman said 'the whole time I was paranoid and kept saying are you going to take my baby'. This fear meant that one parent had avoided all antenatal appointments and had gone through an unattended birth.

Laura described how the fear of removal had prolonged her labour:

They were asking me questions like when are you due, what's the exact date. So I said are you planning to take this baby. I was pretty much planning that my baby was coming home with me. But I was also suspicious because of the conversations I'd had with them, I didn't trust them. I was really scared. My labour went on for ever and ever. A few hours into it when it was just me I opened up my file not far from my bed and flicked through it. I noticed it said alert placed on file, CSS need to be notified immediately this baby is born. I just didn't want to give birth after that and I sometimes wonder whether that had anything to do with it. I just didn't. I felt like I was holding back. (Laura)

Cheryl described how she had been allowed to take her baby home only to have him removed some hours later from her home:

Nolan came along 12 months after the girls were removed. About a month before he was born child protection said he was coming home. They told us there were no UBAs and that he is coming home, make sure you have everything ready. They told me I'd done a complete 360 since the girls were removed. But four weeks before he was born this CSW came back off leave and there were four UBAs apparently. On the day they released us from the hospital child protection never showed. We left and we were home with him for six hours. Then at 7 on a Friday night there were six cop cars, two child protection workers, with two phone warrants to take him. As they were walking out of the yard the two workers were laughing to themselves and having a joke as they walked away. (Cheryl)

During pregnancy, and because applications for CPOs are not issued prior to birth, few parents had access to any legal advice or help unless they were already in contact with a lawyer assisting them with their other children in OOHC. Kaylee described how legal advocacy had been crucial for her in arguing that her circumstances had changed from the previous removal and reduced the risk she posed to her unborn child:

I was terrified about what might happen. I didn't go to any ante-natal appointments. They put a baby alert on him. I didn't know that until I went into hospital. I was terrified and thinking there we go again, they are taking another baby off me. I didn't trust any of them. I didn't trust the male doctor down there at the hospital. I didn't trust the GP down at the medical centre. I didn't trust any of the hospital doctors. No one got close to me. The lawyer was there round the table with child protection and told them to back off from my client, leave the baby alone, stay away from the baby, don't put your hands on the baby. She is in a different relationship with a different partner and they all backed off. I still feel really unsafe with child protection and I've lived in fear. It's horrible. My story is about living in fear. (Kaylee)

Pregnancy can present a crucial opportunity to initiate change and build on parents' motivation, address safety concerns and change circumstances. Both Emily and Jackie described their drive to change their circumstances during pregnancy so that they could avert another removal.

They wouldn't even give me the time of day with Mia and they were going to do the same with Brandon. We called them and told them I was pregnant so we did the right thing and they knew from the start. I had separated from his father and I was doing everything to move in here [supported accommodation] to give me a chance. I broke down in front of [the support worker] and said this isn't right I should have a chance. I want to prove that I can do it and I am not the person I was. She said what about if we get you in here [supported accommodation] for the rest of your pregnancy, you do everything they want you to do which was see a psychologist, keep all my ante-natal appointments, keep all my visits with the girls, do parenting courses and all the supports through here. I only had eight weeks left to go so it was rush, rush, rush. I've been doing everything. Child protection said we'll give you three days a week for four hours each day access. It's much better now that I've got the supports around me and because I'm proving I'm doing everything right. (Emily)

When the girls were taken I just started going back downhill again with the drugs. It was horrible. And then I was pregnant and still trying to get off the drugs. I went and told child protection about the pregnancy and they said just keep on doing the right things. They kept on asking questions and I told them when I messed up. I thought having everything ready for Bryson would have helped and that I wasn't hanging around with the people I was hanging around with before. I thought that would have helped. The clinic swapped me over with the methadone because they said the baby was getting it all. I also went into rehab before he was born. I wanted help. I wanted to get off everything. I wanted my kids, I wanted them all together. I thought I had a 90% chance of keeping him. (Jackie)

Emily also described how she had taken her second child home but then experienced removal some months later. Living under the shadow of CSS meant that she was reluctant to seek medical attention for her child in fear of reigniting CSS interest in her circumstances. She also described that, despite struggling, she was reluctant to engage with services more generally and seek out the support she needed in case it led to further notifications.

3.6 Removing newborn babies

The process of removing a newborn baby can be especially traumatic for all involved. Through the pre-birth conferencing process CSS will try to involve parents in planning the removal and the way in which they would like it to occur. However among parents in the research there had been little involvement in removal planning. Removal came as a complete shock and the reassurances they had received during pregnancy meant that they felt deceived and lied to. Women spoke about the trauma of removal, the embarrassment and shame of having their baby removed in a public space like a hospital and having to leave the hospital without a baby:

I had a C section. We went up to the ward and I was holding my baby. They said if I don't hand my baby over they will get the police. At that point I was still holding my baby and I didn't hear them for a long time. He went into nursery care so I had a chance to say goodbye. I was allowed to go to the nursery any time I wanted but then I got told to go because it was time to take him. He was in there for three nights and then he got taken away to a foster carer. I walked out of hospital without my boy. I just felt devastated. I've been traumatised and am wearing the scar but I don't have my baby. That's how it feels. (Janine)

They popped him on my belly and he was fine. I had my shower and that sort of stuff and then was admitted to the ward. I gave birth at about 5 in the morning. I think it was about 10.30am. I thought now I can finally sleep and two men came in from child protection. I hadn't met them, they were new. They introduced themselves, one was the case worker and the other was the team leader. There was a midwife hanging around in the room and another lady because it was a shared room. They both stood at the end of my bed. He couldn't have said it any louder. He introduced himself and said the decision has been made that Jack is going to be taken into care. There were other people in the room, another family. Oh how embarrassing, oh my god. There's a happy mum over there and look what's happening here. The nurse nudged them and said guys can I take you up to another room please and she did up to the birthing room. I shouldn't have been told like that. (Laura)

Post-removal, parents described a number of challenges. These included having to access legal advice and attending court within days of the birth when most women are instructed to rest. They also included making decisions about breastfeeding. This presented a host of challenges including difficulties in expressing milk, accessing breast pumps and getting the collaboration of carers and CSS to pick up the milk and to use it:

I was told I had to stay in the hospital for five days with him and then the hospital wanted my bed. They put my baby in neo-natal as a boarder and told me to go home. I could come into the hospital when I wanted to see him. I

was breastfeeding and I couldn't keep up with it. I did try and explain that to them that I wanted to keep my milk going and I couldn't seem to. You just produce what your baby needs and they take what they need. They said well get a breast pump. But of course you can't do that all the time. You need your baby with the hormones but they didn't seem to understand that. I asked the hospital for a breast pump. Because I was discharged they said no there are other mums that need it. I was trying to chase up a breast pump with different chemists because I heard you can hire them. I said to the child protection worker, can you get the foster carer to send my baby's dirty clothes home so I can wash them. He said yes sure, that's fine. It was not only because I wanted to wash them, my baby's little things, but the smell of my baby kept my milk going, it worked. He went onto formula which I wasn't really happy about.

(Laura)

Apparent from the descriptions of mothers was the lack of emotional support during and immediately after removal. They described attitudes from hospital staff ranging from helpful and supportive to disruptive and cruel. One woman said 'they were really mean to me in there because they knew I was a child protection case'. But often nurses and midwives were the only support available.

Worryingly, Gill described being discharged from hospital after her newborn was removed with little attention being paid to her own medical needs. Another mother commented 'they only checked on me once after he was born, they didn't care'. Service providers also described cases they had worked with where a quick discharge after a removal had failed to identify ongoing maternal health issues:

The birth was really quick. I just had him and they just took him straight out to the carer. I got dismissed out of hospital and I wasn't well at all. I was really sick and horrible. I was so down and had no energy. I couldn't walk. Because I was so in pain I didn't want anyone touching me. I couldn't drive for 12 months and I was in pain all the time. It was a prolapse but it wasn't really diagnosed and because the baby wasn't in hospital anymore I was discharged but I couldn't move. I was struggling and I told them I was in pain. They did give me tablets, painkillers, but I needed more. I argued with the doctors over it but they wouldn't give me any more. I had to be in court the next day but I couldn't drive and then they said to me don't you want to have anything to do with your son. They were so cold. When I was supposed to be in court I was in so much pain I thought I was going to collapse. (Gill)

3.7 In summary

The research revealed:

- A highly vulnerable group of parents with histories in the OOHC system and high rates of mental health issues, substance use and contact with the criminal justice system. In addition they also experienced financial problems and insecure housing, abusive relationships, isolation and low levels of education and employment.
- Pathways into the child protection system which reflected risk assessment and monitoring rather than the identification of need and provision of support. This was especially the case for young mothers in and exiting OOHC.
- Removal processes which were traumatic for both parents and children and in the absence of any specific emotional support for parents. Confusion about the reason for removal and lack of understanding about safety concerns added to the 'black hole' which parents encountered and to their sense of injustice and moral injury.
- A range of collateral consequences after removal which reduced income, threatened housing and overwhelmed parents with grief and loss. At a time when they were having to deal with legal processes, meet any conditions imposed by CSS and maintain access to their children, the system-induced trauma exacerbated their vulnerability making it more difficult to cope. This was described as a 'perfect storm'.
- Removal without adequate levels of support to the parent increased the risk of a rapid subsequent pregnancy. Recurrent removal came on top of increased vulnerability and was typically characterised by pregnancies which were monitored rather than supported and which induced high levels of anxiety and uncertainty about whether newborns and infants will be removed.
- The removal of a newborn or infant from a mother already experiencing deteriorating circumstances and unaddressed grief compounded her difficulties, impacted on decisions about risk and safety and reduced her ability to deal with legal, court and CSS processes and meet the conditions attached to orders.

It becomes a self-fulfilling prophecy by Child Safety. They remove the children mostly for quite justifiable reasons because they need to be kept safe and that the parenting is poor. The removal throws the parent into this spiral and reduces their income which reduces their ability to actually connect with the child and proves that their parenting wasn't good enough. So Child Safety thinks they have done the right thing and we have this self-fulfilling prophecy about parents rather than helping them to be a better family unit. (Support worker)



CHAPTER FOUR

Getting help
and support

When children are placed under a Child Protection Order there is no statutory obligation to provide support to their birth parents. Despite their vulnerability, a CPO does not elicit any automatic pathway to assistance. In an environment of multiple and fragmented services operating with limited resourcing parents find themselves struggling to access support they can engage with and is appropriate to their needs. Whether they find it or not is more a matter of luck rather than design. Parents experiencing recurrent removal are often described as 'hard to reach' or 'difficult to engage'. Parents involved in the research might better be described as the victims of 'too little too late' or in some cases 'too much, too late'. One mother said 'there is no support post-removal, you are left to fend for yourself'.

This chapter describes the network of services working to support families in Tasmania and parents' experiences of accessing and using them. All interviewees were asked what kind of help and support had been available to them to deal with the challenges they faced prior to removal, during removal and post removal as they struggled with the collateral consequences. They were also asked about the consequences of accessing or not accessing support and what impact these experiences had had on them longer term, on their parenting capacity, on their children and on what kind of future they pictured for themselves.

4.1 The service network

The Tasmanian Child Safety System works to secure the welfare and safety of children who are considered to be at risk of child abuse or neglect and to assist families to better provide a safe environment and improve their parenting capacity. In addition there is a complex network of programs and services which support families to care for their children. However few are targeted to the specific needs of parents who have had their children removed or who experience recurrent removal. This means that parents may be accessing a range of services which, although supportive, cannot necessarily respond to their specific needs. There are also regional differences and the availability of services and their practice varies across the state. What is available in the South may not be available in the North or North West.

4.1.1 THE CHILD SAFETY SYSTEM

The *Children, Young Persons and Their Families Act 2013* provides the legal framework for Tasmania's Child Safety System. The object of the Act is to provide for the care and protection of children in a manner that maximises a child's best interests and which recognises that a child's family is the preferred environment for care and upbringing. A child should only be removed from the family if there is no other reasonable way to safeguard wellbeing. If a child is removed then:

- the family is entitled to be treated with respect at all times;

- contact between the child and family should be encouraged and supported to preserve and strengthen relationships whether or not the child resides with the family; and
- eventually the child should be returned to the family.

The Tasmanian Government has responsibility for safeguarding the wellbeing of children and, if required, assisting families in fulfilling their responsibilities for their care, upbringing and development. The current redesign of the Child Safety System in Tasmania is promoting a more integrated system which can better engage with families who are struggling and provide more holistic support through Intensive Family Engagement Services (IFESs) to those in crisis in order to avert removal into OOHC.

Generally families come to the attention of Child Safety when someone is concerned about a child's wellbeing and makes a report or 'notification'. An initial assessment is made by the Intake Team and information gathered from the notifier and other services to make a judgement about any immediate safety issues. If the assessment concludes that further assessment is required the case is passed to the Response Team which carries out an investigation. The Response Team will meet with the family, talk to the child and collect further information from any other services involved to identify safety issues and consider how they might be resolved. If the investigation finds continuing harm or risk to the child the investigation is substantiated and a decision made about applying for a Child Protection Order through the courts. The case is then passed to the Case Management Team and a case manager is allocated to oversee the development of a case plan for the family. The plan may include the referral of parents to a range of services to promote their ability to care for their children and address safety concerns.

There are a range of Orders available to protect children:

- **Assessment Orders** are usually for a period of 4 weeks and allow time for specialist assessments to be carried out with both parents and children. During this period the child can be removed temporarily into OOHC or remain with their family, and parents may be required to address safety concerns, for example by attending parent support groups. Assessment Orders can be extended for a further four weeks if required.
- **Care and Protection Orders** are issued if it is decided that the child requires longer term protective intervention. Orders may impose conditions on the parents to improve their parenting capacity or address their needs. The child is removed to foster, kinship or other care. There are:
 - Short term or interim Orders. Recent changes to the legislation mean that these can be flexibly applied from 6 months to 2 years to tailor them to the circumstances of individual families. During the life of an interim order parents have contact with their children usually through supervised access; and

- Long-term Orders. These place the child under the guardianship of the Secretary of State until they are 18 years old. Although access is decided on a case-by-case basis it is often restricted to a few times a year.

At every stage in the child safety process risk is assessed using the Tasmanian Risk Framework which provides a tool to guide child safety practitioners to assess the risk of harm to the child. In addition the redesign process is promoting the full implementation of the Signs of Safety Framework across the Child Safety System. This is a risk assessment, family engagement and case planning framework which involves families in identifying and responding to safety concerns and developing a Safety Plan.

4.1.2 TARGETED SERVICES

There are three programs which specifically support parents when children have been removed:

- **Salvation Army's Doorways to Parenting.** This operates statewide providing support for families both pre- and post-removal of children. It offers a four-tiered model:
 - supervised access both in-home and through a playgroup;
 - parent education groups including Circle of Security, 1,2,3 Magic and Bringing Up Great Kids to address attitudes to parenting, attachment, discipline and insight into how to break cycles of behavior;
 - individual counselling and case management; and
 - post reunification support

The work includes an intensive 10 week therapeutic group program, SPARK, for those who have children in care. This explores issues of loss and grief, parenting skills, family violence and information about how to work with CSS, the legal system and address issues to do with access to their children. Although primarily working with those families where there is a chance of reunification, they also support parents whose children will not be returned. Parents can be referred to Doorways by CSS, by other services or self-refer. The program operates to full capacity with a waiting list. It can take up to six months for parents to access the program.

- **Parent and Family Advocacy Service (PFAS)** is run by the Red Cross and operates in the South of the state. It was established in 2013 as a pilot to provide advocacy for parents dealing with CSS and legal processes, assist them in their communications, support them in meetings and court hearings and develop self-advocacy skills. Its future is currently under review. It operates on a peer advocacy model with one paid part-time coordinator and volunteers. It is currently working with over 30 families but reliance on

volunteer support means it has limited capacity to meet the needs of parents and operates with a waiting list.

- **Pathway Home** operates statewide and can provide wraparound support to families who are reunifying and post-reunification support for up to 6 months. Families cannot nominate themselves to the program for reunification but are referred in by CSS. Not all reunifying families are referred to Pathway Home and some are managed by CSS in-house.

There are also a range of organisations providing supervised access facilities for parents separated from their children. Some of these will be used by families with children in OOHC. Doorways to Parenting and Contact Play and Learn run by Save the Children work with parents whose children are in OOHC and provide supervised access in a playgroup environment, assistance to develop parenting strategies and the modelling of parenting behaviours.

4.1.3 MATERNITY AND HEALTH SERVICES

Particularly relevant to supporting parents experiencing recurrent removal are the procedures in place in maternity hospitals to identify and work with vulnerable women who present as a risk to their unborn babies. At the Royal Hobart Hospital the key strands of these processes are:

- **Psycho-social assessments** generally conducted by hospital social workers when women book in at 20 weeks gestation. The assessment can act as a trigger for CSS involvement.
- **Complex Care Antenatal Clinic.** This was established in 2006 and works ante-natally with women with complex psycho-social problems, addiction and mental health issues. The Clinic offers case management, care coordination and access to support. About one-third of their patients have CSS involvement and/or have been in OOHC themselves. They are unable to work with women post-natally but during the ante-natal care phase they can refer women to external support services.
- **Unborn Baby Notifications and Alerts (UBAs).** These processes provide for the earlier identification of safety concerns and referral to support services where necessary. They are coordinated by the Child Safety Liaison Officer (CSLO) and involve an initial invitation to parents and family to voluntarily engage in an assessment process to prevent the need for CSS intervention at birth. If the level of risk identified is high it triggers an Unborn Alert and regular multidisciplinary meetings attended by health and social work staff and any other relevant agencies including drug and alcohol service, family support and the Tasmanian Aboriginal Centre. Chaired by the CSLO, the meetings discuss the alert, whether it requires further investigation and how to meet support needs. UBAs commonly progress to the Response Team for further

investigation and to ascertain the safety of the unborn child post-delivery. Where the family already has children in OOHC these matters will generally be managed by the same Child Safety Officer. A CSS Admission Plan will be developed and distributed to all stakeholders. The Plan provides guidance to hospital staff about CSS involvement and plans for the unborn child. In most cases families are made aware of the UBA. However if they are identified as a high risk of causing harm to themselves or the unborn child or considered to be a flight risk they are not informed. These processes can be restricted by late booking-in and high caseloads. They are carried out within the Signs of Safety Framework to maximise family involvement and support collaborative decision-making. Although parents are encouraged to participate many do not engage with the process.

- **The Perinatal Mental Health Service (PIMHS)** established by the Child and Adolescent Mental Health Service provides a specialist team of psychiatrists and psychologists to work with pregnant women affected by mental health and psycho-social issues, domestic violence and substance use. Women are referred by maternity services or their GP. The team can work therapeutically with them during the pregnancy but is limited to making referrals once the baby is born. In the past 12 months 216 women have been referred antenatally for assessment, with 36 presenting as a risk to their unborn baby or to other children. PIMHS works closely with CSS and attend UBA meetings. An identified gap is their inability to offer intensive therapy which can work with the whole family both pre- and post-natally.

Services working with at-risk pregnant women are most developed in the South of the state. There is currently no PIMHS in the north and north-west and no Complex Care Antenatal Clinic outside of Hobart, although there has been lobbying for a state-wide presence. The role of CSLO has been developed in the South and is only recently being implemented state-wide. These regional differences constrain both the identification of at-risk women and the kind of work which can be done to support them during pregnancy.

4.1.4 POST-BIRTH SUPPORT

Once babies are born a range of services are available to support parents who have custody of their infants. None are specifically funded to work with non-custodial parents unless they are placed on a reunification path, yet they may at times be working with parents whose children are in OOHC or with vulnerable pregnant women to provide support. They include:

- **Child Health and Parenting Service (CHaPS)**. CHaPs is notified of all births at Tasmanian hospitals and provides universal home visiting and child checks made at regular intervals. They also offer an enhanced home visiting program if families are assessed as needing more due to post-natal depression or

other difficulties and referral on to other services including CSS. Enhanced services include CU&Home for young first time parents aged 15-19. This offers home visiting during the ante-natal period and until the child's second birthday. CHaPs is limited to those who have care of their children, although they may work antenatally with vulnerable pregnant women.

- A range of services supporting the parents of young children. **Newpin**¹² is the most intensive. It offers therapeutic intervention and parenting support over a two-year period. Although eligibility for the program targets custodial parents or pregnant women, it can also work with those whose children have been removed and are on a reunification path.
- **Integrated Family Support Service (IFSS)** through Gateway¹³ works with families who voluntarily engage to achieve self-identified parenting goals. Once CSS are involved and children are removed families are no longer eligible, but a small number may continue to engage if they have other children still living at home. This continuity can be highly valued by families who have developed positive working relationships with IFSS support workers.
- **Good Beginnings** is a volunteer family connect program. It is able to work with parents and address parenting capacity in families who may only have their children during access visits.

These services can deliver a range of parenting programs to improve parenting capacity. These range from low level support with parenting suitable for the general population to more intensive work to address childhood trauma and its impact on parenting and attachment behaviours which is suitable for non-custodial parents. Programs include Bringing up Great Kids¹⁴, Circle of Security¹⁵ and Theraplay,¹⁶ which focuses on rebuilding or establishing the bond between mother and child. The Parenting with Feeling Program teaches those with mental health issues how to better interact with their baby. Marte Meo¹⁷ uses film taken during access visits of parent/child interactions to feedback to parents and improve parenting capacity.

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- 12 Newpin - New Parent and Infant Network - is a therapeutic program which aims to break intergenerational cycles of disadvantage, poverty and poor parenting. It is intensive and is aimed at parents who have been identified as being at risk of CSS intervention.
 - 13 Gateway provides a one stop shop for families with a range of needs to prevent them from entering CSS.
 - 14 Bringing Up Great Kids is a suite of parenting programs produced and supported by the Australian Childhood Foundation.
 - 15 Circle of Security parenting program supports the building of secure parent-child relationships.
 - 16 Theraplay is child and family therapy for building and enhancing attachment, self-esteem, trust in others and joyful engagement between parent and child.
 - 17 Developed in Holland in the 1970s, Marte Meo focuses on the importance of communication in the building of relationships and emotional connections, or the 'how to' of attachment.

4.1.5 RESIDENTIAL SERVICES

Although not specifically targeted to this group of parents, there are residential services which may house and support pregnant women and women with children in OOHC or at risk of removal. These include:

- **Women's shelters** across the state providing temporary accommodation and support for those with or without children.
- **Small Steps**, run by Hobart City Mission, targeting young mothers at risk of losing their children due to homelessness and/or lack of support. Small Steps provides 12 self-contained bedsit units and 24-hour support from a volunteer coordinator living on site. It offers a suite of programs including parenting, a playgroup and re-engagement with education. Residents can stay for up to two years and over half are known to CSS, with a number working to progress reunification. City Mission has recently received funding to establish accommodation for homeless parents to enable families to stay together.
- **HOPES** (Housing Outreach and Parent Employment) in the North West is run by Anglicare. It houses 9 young mothers aged 16-25 at risk of homelessness. A number of residents have a history of being in OOHC and have experienced the removal of their children.

4.1.6 POST-REMOVAL SUPPORT

What support there is for parents post-removal comes from mainstream services like health and maternity services, mental health, drug and alcohol treatment services and legal services and from a diverse range of programs offered by community service organisations (CSOs). These might provide support with mental health and substance use issues, family support, housing and homelessness, counselling and emergency relief. Parents are referred in by CSS to tackle particular issues like parenting, anger management or to access counselling, or they may self-refer for help with a wide range of issues generated by the collateral consequences of removal.

Few, however, are targeted to this cohort of parents and dealing with child safety issues is not their core business. They described working with parents involved with CSS as working 'by default'. Child safety is often not the presenting problem. Nevertheless as relationships develop with support workers parents will increasingly reveal their difficulties with CSS. These services can provide:

- immediate financial or material support through brokerage funds, emergency relief and food vouchers. This can include help with transport, the costs of medications, part payment of utility bills, clothing and budgeting assistance;
- assistance in dealing with Child Safety including helping with communications, understanding processes, support at meetings and during court proceedings, help in negotiating access visits;

- referral to other services and providing letters of support; and
- emotional support and a listening ear to deal with the trauma and loss, anger and frustration.

One support worker described her input:

They were referred by Child Safety because they stipulated you must work on your relationship and do alcohol counselling. But what I do is support them through the process in so many ways. Sometimes they come and say they feel so angry. If they actually ring the department and get stroppy then there is a black mark by their name. It's about keeping them as calm as possible and trying to normalise the behaviour and we would all feel angry in that situation. I think it was just resignation at first. That's it, the children are gone now. But then she got herself clear of drugs and alcohol and then wanted them back. I have been supporting them for some time and it really has spread out to the whole reunification process. When they come to me I think they leave feeling a bit more hope and think yes let's just keep going and we'll get there. One of the saving graces is that they can come in and talk to someone about how they are feeling, the frustrations they feel and for someone to say yeah it's quite normal to feel that. (Support worker)

Community-based mental health support and recovery services were especially involved in working with parents post-removal. A number described the removal of a child as a fairly common precipitating factor in suicide attempts, where the suicide attempt had brought them into contact with the service. They described the risk of suicide as being high on anniversaries like the day children had been removed or on birthdays or at Christmas:

I am working with a couple of young women who have made a suicide attempt following removal. In one case it's a young lady who is 19. She tried to hang herself late last year while she was about six months pregnant in anticipation of child protective services removing her child. She had already had one removed and had given birth when she was about 14 or 15. She was fairly certain child protection would take the child when it was born and she tried to end her life last year. It was brought to our attention after the recent suicide attempt. (Support worker)

4.1.7 USER-SPECIFIC SERVICES

There are also services who work with particular population groups who have a heightened risk of involvement with CSS and the experience of removal. This list is of course not exhaustive but rather provides an indication of the kind of support available to particular groups of parents:

- **Speakout** works with people with intellectual disability. Their state-wide advocacy team routinely has up to eight parents on the books with CSS issues who have either self-referred or come through Gateway. They are currently conducting a project called *Mainstream and Me* through Inclusion Australia which is exploring pathways into child protection for people with intellectual disability in Tasmania, including trigger points and how to better support parents. A key issue is how to better skill up parents so they can parent effectively and some attempts have been made to access supports for those at risk of removal using the NDIS.
- **The Tasmanian Aboriginal Corporation (TAC)** offers an integrated support model to parents involved with CSS with the goal of keeping them out of the system. They are informed of all Aboriginal notifications and UBAs. Family support workers can provide wraparound support with legal advocacy, parenting programs to build parenting capacity, counselling, psychology and psychiatry and addiction treatment and referrals. They will accompany clients to meetings with CSS and advocate on their behalf. They can also facilitate contact visits, provide supervised access, support reunification processes and help with practical issues like transport. In keeping with the Aboriginal Placement Principle, if children are removed TAC will promote a kinship placement. In-house health services include pregnancy support workers, child health nurses and midwives. Their capacity is limited and they are funded for one family support worker in each region.
- **The Link** works with young people aged 12 to 24 to provide health information, services and support in Southern Tasmania. They offer a walk-in service and see young pregnant women and parents on a daily basis. A number of these young people have contact with CSS and/or have experienced removal. They have recently implemented a weekly drop-in run by the Community Law Centre partly in response to the numbers of young parents seeking advice about CSS and their legal position.

4.2 Family, friends and informal supports

Parents described varying levels of support available from family, partners and friends. For some the support of family had been vital in their survival. One woman said about her partner, 'If Pete hadn't come along after Leah was taken I probably would of done myself in because you feel you have no life to live'. However what was striking was the degree of disrupted family attachments which limited the

support available from their own parents, grandparents and extended family. In some cases these relationships had been further fractured by recurrent removal, domestic violence and by kinship care arrangements where placement of children on orders with family and in-laws, often in the face of opposition from birth parents, had further cut parents off from support within their own family networks. One woman said 'my family abandoned me':

My birth mum she won't talk to me and won't meet any of the kids. She doesn't want nothing to do with me. Apparently I have a brother and sister here in Tassie but they're not my brother and sister, I don't know them. They are not family. I have made my own family and that's where they hold it against me so much because we haven't got the supports that everyone else has because basically I've grown up in the system. (Adam)

I wasn't allowed to talk to my mother or have anything to do with her because of Sarah [her daughter] living here. I wasn't allowed to be anywhere 50 metres from this house and I was not allowed to go to my grandparents because Sarah went over there. So I had to move from there. I had no friends. I didn't really have anything to do with anybody. When I had the kids living with me I didn't really have anyone around. Dave [ex-partner] wouldn't let me have anything to do with my friends. I had nobody and all my friends cut me off because they didn't want anything to do with me while I was around him. (Gill)

Social isolation was also a problem for those trying to tackle drug and alcohol issues, which could involve separating and distancing themselves from their social group. Relationships with other parents in similar situations, although supportive, could be challenging as they compared their situations:

I only know a couple of people who have gone through the same thing as me. They've been through some traumatic stuff as well and it's good to talk about what they've been through and what I've been through. But hearing that other people get their kids back and get a second chance really does hurt. I haven't been given that chance and half the time I have to tell them to stop because it hurts. I don't even get to see my oldest son. That's what I tell them all the time when we talk about it, you have it easier than me. (Janine)

One mother described how important her dogs had been to her during difficult times:

They don't value pets, child protection. When my kids were taken the second time both my dogs refused to eat for a couple of days. I was desperate. When it happened it was the thing which kept me going, my relationships with them. In some ways they were like assistance dogs for me, psychologically. I felt like I had a friend beside me and some of my family left, a child because they are childlike. (Laura)

One thing that parents had found helpful was access to education, training, employment and volunteering opportunities. Having meaningful occupation had supported them in coming to terms with their situation, dealing with loss and isolation and giving them a more positive vision of the future.

I always wanted a really good work ethic. There is the intergenerational thing where we've all been on Centrelink payments. My mother never worked, I have been on a Centrelink payment all my life but I made a decision when I was 16 that I wanted to work. I got my first job at 16 at McDonalds and I went back to study in 2010. The course gave me a better understanding of domestic violence and that it's not my fault and I'm not the only one who has been trying to leave for 5 years. Then I switched to a cert 3 in disability support work. This was really helpful for me with the boys and learning about the ADHD and the autism spectrum and how it impacts on them. (Mary)

For those who had experienced difficult childhoods or been brought up in the OOHC system the lack of supportive informal networks and relationships could be one of the main risk factors identified by CSS as compromising children's safety.

4.3 Accessing formal services

The collateral consequences of recurrent removal indicate that parents have a wide range of support needs. They include addressing both the trauma from their own childhoods and system-induced trauma alongside a wide variety of more practical issues like help with housing and legal processes. Parents were either already in touch with a range of mainstream and community-based services when children are removed or they might seek them out or be referred to them after removal. Depending on the attitudes of individual CSWs referrals can be made to programs in order to assist parents to meet the conditions attached to Orders. These include mental health and drug and alcohol services, housing, parenting programs and anger management, domestic violence services, financial management and general counselling.

Parents described their experiences with a wide range of services. Referrals by CSS and self-referrals to parenting programs elicited a range of reactions from parents. Parenting programs use a number of different programs including Circle of Security, 1,2,3 Magic¹⁸, Flight and Fight¹⁹ and Bringing Up Great Kids. Most had found something of use in them.

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18 1-2-3 Magic teaches effective child discipline.

19 Flight and Fight teaches parents how best to respond to difficult behaviours.

In particular Bringing Up Great Kids was highlighted as being valuable in addressing the impact of past trauma on their current parenting capacity:

I had to engage in parenting programs. I've done two now. I did find them useful in the sense of strategies and techniques I could use with my children. It was hard actually doing the program because they weren't in my care so I am trying to practice the strategies they are teaching me whilst only having him one night a week. It was tricky but it helped me to become mindful about how I was communicating with my children and I started to change quite a few things. Bringing up Great Kids helped me to understand how my past traumas impact on how I parent and the types of messages that have been passed on to me through my childhood and the types of messages I pass on to my children. I can go into the fight or flight mode. It's a survival mode I've had to endure all my life too. So it's about being mindful about being like that. (Mary)

They especially valued counselling and their contact with psychologists. This support can be accessed through a GP's Mental Health Plan and through specific counselling services. For many it was the first time they had had access to talking therapies with a skilled practitioner and it enabled them to open up and address issues from their own childhoods:

I rang up for a relationship counsellor and now we get on like a house on fire. She has given me someone to talk to, to cry on. I have had her for about six months. She is taking my anger and backlash on the department. She has a broad shoulder and has sat down and listened to me. This is what I wanted in the first place. (Kaylee)

However from parents' descriptions of what they found helpful and not helpful, some key characteristics emerged. They wanted support which was holistic, offered a case management approach and was non-judgmental. They valued having someone they could ring who knew their story, who they had a trusting relationship with and who could walk alongside them as their situation changed. When asked what their main support had been beyond family, they were most likely to identify services able to provide wraparound support and a consistent relationship. Some parents were finding this kind of support at various points in the service spectrum. Key providers were CSO support workers and mental health and drug and alcohol recovery services:

Mental health services were really good. I had a case manager so I was not just going and seeing the psychiatrist and getting medication and retelling my story. Psychologists and psychiatrists change all the time but case managers don't. They stay and that is what makes all the difference. I actually had a separate person who would support me with meetings with child protection. She would ring on my behalf, any other court dealings and she supported me

through the mental health court. Even when I went into DPM (Department of Psychiatric Medicine) for treatment she organised for my dogs to be cared for at the dogs' home so I didn't have to worry about that. She was really consistent. She knew my story, she was there with all the changes, right through it all as it was evolving and unfolding. She was that one consistent worker. I worked with her for six years. (Laura)

My worker she came out every week and I chatted to her about what was happening, how I responded to it. It's been the mental side of things which has got me the support I need. I am diagnosed with clinical depression and anxiety and post-traumatic stress disorder. I don't know what I would have done this time around without her. She has attended every single child protection meeting, every single court proceeding. She has met with my lawyer numerous amounts of times to help. She helped me to respond to their affidavit this time around. She's been amazing. (Mary)

Laura emphasised just how important it was to have someone to provide hope and encouragement. In her case the words of the judge had made all the difference in how she felt about her situation:

The judge was really good. She was so kind hearted and it stuck with me the words she said and gave me the strength to keep going and work with these people. She said I have been completely struck by the type of loving mother that you are. She said I can see you love your baby very much. Because this baby is an infant I want you to have access three times a week. I said I was breastfeeding and she listened to me. I thought okay I have some understanding here. It was helpful. It really inspired me to keep going. (Laura)

When this kind of holistic support was removed the impact could be devastating. One couple described how they lost their support worker when the reunification process was stopped by CSS:

It wasn't until a reunification plan was made that we finally received some support. Before that we didn't have any support, nothing. We were given a support worker and they ripped her off us. We were told she couldn't be our support worker because we weren't reunifying anymore and they wouldn't allow her to support us any longer. She was only for reunification. (Adam)

The parents who participated in the research were identified through services. This meant they had some point of contact with the service network. However both they and the services they worked with were aware of other parents who had little or no contact with the service network at all. The trauma and challenges faced post removal and deteriorating circumstances meant, as one parent said, 'people deteriorate down into a black hole of despair and they tend not to be looking

out for these types of supports'. Despite their contact with services parents in the research spoke about their loneliness and sense of isolation. One woman said 'All the way along I didn't get help or understanding. They didn't understand me at all'.

We had support from various organisations over the years but there is no support whatsoever once they take your children from you, none whatsoever. Once they take those children from you there is nothing at all. You have had the carpet pulled from under you and there's nothing. (Amy)

4.4 Child Safety Services

How much help and support did parents receive from Child Safety Services? There were parents who had self-reported and had come to the attention of CSS because they were looking for help and advice. Others, once in contact with CSS, expected support to help them through the challenges they faced and to have their children returned. However a negative view and hostility towards CSS was almost universal, as parents described how their children should not have been removed, that they had not received enough support and that CSS just did not listen to them or understand their circumstances. They reported a lack of consistency in expectations and support, problems with the skills and attitudes of CSWs and how difficult it was to escape their pasts and to be seen as someone who is capable of change.

Although many parents had, at times, worked with helpful and empathetic workers, they commonly reported a lack of consistency in the way CSS responded to them and a family's pathway through CSS being driven by the judgements of individual CSWs. What might be 'good enough' for one worker might be unacceptable for another. This meant that a change of worker could completely alter the trajectory of parents.

Some parents (and services) described developing accessible, respectful and non-judgmental relationships with CSWs where their case was progressed and 'warm' referrals were made to a range of support services. They had developed productive relationships where workers were willing to give them opportunities to make changes and to assist them in doing so. They also appreciated small amounts of financial support when they were in transition or to fund services that they might need.

Child Safety have supported me in the way of paying for things for me like the psychologist. When [my daughter] does come back into my care I am going to be asking for funding to get her a bed, some clothes. I know they can do it. I had a meeting with my new worker and he is excellent. He is very bam, bam, bam and I haven't had an issue with him yet. I can call him, I have his email, we talk by phone and he will answer the phone every single time. Every other worker I've had I've had to leave messages, run around to find the team leader. For the past year I have been doing things by myself without knowing what to do. I wasn't told anything up until I met him and he has helped me a lot. He gets things done. He wants me involved and I want to be involved. (Abigail)

Others described difficulties in getting in touch with CSWs and in developing good working relationships with them. They felt judged and disrespected and the continual turnover of often young and inexperienced workers made it difficult to develop any kind of satisfactory relationship with them or to progress and deal with their problems. One woman said, 'They just make ways to make me sound and feel like a bad mum. I feel they are against me all the time. I always feel like I am trying to defend myself'. They described being put in intimidating situations, not being given the information they needed and being given unrealistic expectations about the goals they needed to achieve. They might be asked to 'engage with services' or 'address their mental health' with little idea about how to do it or how to prove that they had done it. There were misunderstandings about what constituted good parenting or good enough housekeeping:

I had a mother who was binned because she had done a load of washing. It was winter and she had the washing on a clothes horse in the lounge room. The worker walked in and said it smells like washing in here. Who sets these expectations? When we took over this case we moved from a worker who said that is good enough to a worker who said this is way unacceptable and stopped visits. So how conflicting is that for the parent who has been told by one worker it's clean, its tidy, it's safe to another worker who says this is so unsafe you cannot have a child there and have visitations removed to a different venue. (Support worker)

There have been countless times I've rung and left messages on her answer machine and when I finally get hold of her and tell her she says sorry I haven't checked my messages. Well come on you're a welfare worker you should be checking your message machine every day, every morning or every night, one of the two. How many people would be leaving messages, a fair few. She is always saying I haven't just got you as a responsibility, I have 13 other families I have to look after. Well that ain't my problem. (Bianca)

The absence of a standardised approach meant that the perception of risk became dependent on the judgement of a particular worker. One provider said:

During the signs of safety meeting there was lots of pressure and quite intense and she got quite emotional. They were trying to frame that she's not ready and not wanting to make changes. But then outside of that room she was. They were looking at her in that room and saying you don't seem to have the right attitude but they weren't looking at any evidence outside of the room. The worker said you're too emotional to her because she cried a lot. So one time she went in there and kept her face straight and took all the information in and as she left she said how did I do? Later on I got the information saying she didn't show any expressions. She didn't seem interested in hearing about the kids. (Support worker)

The post-removal period is overshadowed by a lack of clarity from CSS about how to address safety concerns, the possibilities for reunification and what parents have to do to be considered reunification ready. Again this decision lies with the individual CSW in collaboration with their supervisors. But the process of decision-making and the way in which it is communicated to families is opaque. It means from a family's perspective that they can be categorised very early on as not viable for reunification with little attention paid to the kind of barriers they might face. As one support worker said:

I have asked a direct question, can you tell me what it is you require and they can't give you a straight answer. If they can't give a straight answer or you're vague about your answer, how can you expect change? If you walk in and say we need the house tidied up what does that mean for someone who has never cleaned a house, doesn't know what a tidy house is. And using this to say I'll take your kids away is not a reason or an education. I can think of several meetings I've sat in and I've asked straight out but I am no clearer in knowing how to support this family to meet Child Safety's requirements because I have not been given an answer. It's another eight weeks till the next meeting. What is the family working on or doing in that eight weeks, nothing. And then Child Safety say well you haven't done anything. (Support worker)

Parents also commented on the skills, experiences and attitudes of workers. They described young inexperienced graduates and those who had been in CSS for many years and who had 'hardened' and treated parents like a statistic.

Some are better than others. The one I really clashed with with the second removal was a new university graduate. She just had no clue about life, about children. She was younger than me and I felt really weird. I couldn't work with her properly. She was all about documenting everything for affidavits, really long ones. She documented every little thing and things are open to interpretation anyway. If I'm not answering the phone it's not because I was in the corner chewing my nails but I was actually out in the garden. The reason I didn't ring back was because I didn't have credit on my phone. I had to get to the phone box if I had the change but it might be a couple of days before I ring. She would write it up as mental health problems, avoidance, not wanting to build a relationship with her. (Laura)

They found it especially difficult to deal with workers who tried to empathise with what they saw as the injustice of the situation parents found themselves in. At the same time they resented the fact that they did not raise their voices to champion families within the system:

Our workers actually quit the job because they weren't happy with what the court decided so they quit the job. They walked out. They said if we had a carer coming to the house 4 to 6 hours a day we could manage, but they took the kids off us. It's costing them \$7,000+ a year for each one. A lot of people who work in the department quit their job because they don't like how it's run. That's why they don't have enough workers because they don't like working for them. They get good money but they say the job is not worth it. (Shirley)

These workers they are meant to be a voice. They say they are a voice for the children but at the same time there is no change within the system. Workers say yes it's awful, I don't agree with this and I don't agree with that. Well you have the goddamn voice, speak up. But none of them do though, none of them actually speak up. Why aren't Child Safety workers protesting about what is happening to families, why don't they have a voice? They just leave instead. (Mary)

The lack of understanding and trust in relationships with CSWs meant that some parents always ensured they had someone else with them when they met with CSS to witness the interaction: a friend, family or a support service. This helped them to understand what was happening in situations where they felt they had no right or were too embarrassed to ask questions. This was not always well received by individual CSWs:

She carries on at me if I have someone else with me for one-on-ones. The way I look at it if I've got someone there she can't say I did this or that, if I have a third party sitting there. She carried on about it and reckons I'm not allowed to do that. Well I am. I do have rights and I am allowed to have a worker present while I'm dealing with you. If our relationship weren't so stuffed up maybe I wouldn't have to have someone there with me. I'm not saying she's not a good worker. I've had her for three years. You get a worker like mine who you can't have a relationship with in any way and it gets you nowhere. (Bianca)

They should explain it properly. They put things in big words and they know I'm not understanding what they are saying. If they said it straight out bluntly I would understand. They confuse me so much that I end up saying yes to something you should be saying no to sometimes. (Jackie)

Both parents and services remarked on the role of a parent's history in the assessment of risk and decision-making by CSS where past behaviour is used as the best indicator of future behaviour. They commented that changed circumstances were not enough to alter the assessment of risk for individual parents and once one child has been removed history was stacked against them and it was assumed they were incapable of change. No matter what they do or what efforts have been put into changing their circumstances CSS have made up their minds:

We see cases where Child Safety are really not convinced right from the outset that any work could be done to shift and create a difference. For parents who have multiple children already in care and perhaps subject to 18 year orders already, Child Safety is applying for an 18 year order on the birth of a new child. They may have been in foster care, doing okay and to be very keen to avoid what happened to them and to have a very different path for their child. They may well be with partners who were also in care and who are angry and may have experienced abuse in care. Those with a history of care do get some good outcomes, have good access to services and engage. For others there is so much history, poverty, chaos, contraception problems, and an enormous desire for a baby and family and the need to intervene in a very short space of time. But no matter what happens some are doomed and history comes back to bite them. (Health worker)

Parents described being condemned, where any requests for help to improve things and change their circumstances were interpreted as additional risk and received a punitive response rather than encouragement:

We often see clients doing positive things off their own bat but workers misinterpret it. For example one family on the cusp of removal decided they needed family relationship counselling to deal with various issues. This was seen as a positive move by Child Safety but then they wanted to know why they needed it and what that said about the relationship. It then became a safety risk rather than a positive change. (Support worker)

Jackie and Amy emphasised how harshly judged they were because of their own backgrounds and how they struggled against the odds with little support to address safety concerns. As one mother said, 'we are all put into a box and we can't get out', and once one child has been removed the likelihood of further removals increases:

Everyone is different in the way they bring their kids up. It's like how they were brought up. I tried to do something different with my kids to the way I was brought up. A leopard does change its spots. They say they don't go on the background, on the history, but that's everything they go on. I just don't trust them, that's all I can say. They are not there to support you, they take your kids.

They say it's what you do from there on but it's not really. You have to try and make things different but you are jumping through hoops and they make it impossible. (Jackie)

You are judged, you are executioned. What are the rules about having your child? Do you need a licence to have a child before you have one? When does help step in? A lot of it has to do with where you live, the job you might have, you're on the dole right you can't afford a child. What is your standard? If you change your baby at 6 and it's supposed to be a 5 will you be crucified for that. Every family is different. The powers that be can do no wrong. I got no support from them until it was too late. At the end of the day they have all the power. I haven't. (Amy)

Parents were asked if they felt CSS operated differently for young parents, for those with a disability or a substance use issue and for those with Aboriginal identity. There was a consensus that all these factors could affect the way in which they were treated by CSS. A lack of awareness about substance use and the recovery process meant unrealistic expectations of parents, where a slip up in the recovery process was seen as a risk factor rather than something a parent might need help with. Few rewards were given for small but significant changes which went unrecognised:

I swear they just concentrate on what you was like and not on what you are like now. Even though I've done nearly 14 months clean I still feel that they look at me as a drug user and that I'm not going to be any different. Not once has she said you should be proud of yourself. Not once has she said I think you've done a good job. I invited her to my graduation here but she didn't turn up. When someone has done the right thing and done everything they wanted you to do they should acknowledge that in some way. There is no praise, no nothing. I have said to my worker you don't understand that when you stress me out my stress levels go up, I get triggered. They don't understand none of that and if they did they would just see it as another risk. (Bianca)

Those living with a disability felt the same: that instead of CSS exploring how they could support parents in dealing with the challenges they faced, including providing more in-home support, they used those challenges as evidence of their inability to safely parent a child:

I was going insane in meetings with child protection, yelling and carrying on. They said I was a retard. I am not a retard. I did an IQ test and was not happy with the result. I rang up and he [the CSW] refused to speak to me and hung up. This hadn't come up in my school tests and I have been coping with the business diploma fine. I really enjoy it and I've also done my RSA (Responsible Serving of Alcohol) and RGS (Responsible Gambling Services) with no problems. They are saying I'm disabled but I'm not disabled. They said I should

be on Disability Support Pension but Centrelink say I can work seven days a week, for 40 hours. I got sent to a psychologist too but she was no help. The department just doesn't care. (Gill)

Aboriginal parents expressed numerous concerns about the lack of understanding and awareness of cultural issues which again could be misinterpreted and used against them. One father said 'for me it feels like the next generation of stolen children'.

Child protection don't understand. They are quite happy to mention someone who has passed away. When the kids went into care and I didn't have money to buy presents I decided I would make them cultural things out of shells that I collected. They had support workers in access questioning my mental health because I kept sending these piles of shells back with the kids. That was really offensive to me that I was viewed as mental and it was actually just a gift because I couldn't buy anything. I had the worker ringing me and questioning my mental health. I got so sick of it I wasn't answering the phone. They made a big do about that and it got written up in an affidavit. I felt I had lost everything, why should I lose my own identity, why should the kids lose their identity. (Laura)

4.5 Engaging with services

Parents experiencing recurrent removal are often described as 'hard to reach' or 'difficult to engage'. They may have a long history of non-engagement or a lack of contact with services. Certainly parents in the research described periods of time when they had dis-engaged from all services to 'go it alone'. Given that a productive working relationship between parents and CSS can be crucial to smoothing a path through the system and determining outcomes, engagement becomes an essential component for a good outcome. A failure to engage with CSS and with other support services increases the risks of further removal.

CSS described missed appointments, cancellations and parents saying no to their involvement despite court orders, having to meet conditions and already having children in the care system. As one CSW said about her work with pregnant women:

Those who already have children in out-of-home care may only engage at seven months and then there is a late dash in an attempt to avert removal. Midwives will do all they can to engage parents with support and with social workers and can do warm referrals where services are invited in. Services go above and beyond to try and engage but parents won't answer the door, they won't let them in, they refuse to engage with help. And in the end it comes down to their willingness to engage. Post-removal there is the grief and loss but they often don't want to hear about support at this stage. (CSW)

The PIMHS also described the challenges they faced in engaging with women during pregnancy. Although they might attend one appointment, opening ‘Pandora’s box’ and trying to deal with their trauma was often too overwhelming, particularly on top of significant mental health issues like depression:

Some referrals never engage. Some might come once so we see the problems but can’t do anything about them. Some engage and work with us but many don’t wish to engage or there is nothing to engage with. Non-engagement is about past experiences, trust issues, not being able to develop relationships and also the limited capacity of services to provide input that they would benefit from. If a service is unable to offer what they need it is not helpful for them to engage with it. Trauma can mean they are very sensitive to rejection. It leads to statements like ‘my baby hates me’. So if a worker is late for an appointment that is interpreted in particular way and there is a reluctance to form a relationship. To tackle this requires real expertise and in-depth work. (Health worker)

Parents described facing a number of obstacles in effectively engaging with services. Unaddressed grief can spiral into anger towards CSS making it impossible to communicate or to work with them. This can be compounded by PTSD from a previous violent relationship or trigger memories of a childhood in OOHC or of neglect and abuse. Yet aggressive, confrontational and uncooperative behaviour towards CSS staff is seen as bad behaviour rather than a trauma response. While CSS may say ‘we have told them a dozen times’, parents suffering high levels of stress and trauma are unable to absorb the information. Given the multiple difficulties and stresses faced by parents experiencing recurrent removal, they were asked how far they felt the CSS recognised these difficulties and the trauma and stress they induced. Both parents and services commented on the lack of awareness and understanding among CSWs about the reality of people’s circumstances, system-induced trauma and how this affected their behavior and ability to cope with the situation. The words most often used about CSS were ‘cruel’, ‘heartless’ and ‘emotionally detached’. Many said ‘it would be nice to be asked if you were coping okay’. A key role for support services becomes working with their clients so they are able to engage productively with CSS:

When I first started working with the client they couldn’t get through the first five minutes of a Child Safety meeting without f-ing and c-ing and slamming the door. Because he has now had support and been valued and been taught new skills we had a six and a half hour family group conference he could get through. That is because it has been part of that therapeutic approach and getting him to deal with his own trauma and to understand the needs of the children. If they haven’t dealt with it in that therapeutic way then every meeting they go to they are not moving forward, not understanding Child Safety or when they talk about why your parenting needs to change. (Support worker)

Adam described how he had developed mechanisms to cope with CSS meetings. He would take a colouring-in book and concentrate on that while others did the talking. This enabled him to feel calmer and suppress the anger that he felt:

They would run me down. We would go to a meeting and for the first 20 or 30 minutes it would be about me and my drug use. I couldn't even look at them in the end because they would just run me down and run me down. It was read out in court that I am an angry and violent person and that I get up and throw chairs and walk out of the room. They don't know me, they only get a glimpse. From day one they judged me. (Adam)

Engagement is also dependent on there being something to engage with which is appropriate to need. Parents described difficulties in engaging with programs which were not designed for people in their situation. In particular, being referred to parenting programs where they were asked to practice parenting strategies when they only sporadically had their children in their care increased the risk of disengagement. One woman had been asked to attend a local playgroup accompanied by a worker wearing a CSS badge. She found this humiliating and it made her reluctant to attend. This was then recorded by CSS as a refusal to engage or improve her parenting capacity. It was later used as evidence in Court to grant an 18-year Order:

I went to the one [parenting program] and it was really boring because I already knew all the parenting skills and I knew all the answers. Newpin was useful a bit because I was doing it all totally different. But that is so full on and I had to try and do it on top of looking for work and access. And I didn't have a child with me to say this is what happened this week with him, so I couldn't really use any of it because I didn't have the child. But child protection put in an affidavit that I declined to do parenting courses which is not true. (Gill)

Laura commented she felt that the conditions she was asked to meet and the programs she was expected to attend were not necessarily tailored to her own individual circumstances. Case managers were instead following a checklist issued to most parents:

It just seemed like a list that they write for everybody. It had everything listed like drug and alcohol that I could think of. It was pretty universal. Some of those conditions they didn't even agree with. I was blamed for the domestic violence and they didn't bother with that but it was written there. (Laura)

Both services and parents might have a ‘tick box’ approach to engagement. Parents may see it purely in terms of meeting the conditions set by CSS rather than having their support needs met and instigating change. As one counselling service said:

They are unsure why they are here or what counselling can do for them. They don't have goals, they don't link the referral to the reasons why the child was removed. They often fail to engage, which can be interpreted as a lack of motivation by Child Safety. They get very little information from Child Safety, they are starved of information and unsure about their situation. Counselling is not seen as their immediate need. People may need a lot of pre-work before they are ready for counselling. What they need is practical support at this point prior to any counselling intervention. So when they are referred to counselling they are not ready for it and they don't take it up. (Counsellor)

Services described how parents are most likely to agree to support when it involves tackling the very practical difficulties they faced like housing or dealing with Centrelink. Doorways to Parenting, which works specifically with parents post-removal, felt engagement with the program depended on how it was described to parents and on allaying their fears that it would be judgmental with people telling them how to parent. Their assertive approach to engagement – sending constant reminders, not giving up despite a series of missed appointments, and the ability to do outreach work in people's homes – meant higher levels of engagement. Services said it depends on the quality of the initial referral and being appropriate. One support worker commented ‘it's not about chasing families it's about demonstrating our relevance’. Yet eligibility criteria can mean that the needs of parents have to be fitted to services rather than vice versa:

Often there is quite a bit of wariness. They have had children removed and they feel that whatever they say might be reported to child protection so perhaps they don't want to go into their own experience because they feel it might make them look less competent. There is a sense of being mandated to see a counsellor or attend a program and we are then seen to be agents of the department so it's hard for them to trust. Obviously if they haven't got housing, counselling is going to be a low priority and it makes it tricky to keep continuity of assistance to them. We try to get across that we are not agents of the department. The department say you have to do it but we are not going to let you into the program unless this is something of value to you. (Counsellor)

CSS are currently embedding the Signs of Safety Framework across the state. This provides a strengths-based framework for engaging with parents and working with them in an inclusive way to address any safety concerns. Services and those parents who were aware of it and had experienced it were complimentary about the process. It was seen as a very positive and effective mechanism able to reduce

and in some cases eliminate so many of the difficulties parents experienced in their dealings with CSS. It introduced clarity into the situation, clearly identified strengths, risks and strategies to mitigate risks. It was a simple process, understandable to parents and provided them with the opportunity to offer their own solutions. At the same time it had the potential to standardise responses to parents in terms of expectations and whether or not they have been met. However interviewees also reported a range of practices where delivery depended on the individual CSWs rather than being consistently applied.

4.6 Surviving removal

There was a spectrum of experience among the parents who participated in the research, from those in the midst of coping with the immediate impact of removal to those who were able to reflect back on removal experiences and what it was like to live their lives knowing their children would not be returned to them. How had the experience of recurrent removal and their access to and use of services impacted on them personally, on their ability to be a parent, on their children and family relationships and on how they felt about their future, with or without their children?

4.6.1 PERSONAL IMPACT

Commonly parents described an initial acute period of grief and loss which was for many combined with the escalation of problems which had initially brought them into the CSS, including mental health and substance use issues, domestic violence and poverty. This escalation had made it more difficult to begin to tackle the safety concerns identified by CSS. These reactions sat alongside coping with the stigma, shame and embarrassment of having their children removed. As one father said, 'there is the judging of everyone and the community as well if you have child protection in your life'. And there was the impact on their own identity both as individuals and as parents:

We've both had heart attacks since the kids got taken and I am only 29. I know when I'm stressing because my hair all falls out. The hairdresser says that's caused through stress. Since my kids have been taken I've been getting more animals because it takes my mind off them. I've cut my arms before. The animals replace my kids basically. But it's getting to the stage where I can't afford to have the animals. (Shirley)

Many carried an enormous sense of injustice and moral injury about what had happened to them. Despite their efforts to do better than their own parents, this had not been acknowledged and their children had not been returned:

I'm a young mum, I'm only 24. I was 18 when I had Leon and I've been very traumatised. No mother should deserve what I've been through. I believe I was

a good mum. I never thought in a million years I could lose my kids. I was a stay at home mum and a parent for them. I always used to put my kids first. I didn't deserve this. I really just want my kids back and it's all I've ever asked for. I've never felt so lost without them. One of the main things that's come from it is I have anxiety and depression so it's not very good. That's been since the loss of my children. (Janine)

Depression is the big thing. It intensifies my depression and my anxiety and it impacts on the way I look at myself now. I am my harshest critic. Nobody else out there can judge me harder than I judge myself. Basically I'm being told that I am not fit to raise my children, you're not good enough to be a mother. I worked my bum off to make sure the apple fell far from the tree and they are just treating me like I'm no different to my mum and that's not fair. I have never hurt my children like she did us. I used to get whipped with hoses and jug horns and belts and punched and hit round the head with hair brushes, all of that. When I told my mum that I was sexually abused by her brother her response to me was you dirty fucking slut, go and get the scissors so I can cut off your hair because your hair is what makes you look pretty. Then when I refused to give her a kiss good night she poured a bucket of cold water on me in bed and made me sleep outside, that's abuse. (Mary)

The stresses and pressures had led to both escalations in domestic violence and the breakup of relationships. One mother who had come through a number of domestic violence situations said 'I will never have a relationship again, I don't have it in me to do that, I feel safe on my own protecting my kids'. Parents talked about the breakdown of relationships not only with partners but also with their wider family, particularly when they were involved in kinship care arrangements, leaving them more isolated and less supported than they had been before:

I have been with my partner for nearly five years and child protection have their ways of making us not strong, trying to stay together. They always used to tell me you are picking him over your kids. But it's not like that at all. I want my partner, I want my kids, I want both. Stop making me choose. It wasn't like violence, violence, it was arguing, just normal. It wasn't physical violence and not what they've got written down anyway. Through all this stuff we've been through we are actually going our separate ways at the moment. Since the 18 year order it all got too much, too much pressure trying to stay together, trying to feed a relationship, trying to get our kids back. It got too much. (Janine)

With this 18 year order I'm stuck. It's taking away my choice. I'm 30 years old. What have I got to show for my 30 years, nothing but child protection, a whole lifetime of child protection. I just want to be done and rid of them. I'm fed up with being scrutinised all the time. I'm fed up with being compared and judged and being treated as if I'm scum and yet I'm probably a better mother than half of the workers in there. Is it really that hard to believe I am one of those people that made it out the other end? (Mary)

4.6.2 IMPACT ON PARENTING CAPACITY

Ideally, working with CSS and other support services should assist with addressing safety concerns and improving parenting capacity. Research is clear that a positive relationship between children and birth families can improve outcomes for those in OOHC whether or not reunification occurs. But the work of supporting the development and maintenance of positive relationships is often left to the discretion of individual CSWs. How does having children in long term care impact on the parent/child bond, parenting capacity and maintaining an identity as a parent?

For those who had lost children when they were babies and infants, the separation and the lack of opportunity to attach and develop a relationship meant that they felt little bond to their child. Despite their determination to maintain contact this could be challenging in the absence of attachment. Shirley experienced this as an ongoing grief and a loss which could never be resolved:

I don't feel like I have a bond with Lynn or my other son because he got taken when he was very young. I only really have the bond with my older one, with Alice, because she got taken when she was two and a half, so me and her have that bond. It's just a matter of time and of waiting until they turn 18 I suppose. (Shirley)

If I had any choices I would wish this hadn't happened and Jason was home with me. It's a big hole and a part of me that's missing, that child. If I had a wish it would be to have Jason. He doesn't know me and that's a big hole, that child is missing. (Kaylee)

Laura described the lasting difficulties she encountered through having little opportunity to attach and bond with her baby taken within hours of birth:

Access can get quite weird when you don't have a bond. At times I have felt like a random visitor, almost in the position of auntie or distant cousin. So just lacking that closeness. Bonding is really important and it should be encouraged and not treat it like, you're being watched. Encourage you to do things with your child, playing with your kids, being with your baby, washing kids' clothes if you want to do that, storytelling. I felt worthless inside because I wasn't really supported in bonding with them. I wasn't able to be excited about their milestones that I might have seen in access. (Laura)

For those who held out some hope of reunification the impact of CSS involvement was not all negative. They described how these experiences had motivated them to improve their parenting and strengthened their resolve to make any changes necessary to have their children returned. One young mother had experienced four removals but was now, given higher support levels, hoping to reunify with her youngest child:

I'm 22. It has been a long journey and it did take its toll on me but with all the supports and knowing I have a chance with him to prove them wrong. Getting him home fully is my light at the end of the tunnel. And the kids even though they might not be home with mum they still know they have mum so that is pretty much what's kept me going. It's made me stronger knowing what I've been through and knowing I don't want to go back down that road where I went downhill. I hit rock bottom at one stage not long after I found out I was pregnant with him. I hit rock bottom and didn't want to even be here anymore. It was pretty hard. But knowing that the children need their mum at the end of the day and I was staying here for the long haul and doing everything I can to get them home. (Emily)

It's made me a different person, a lot stronger and a lot more determined to do these things. I've pushed myself out of my comfort zone which is a good thing because everything I'm doing, TAFE, a job interview, everything is for my girl. I have goals now. I never used to have goals. I want to go to Uni in five years. In a way it's kind of made me see the bigger picture if that makes sense. I have come a long way from where I was. I was very suicidal, attention seeking and things like that. Now I'm a different person. I want to be a strong person. (Abigail)

Jackie had found the motivation to reduce her drug use:

I'm stressed all the time. I self-medicate with valium. I still haven't got on the other drugs though which surprises me, how much I've been straight for my kids. I need to do it for my kids, for welfare, that seems to be a big motivation. These days I'm calming down and more or less doing everything they say. Before I used to rebel but never win the argument. Now I just haven't got the energy for fighting anymore. (Jackie)

Others were driven by the determination to prove CSS wrong, to show that change was possible and to overcome the shadow of their own past:

It's no wonder people don't make it out the other end. You are only just keeping your head above water and they are coming down on you and pushing you under. That's how it goes. They sit on you and you drown. If that history wasn't there they would not have taken my son. They would not be

applying for an 18 year child protection order. It's all because of history. That should not define a person. What drives me is I want to prove them wrong. I am going to succeed. But it's not always that easy. Is it really that hard to believe that someone can endure what I've endured and still come out the other end? They are not praising me for how well I've done. They are putting me down for my history. You can't possibly be a parent, look at your history. (Mary)

As time in OOHC increases the contact children have with their parents can gradually diminish. Did they still feel like parents? For some, as the time passed and they watched their children adapting to their new lives with carers, they experienced a new sense of loss as parenthood slipped away from them, and they talked about their grief as they missed key elements in their children's lives like developmental milestones or starting school. Although they might feel that their children were well looked after and might even be better off in OOHC, it was hard to witness it. For CSS a child's ability to settle into a placement and develop an attachment with carers was seen as a positive thing. For parents it was experienced as a continuing loss and grief. A key moment can be when children start calling carers mum and dad. This can be devastating for parents who struggle to cope but who have very little support in dealing with it. When guardianship shifts from the Department to a carer, access can become more problematic and infrequent and at this point parents can lose hope and feel they have no value or place in their children's lives:

They are spoilt rotten. They have iPad, they are going to Queensland next month, we can't do that. They have come from Housing basically up to a rich lifestyle. Both girls are getting braces. There is no way we could have paid for them, not both sets. We are grateful that they are getting that care. Last week my daughter had severe attitude and I said look if you're going to keep this up I'm not coming next week. Then all of a sudden she doesn't want to see me. It's hard. We are actually giving guardianship to the carers so they can make decisions because realistically they are not coming home. They are on 18 year orders because the girls have said they do not want to come home and they even want to change their last name to the carers. I said no, that's not happening, that is your identity and you're not changing it. Everyone says it's not a competition but to us that is what it looks like. They don't even go to mum's anymore. They used to go there once a month. It's a mess. (Cheryl)

It went fine for a while. First I had visits at the park and then at home, then the visits at home stopped and it went into the carers and was supervised for a while. Then for a while it was unsupervised and then I don't know why that all stopped for some unknown reason. First off she was on a six week order, then it went to 12 months. That went on for about three years and then they put her on the 18 year order. Now the carer has full guardianship and access went monthly. (Shirley)

Many parents had overcome incredible odds and personal challenges only to lose their children to CSS. Commitment to their children and to continuing to be there for them had assisted them to come to terms with what had happened and at some level to survive the experience.

4.6.3 IMPACT ON CHILDREN AND YOUNG PEOPLE

From a parent's perspective, what impact had removal and separation from birth families had on their children? Firstly they talked about the difficulties of witnessing the distress of their children during access visits when they might ask to come home or be reluctant to end the visit and return to the carer.

Within the first month Ava was quite distressed. She would be banging her head up against a door and things like that. She would sit down and bang on the back of her head. She didn't know what was going on. (Abigail)

I have a little girl that I can't see. I can see her but she says to me all the time about staying with me. I have to say no bubby you can't and she has to go back to her nan's. That is heart breaking when you have to tell your child that they can't stay the night with you. It's impacted me a fair bit emotionally. (Bianca)

Secondly they spoke about the quality of the care their children were receiving in foster and kinship care placements. Some expressed gratitude that their children were being well cared for, that they had good relationships and a working partnership with the carers who kept them informed about their children's activities and development and were happy to provide access. Others were concerned about the kind of care their children were getting. They reported obstructive relationships with carers, not enough contact between siblings living in different placements and a general dissatisfaction with the care they received. In some cases they reported neglect and abuse. One mother said 'they have said the kids are better in there because they are better looked after, but they're not'.

We have Natalie every second week. Adam had to go and buy her new shoes for playgroup a fortnight ago. Her shoes were a size 4 and Adam had to buy size 6. Her feet were all cramped up and she looked so uncomfortable. She was in size 1 overalls and couldn't bend over. She is very unhygienic, she smells down below, she was covered in nits. One week at playgroup about three weeks ago she had a massive splinter in her foot and bites all over her arms. They never send photos, we don't know anything about her. We don't know her first word or when she first crawled or walked. She was taken out of our care due to unhygienic and all that kind of stuff. The foster carers have her in shoes two sizes too small, unhygienic and they still get to foster care. It's crazy. (Cheryl)

They talked about the difficulties for children in forming their own identities when separated from their parents and how to maintain family values in the face of what could be a series of different placements:

Child protection should respect the family's values and try and get everyone working in that direction instead of people doing different things with the kids because it's really confusing for them. It makes bonding hard because they don't know where to roost in themselves and where their identity is. Maybe these things need to be on offer like the bonding. I have my beliefs and that's another thing that's been affected. Because they were in a home that used a certain belief structure and discipline it's affected how they see things and also our family history and background and our beliefs and values. (Laura)

Difficulties with maintaining identity could be compounded when children were not placed with their siblings or helped to sustain sibling relationships. A shortage of placements means few options in placing large sibling groups. Parents described situations where they had pleaded with CSS to keep their children together but had been met with a negative response.

A key concern for parents was the behaviours children had developed and whether or not they were receiving the therapeutic support they needed. They commented on how their children had learnt to manipulate the child protection system and their parents. They also commented on children witnessing domestic violence and modelling the behaviours of abusive fathers:

There was lots of trauma that Logan had experienced, watching me be strangled all the time. At one point his father became aggressive. I threatened to call the police and he flew at me, dragged me up by my throat and while he had me in a headlock Logan punched me half a dozen times back. He stood there and bashed me with his father. At primary school he was suspended about six times in six months. The majority of suspensions were around him physically hurting a girl. He actually put his hands around a little girl's throat and strangled her until she went blue. When I asked him why did he do that his words were because it reminded me of when daddy did it to you. I knew there were lots of things I was dealing with. (Mary)

Mary went on to describe the impact of CSS on her younger son, Ryan:

He's learnt to manipulate the system very quickly early on. He knows exactly what to say and how to say it to get the reaction he wants. I am riddled with fear every fortnight that he comes. If I said no to him he said well I'll just tell child protection you done this and I won't come next time. How am I meant to respond to a child who says this? We have worked so hard to instill values and morals into Ryan and to make him realise the world is not just about him. Child protection work against you because they give you things. We have showed him that you have to earn things. But the department are just destroying all this work. (Mary)

A number of parents talked about the inter-generational nature of these experiences and their enormous sadness in watching history repeat itself while feeling powerless to do anything about it. Amy had five children removed at different times. One of her sons had committed suicide in his late teens and she was now watching her two grandchildren being removed from the care of her eldest daughter:

It's a vicious cycle. You've been in care, your children have been in care and your grandchildren are in care. I haven't raised any of them really. I've just had them ripped out from underneath me and had different people tell me they are going to raise them. That's been hard. We lost their brother to suicide. He hung himself at his father's place. There are a lot of contributing factors ultimately in what happened to him. He was made to feel he was nothing. The carers didn't want Nathan because he was trouble and no carers will take on 13 year old boys. He just wanted to be with his mum. He was under youth justice, under the police, under welfare. I knew from a young age he had anger management issues. He didn't know how to vent his anger, how to put all that negative energy into something more positive. He just grew up very aggressive unfortunately and welfare did nothing. I'm not saying that's all welfare, it was the whole system. There was no support for him. I will with my last breath blame the system for stuffing him and other children around. They are not given the support. The system has let my kids down, it's pretty obvious. (Amy)

Two parents were now experiencing their children re-unifying with them in adolescence and as they exited from OOHC at 18. They and support services raised concerns about young people, often damaged by their time in OOHC, returning to still-grieving parents who have not necessarily tackled the issues that brought their children into the OOHC system in the first place. Reunification under these circumstances and in the absence of any support could potentially re-traumatise both the young person and their parents and increase the risk of history repeating itself.

4.6.4 THE FUTURE

Parents may have lost their children from birth or during infancy and accept that they are better off with their carers. However they are still parents and most wish to retain contact with their children and be able to offer a parenting role. They were asked what sort of future they saw for themselves and their children.

There were those who were working towards changing their situation and held onto the hope that they would be reunified, that despite having lost children in the past they would have an opportunity to prove themselves and regain custody:

I am still worried about Ava not coming back to me. That is always in the back of my mind. It's a fear of mine not getting her back. Ultimately what I want to do is break the cycle from my family, the way I've been brought up, the way they've been brought up. I don't want that for Ava. I want her to have a good life, something I didn't have. That's why I do these things so I can build a platform, a foundation, for her to build off for her kids. I am trying my best. Sometimes I do get upset out of the blue and I will cry and cry because I miss her. It's a hard thing seeing your kid once a week. Some days I find it too hard and want to give up but I feel like that would make me less of a person. I have to do it for her. She needs her mum happy and stable and that's why I push through. (Abigail)

There were also those who had accepted there would be no reunification but who wanted the best for their children and hoped they would return to them when they were 18. It was this that kept them going and gave them hope.

I hope they will come back home one day. It's the only hope I've got. That is the only thing which keeps me going. I want what's best for them, that's all that matters to me. I am waiting for my girls to come home. Zoe is 18 this year and Anna is 14. I could look back into why I was in care when I was little. I could read my file about how my mother betrayed me but it's not going to do me any favours at the end of the day. It's best to leave some things there. We all fall short, with the best intentions and we all fall short. We need to be talking about it. I felt I was the only person in the whole world, a statistic mum. I tell everyone that's been through the same experience hold strong, one day they will come back to you, it's not for ever. (Amy)

Some were trying to rebuild a life through education and employment. But they also described the continuing fear and a lasting legacy of a life overshadowed by their involvement with CSS:

Child protection are in my life until they are 18. They will always be in my life. When they need you or something happens with the children they ring up. You never lose them, the department are like leeches. It's the worse stress possible. I've lived in fear. It's horrible. It's had an impact on myself and the children and

my relationship with them. It's affected my relationship with my partner. They have ruined a nice happy family. I have a lot of trust issues and I don't trust anyone with the department. They ruin families. They have come into our home not to help us but to take the children. We have been abused and neglected and hurt. They have told me I have not done a good job by my children. I have been abandoned and kicked as a mother. It's been appalling. (Kaylee)

They take your children and it snowballs into all other areas of your life and stuffs you up. You cannot escape your past history. They judge you. It's just never ending. (Mary)

One parent was taking the difficult decision to break off contact with her daughter:

I don't see Layla at all now. I was able to come to the realisation that I just couldn't be a mum to a girl. The way I explained it to her, if you think of your favourite story book and you know the words off by heart and the pictures, try to rub out those pictures and create new ones. It's so difficult to do that because you know what picture is meant to be there. Well that's my relationship with my mum. That picture has been made, it's imprinted in my mind of what a relationship between a mother and a daughter looks like. I didn't know how to rub out those pictures and create new ones with my daughter. I decided it was best if I become absent from her life because it was doing her more damage. (Mary)

All parents were asked if, given their current circumstances, they would consider another pregnancy. Responses varied. For some the thought of having to go through these experiences again and cope with the threat and reality of removal was too much. One woman with a new partner said, 'we have thought about having a baby but I am riddled with fear':

No, that wouldn't be on the cards. If I found out I was pregnant today it would be an abortion. I can't cope with what I've been through, I would probably be more down. I can't do that again. I can't do that again. (Janine)

For others desperate to fill the gap they or their partner were prepared to consider another pregnancy and to create the family they had never had.

Yes, I would to fill the gap of Jason and the heartache. I would adopt a child to fill that gap. (Kaylee)

I would always have that fear that they would take it and I've had six pregnancies. Adam wants more, not for the fact just to have another one, but he has never seen them grow right from the start and he is yearning for that big time. He wants to see a child grow up and we deserve that. So I couldn't for myself but Adam is all for another one. (Cheryl)

4.7. In summary

Tasmania has a complex network of programs and services supporting parents whose children have been removed. However:

- services specifically targeted to this cohort are limited, vary according to region and are usually working to full capacity. This means that both mainstream services and community service organisations providing a range of different programs describe working with parents experiencing recurrent removal as working 'by default'. Parents described a spectrum of involvement with services post-removal, from multiple involvement with a range of services to very little contact and at times none at all.
- Levels of informal support from family and friends varied. In some cases this support had been vital to their survival. However a history in OOHC and/or removal had often fractured these relationships, leaving parents isolated. This is then seen as another risk factor in their ability to safely parent a child.
- Although many parents either approach CSS for help or assume that help will be offered to them by CSS, what they found was support needs being translated into risk, which then justified removal decisions. They praised CSWs who were understanding, empathetic and supported them to change their trajectory through CSS. But they also reported difficult relationships with overworked, inaccessible and judgemental CSWs where expectations were unclear and unstandardised, there was little recognition of the impact of grief or trauma and where their own histories were held against them in an environment where change was often considered unlikely or impossible.
- Those who experience recurrent removal are often considered 'hard to engage', but what both parents and services report is a number of barriers to engagement. These commonly include mistrust, fear of further notification, system-induced trauma and referral to inappropriate services which were unable to meet their needs. Non-engagement was often a function of service appropriateness rather than parent failure.
- Whatever the level of involvement with services, there was a consensus about what effective support looked like. What parents found most helpful was holistic, wraparound support with a case management approach which was non-judgmental and able to walk alongside them in the longer term, providing encouragement, hope and assistance with both practical difficulties and psychological support.

- Removal can strengthen the resolve to improve parenting capacity, address safety concerns, demonstrate change, overcome history and promote reunification. The ability to change was promoted by encouragement and support, determination to do better by their child, proving CSS wrong and fear of another removal. Hope can be a vital psychological mechanism to cope with difficult circumstances and imagine a different future. At the same time removal can also have a severe negative impact on personal identity, on the challenges which brought parents into CSS and on their confidence as parents.
 - The majority continue to see themselves as parents, whether or not reunification is a possibility, and consider they have an important role to play in their children's lives. They hoped their children would return to them, when they reached 18 years if not before. However, what was happening to them in OOHC was a continuing concern. Even though they might feel their children were better off with other carers they still wished to know about their lives, and that they were getting the quality of care and the support that they needed. They recognised the damage that removal had caused to the child/parent relationship but were keen to ensure that history did not repeat itself and that their children were given a better start to life.
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CHAPTER FIVE

How to break
the cycle

What do parents and service providers think can be done to break the cycle of recurrent removal? To begin to formulate a Tasmanian response, this chapter combines the views of parents and services with an overview of initiatives being used elsewhere to address recurrent removal and reduce its incidence.

5.1 The views of parents

Overwhelmingly parents wanted to see better access to support prior to removal and to be given more opportunities to prove their parenting capacity. This applied to both the initial removal and preventing any subsequent removal. Any support would need to be able to address the underlying issues faced by parents that were leading to safety concerns and a risk to the child, as well as parenting skills and capacity. They considered that the CSS monitoring many had encountered when there was threat of removal could have been better spent in providing support which was practical and hands on, educative about parenting and delivered at varying levels of intensity:

We want just the one chance to prove we could parent instead of just ripping them out. They need more people with heart. They are cold heartless people, most of them. When I told my case manager we were moving house, I still remember the way she was sitting. She said moving house is just as stressful as losing a baby. That was a case manager. We don't get that chance to prove to them. One chance to have the kids at home and prove we can do it with their help and support instead of coming in and taking them away. (Cheryl)

Welfare have these expectations that you have to be a perfect parent and you only come up as a 9 instead of a 10. You muck up once and you pay for it the rest of your life with them. I've had these people for years and years knocking on my door, but when they've gone that's when you will fall apart. I don't think any baby comes out with a golden book of rules. I didn't receive a lot of care through my pregnancies. That would have been the time to learn if you need help with a baby. I had to go and find support and it took me three children to realise there are different cries for different things. By the time welfare get involved it's too late. (Amy)

November 2012 is when they took the children. 2011 is when I needed the support. Respite was a must and if that support had been put in place.... I was not even given a chance with my kids. It was just we'll remove and ask questions later. If they had contacted me and said we've had some concerns, can we offer some support, I would have said can you get me some respite. But there was absolutely nothing until the day they took him. (Mary)

These views were strongly expressed by parents with disability. One mother said ‘I think with people with disability child protection should give them a fair go and see how they cope instead of judging’. As part of the CSS redesign more intensive support is now being implemented through Intensive Family Engagement Services (IFES) for those on the cusp of removal. Parents certainly wanted to see access to intensive support, delivered on a daily basis if necessary so that decisions are not based on ‘a little glimpse and one small window frame of something going wrong’.

Child Safety didn't help me much before they took Ava off me, and they knew I was struggling. They knew I had mental health issues. I think a lot of mums need support beforehand, before things get too much. They want me to do a parenting course now that my child is not here. Why not do that before they removed her? (Abigail)

They get these notifications and instead of just coming in and taking your children why don't they sit down with you and say right these are the notifications that we have received, how can we help you not do this. Why don't they come in and say we'll work with you for so long and if by that time you still haven't or we feel you're still not up to scratch then come in and say we're going to have a 6 month order or 12 month order. They are about keeping families together so why is it that they just go in and take the kids instead of saying we'll work with you for a couple of months. (Bianca)

Secondly, if children are removed, parents wanted to see more support available in the immediate post-removal period to help them through the collateral consequences, cope with the grief and loss, offer a listening ear, provide information about their rights and about Child Safety processes and be able to walk alongside them. Importantly, this support would need to be confidential so that admitting to problems and asking for help did not mean worrying about further notifications. In this context they commented on the loss of support from IFSS some had experienced just at a time when they needed it most. As one mother said, ‘if welfare takes your kid your family support worker goes’:

Support after removal with the grief and loss. It's no good saying wait for two weeks. I had no idea where the children were, no one would tell me, there was no information and I was desperate. Support, which is what I got from [a CSO], was the support we needed. Not just being sent off to a parenting course. Someone to help you through. There is no acknowledgement by Child Safety of the grief. Perhaps they are too numbed to it. (Carol)

I personally think if welfare is going to take your children, you should be put with a worker that you can work with to get your child back, to help you get them back. Their motto is about keeping families together. I don't feel like they are trying to keep my family together. I feel like they are making it that bit harder for me to get her out of welfare. I get pulled from pillar to post. (Bianca)

Any support post-removal would need to better enable them to work with CSS rather than against them. This required an honest relationship with CSWs where there was mutual respect, less judgement and realistic expectations about achieving safety goals. They wanted positive workers who acknowledged that they loved their children, understood the realities of their circumstances, involved them in decisions, were open to change and sensitive to the impact of removal. They criticised the lack of consistency amongst CSWs and the parenting and housekeeping standards required of them, the turnover of case managers, the inexperience of many workers, and the lack of clarity about their situation. From the perspective of parents this is often interpreted as ‘lies and deceit’ on the part of CSS.

Stop lying for one. They discriminate against people. They shouldn't lie like when they said they would start overnight stays but it never happened. In court they said after two or three months there would be overnight stays. They said that in court in front of the judge and everything. They say things that don't happen, it never happens. (Shirley)

They should not make you hate them. Because that's what they do, you end up hating them. Work in a way that doesn't make you hate them. You want to be able to like to work with them. I hate them, I can't trust them. They failed me when I was younger. They did nothing for me. (Jackie)

They need more down to earth workers. A lot of them they sit on their high horse. They look down on you. You need that mutual respect. I had one worker turn around to me and say I read your case. I didn't think you could get better but you have proven me wrong. How dare you judge me off a piece of paper when you don't even know me. I am a human being, human beings make mistakes, human beings can change. How dare you be so narrow minded. They should be more open minded and not so judgmental. One worker said to me our priority is A's wellbeing and safety and that's my kid! (Abigail)

Thirdly, parents wanted to see better decision-making processes. They expressed numerous concerns about the evidence used to justify removal, false notifications, the use of ‘expert opinion’ in court processes and the standard of evidence being used in affidavits. Parents regularly commented on CSS assumptions that they were unable to change. In particular they wanted any decisions to reflect current circumstance and not to be overshadowed and biased by a parent's history, including already having children in OOHC.

I was 17 when they took Wesley. I was young and I did find it hard to get a grip on it but I managed. Then when it came to Ella they came to do the same again. When I was pregnant with Mia and I said I really want to have a chance, I want my children home. They said well do a parenting course, see

the psychologist or the counsellor and we'll go from there, keep your visits regular. I was doing all that but they still threw it back in my face and just shut me down. It's like are you setting us up to fail on purpose, that's what it felt like, just to set us up to fail. (Emily)

I don't think they should assume just because you were in welfare that your children are going to be in welfare and their children are going to be in welfare. When does the cycle stop? They shouldn't make assumptions. You're an individual person, why should you be tainted with the same brush your whole family is. (Amy)

I did have one worker and he came straight out and told me I am working very hard on changing their attitude towards you but they do think you're as mad as a hatter. I am slowly getting it to shift so they see how things really are but it's hard. So senior staff were making big decisions around an Order but not listening to the case worker and not going to see these kids, just making major decisions about them. (Laura)

Lastly parents wanted help to be better parents no matter what the legal outcome might be in terms of custody. They wanted more access to their children and better support with the challenges of maintaining contact. This included the importance of encouraging bonding and attachment.

We should have more access to our kids and help us too. If you want to see your children you want to see your children. It upsets me. That's when I get agitated and angry and want to rebel and stuff. You should be able to see your kids when you want to, especially on their birthday. We need more bonding with the kids, especially with babies. Fair enough if you don't trust them at least give them a few visits with someone there and give them the benefit of the doubt to have visits by themselves. If you've got a home why can't they be at home, why does it have to be at Woodhouse. (Jackie)

The workers need to have some understanding about bonding. Just because there's a legal order it's like why do bonding stuff. It feels like that's the attitude. I didn't want anyone to know I had children in care. I couldn't deal with it. I felt worthless inside. I guess I wasn't really supported in bonding with them and I wasn't able to be excited about their milestones that I might have seen in access. I didn't believe in myself. If they had helped me bond with my kids at certain times I would have believed in myself a bit more and grown from it. But it took me even longer to get to that point. I got there but not with their help. They should understand that whatever the Order, the mother still needs to bond with the baby and should be given time for that. (Laura)

5.2 The views of services

Services had a lot to say about breaking the cycle of recurrent removal. Like parents, they wanted to see more support available prior to any initial removal, which could walk alongside parents as notifications are made or as parents request assistance with particular issues. They also identified a number of ‘service gaps’ for those caught in a recurrent removal cycle. Addressing these gaps required:

- **post-removal support** delivered at varying levels of intensity through a case management model. Any model would need to be able to address:
 - understandings about and insight into the reason for removal;
 - coming to terms with the loss;
 - underlying issues including childhood trauma and/or a history in OOHC;
 - establishing positive contact with children in OOHC;
 - parenting support and improving confidence in parenting;
 - the management of income and housing difficulties; and
 - referrals for specialist support – alcohol and drug treatment, counselling, mental health services, support with domestic violence.

Parents required an individually tailored holistic response which can support them through the grief, loss and trauma, prevent a ‘spiraling down’ or at least limit it, and provide them with the information they need in a way that they can digest. As one support worker said:

There is a huge service gap once children are removed. There is no support for parents and there is an expectation that the parents will just fix themselves and understand what went wrong and get their children back. That is a huge and unrealistic expectation. They fall through the gaps because there is no support and no one to talk to once your children are removed. Child Safety will only speak to you about access visits and that’s about it. There is no one else to ask what do I do now, where do I go? It would be good if at the point of removal the parents were referred to a service that could help them deal with the emotional trauma and start to help them rebuild their lives. (Support worker)

- **intensive support during pregnancy** so that parents did not lose a second child for the same reasons that they lost their first. Despite procedures in place to identify at-risk pregnancies and coordinate supports to avert removal, all services reported a common lack of engagement and/or willingness to engage with support during pregnancy, especially for those who have already experienced removal. One worker said, ‘it’s report before support and it’s all about what they are doing wrong’:

Through the grief and loss a common reaction is for women to fall pregnant again. It concerns us that there doesn’t seem to be robust work from Child

Safety in some cases to try and shift the direction. We are clear that these women are going to represent and there is a very real practice gap in Child Safety. If we spent time really looking at them and where they are touching services and work to engage them, we would probably solve a large number of children going into care and the deep dark hole about where parents go.

(Health worker)

- **support during removal.** If removal is necessary then services wanted to see a process which was more humane and recognised the needs of both parents and children, particularly when newborns are removed.
- **trauma-informed practice and access to intensive therapeutic support.** There was a consensus that CSS staff and many mainstream services commonly lacked awareness about the complex grief responses of parents after removal and how this and past trauma impacted on their behaviours. At the same time current mental health services and specifically CAMHS are significantly underfunded and have a limited capacity to provide therapeutic interventions working specifically with trauma. One support worker said:

We need better intervention teams dedicated to working with and understanding the psychology of trauma. That would make a huge difference in potentially stopping that generational stuff that is so hard. We know psychologically what goes with all that past trauma, brains change and they react differently. They don't have the same regulation and they tend to act out as soon as they are threatened. That then is not viewed positively within services. There is limited understanding of the psychology behind all those things and that needs to improve. It could help them stop seeing the behaviour as the person and see the person as potentially someone they can support. (Support worker)

Currently few services can provide this long term therapeutic work in an affordable and accessible manner.

They are characterised by significant personality problems and non-engagement with services. They don't wish to engage or there is nothing to engage with. They are very damaged by exposure to trauma and its impact on identity development, self-harming, teen pregnancy and so on. Often there is severe borderline personality disorder (BPD) which is not easily treated or affects parenting capacity. They require a tertiary level intervention service. There is no medication to fix BPD and it requires intensive rehabilitative work and intervention which addresses a parent's own needs and their relationship to their child. Some of this can be addressed in adult mental health services and through perinatal/antenatal services which also address their social situation and attachment issues. (Health worker)

- **supporting parenting.** Whether or not children are returned, parents commonly retain the identity of parent and try to sustain this through access arrangements. Yet as long term orders are applied access may be reduced and there is little support to maintain the parent/child relationship and preserve family bonds and identity. Services wanted to see a better capacity to work with parents with children in OOHC to build parenting skills, particularly if there is another baby.

Any service post-removal needs to address the 'inner child' who has not been parented. There is no opportunity for change until these needs have been met. If they were parented that way that is the way they will parent because they know no difference. They need somewhere where child and family can grow together in safe environment. A short term residential facility like Mothercraft homes with no judgement and culturally safe practices where they can practice parenting in a realistic setting. (Support worker)

- **supporting parents with intellectual disability.** Services commented on a lack of understanding in CSS about the relationship between intellectual disability and parenting capacity. They wanted to see a separation between IQ and parenting assessments and the ability to access appropriate parenting support tailored to the need of people with intellectual disability.

CSS consider someone with intellectual disability as an incapable parent. That is the immediate assumption. Working with intellectual disability is a specific skill set. Psychological assessments may give a low cognitive age even though parenting is adequate. It requires a long term commitment to parenting support for those with intellectual disability, including functional assessment which looks at actual capacity not IQ assessments. Many are too fearful to ask for help if they don't understand something because of the fear of being identified and flagged. (Advocate)

Services commented on a general lack of support for fathers. They also commented on access to community for Aboriginal children placed in OOHC. When this is missing the lack of connection and sense of belonging can never be fully regained.

Full implementation of Signs of Safety consistently across the state was seen as crucial in addressing the issues parents experiencing recurrent removal face. They anticipated that this would not only improve outcomes for families but also improve the job satisfaction of CSWs by giving them permission to work in a more supportive and respectful way with families and incorporate trauma awareness into their work.

5.3 Models of intervention

Increasing international recognition of this ‘hidden’ cohort of birth mothers has led to an exploration of models of intervention that can effectively break the cycle. This is a new field which has been expanding since 2012. It is characterised by scattered local initiatives ranging from extending currently existing services to new stand-alone interventions which are being piloted and evaluated.

It has been pointed out that a proportion of parents will eventually turn their lives around and go on to successfully parent but that much of the detail of their recovery is unavailable (Broadhurst et al. 2017). This research and other studies have identified a number of key turning points for women involved in the cycle of recurrent removal. These include changes in intimate relationships, relationships with supportive professionals, insight and a willingness to learn and change and a desire to do better for children who have been lost or for any future children. Parents themselves see the immediate aftermath of removal as a key opportunity for working proactively and initiating change through intensive support (Hinton 2013).

There is a consensus that crucial in promoting change are:

- consistent relationship-based help where relationships are the focus of interventions and the means through which an intervention is delivered and healing occurs;
- informal support;
- learning from experience;
- harnessing parents’ commitment to their children and improving contact with their children in OOHC; and
- responding to the impetus for change that comes with a new pregnancy.

The forced adoption literature has something to offer in thinking about the kind of services women post-removal may require (Higgins 2014). As well as documenting similar collateral consequences for parents post-adoption, it points towards a service system which is flexible and individually tailored. Most importantly, any support needs to understand the necessary coping mechanisms required to function in everyday life like substance use, be non-judgmental, cover a range of domains including mental and physical health, social and economic wellbeing, and be accompanied by intensive and ongoing psychological and psychiatric counselling.

Of course there are a range of initiatives to work with at-risk mothers who retain custody of their children. These include models of residential care for young families facing a risk of removal, and many specifically target young mothers who have themselves had experience in the care system and face a higher risk of CSS investigation, a lack of social and emotional support and a lack of trust in service

providers (Mendes 2009). Models include supported accommodation for mothers and babies, intensive residential therapeutic services for the whole family, and parent and child fostering which offer accommodation and healthy parenting models in a foster home (Luke & Adams 2017). However the focus in this report is reviewing documented initiatives which specifically target parents experiencing recurrent removal.

5.3.1 THE PAUSE MODEL

This is the most intensive of the interventions which have been piloted and evaluated. PAUSE was first developed in London Borough of Hackney in 2013, co-founded by a former head of safeguarding in the Borough at a time when 49 women had had 205 children removed. It is a voluntary program for women who have experienced or are at risk of recurrent removal. It aims to reduce the number of children being removed by working with women to improve their wellbeing, resilience and stability through an 18-month individually tailored intensive package of support delivered by a dedicated highly skilled practitioner working with a caseload of 6 to 8 families. The support is based on a therapeutic relationship with the practitioner and can address a broad range of emotional, psychological, practical and behavioural needs, including the reasons for removal, improving parenting capacity and delaying subsequent pregnancy (McCracken et al. 2017). Three types of support are provided:

- emotional and psychological support to cope with the trauma of removal, isolation, understanding the reasons for removal and accepting responsibility;
- practical support to deal with issues like finance, housing, budgeting, living skills, access education, training and employment, navigating complex service systems, getting diagnoses, negotiating contact with children; and
- behavioural support including modelling positive social interactions and parenting.

To be accepted onto the program women must agree to using long-acting reversible contraception for the duration of the program so that they can focus on their own needs rather than another pregnancy. For many this is the first time they have been able to focus on themselves as individuals. Women are referred in but also contacted via assertive outreach, with the program being persistent in locating and contacting those identified via social care databases. PAUSE will go into women's homes, accompany them to appointments, court hearings and contact visits and mediate relationships with estranged family and partners. Crucial to engagement is independence from child protection services and its status as a voluntary program. PAUSE also works with partner agencies like domestic violence, health, housing and addiction services at an operational and strategic level to

improve the broader service response to PAUSE women, improve their access and assist with brokering relationships with children in care.

An evaluation of PAUSE examined its impact on removals and women's wellbeing and stability (McCracken et al. 2017). The evaluation found that PAUSE was:

- extremely effective in reducing the number of pregnancies over the 18 months of the program.
- having a positive and significant impact on women who engaged, including improved access to services, improvements in housing stability, substance use and domestic violence and increasing levels of confidence, self-worth and positive coping mechanisms. Women had also acquired new goals for their future including entering employment, education and volunteering. The quality of their contact with their children in OOHC had also improved.
- resulting in significant cost savings within a relatively short time period. Cost savings to the local authority of delivering PAUSE to 125 women were estimated at £1.2-2.1 million per year within two to three years after the 18 month intervention period.
- employing key mechanisms for change. These are an intensive bespoke program of support addressing women's needs holistically, direct advocacy to influence professional practice with partner agencies and working at a strategic level to adjust protocols and increase access and engagement.

The evidence base, however, is described as being in its infancy and PAUSE remains a learning organisation. Longitudinal evaluation is now required to identify the medium and longer term impact on the number of children removed, whether changes are sustained and to refine elements of the program.

Positive evaluation mean that there are 17 licensed PAUSE practices across local authorities in England, with more being established in 2018 and probable expansions to Scotland, Wales and Northern Ireland. However PAUSE is still dependent on individual local authorities choosing to fund it, with support for women being seen as optional rather than essential. Although initially PAUSE only worked with women who had experienced two or more removals, eligibility in many pilots has been expanded to multiple cohorts including those with only one removal and care leavers, with the ultimate objective being to work with women before any children are removed.

Beyond the licensed PAUSE model there are a small but growing number of other programs based on this approach which are being implemented across the UK. These share the key elements of the PAUSE model but differ in cost, referral criteria and intensity of support. Rising costs of removal have increased the likelihood of funds being made available for these kinds of services. They include:

- **Hummingbirds** funded initially through the Troubled Families Program²⁰. This is a voluntary action research program addressing holistic needs over a period of two years. It is facilitated by 1.75 FTEs with an initial target of working with six women in the first year. Relationship-based practice, peer support and group work are an integral part of the service in order to build supportive social networks, and birth mothers have been involved in designing the model (Lewis-Brooke et al. 2017). The local authority is intending to use the model to develop a pre-birth service for women who have had children permanently removed and become pregnant. The model will be formally evaluated.
- **Reflect** in Wales was developed in partnership with Newport Council, Barnardos and the Health Board. It offers up to two years intensive one-to-one support with the primary aim of preventing recurrent pregnancies in the short term when removal is the most likely outcome. It is 'encouraging women and their partners to understand their past, their present and achieve future goals'. Evaluation is ongoing (Roberts et al. 2018). It is now being rolled out across Wales and is seen as key preventative work in improving outcomes for children in OOHC.
- **Action for Change**. This was established across three London Boroughs in 2014. Once care proceedings are completed services refer parents who have experienced removal into the program. They are matched with one of four workers for weekly meetings to build a relationship and provide practical help, referral into services and intensive one to one therapeutic support, which is reassessed every three months. Since implementation, of the 51 referrals, 45 have engaged. Only one has gone on to become pregnant and has kept the baby. It is estimated that the program has so far prevented seven pregnancies and removals with a cost saving of £103,250 in care proceedings alone.
- **Positive Choices**. This has recently been established in Calderdale, West Yorkshire. Unqualified family support workers supervised by a social worker are assigned to vulnerable women who are pregnant and at risk of having a child removed. They are shown techniques to support their parenting and other approaches to deal with mental health issues and drug abuse and to assist in domestic violence situations. Nine women have been assisted in the first year with seven having retained custody of their children.

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20 The Troubled Families Program provides targeted intervention for families with multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse. It was launched in 2012 across England with the goal of reducing public spending on families who require support from multiple parts of the State.

Some jurisdictions in Australia have been considering the PAUSE model. Recognition of the high rates of recurrent removal in Sydney District led to proposals to establish the Sydney District Repeat Removals Project. This aimed to conduct a quantitative and qualitative analysis of the prevalence and nature of recurrent removal, a literature review and to develop a co-designed PAUSE program to support families who had experienced removal to build parenting capacity, improve outcomes for children and minimise the risk of recurrent removal. Forums were conducted with practitioners, the local health district and child protection to discuss implementing PAUSE and/or other alternative options. One concern raised was about eligibility requiring the use of contraception and the withdrawal of services if there was a pregnancy. This means that enhanced access to reproductive health must be part of any program.

However despite confirming that a PAUSE model would be an ideal response to high prevalence rates, a stand-alone PAUSE in its pure form could not be implemented without securing specific funding. Instead it was decided to enhance the current Pregnancy Family Conferencing Program to provide a more intensive model of support to reduce removals at birth and recurrent removal.

5.3.2 PREGNANCY FAMILY CONFERENCING

This approach has been developed in a number of jurisdictions to promote more collaborative working when an unborn baby is identified as a risk of abuse and/or neglect. Over a number of years King Edward Memorial Hospital in WA developed a bi-lateral schedule between the Department of Health and the Department for Child Protection and Family Support (DoH 2014). This was implemented in 2013. It offers three pre-birth interagency meetings within a Signs of Safety Framework to begin as near as possible to the 20 week booking-in procedure. This timeframe is compressed if ante natal services are not involved until the pregnancy is more advanced. Procedures entail:

- first meeting to share and assess all relevant information in order to reach a common understanding of risk and possible support interventions;
- second meeting at 26 weeks gestation to clarify any changes in circumstances and plan for the level of risk assessed; and
- final meeting at 32 weeks to progress the decisions made and promote transparency and openness with the mother.

Unless they are considered to be a flight risk parents are involved in the meetings as far as possible. Any removal must consider the needs of the mother, involve her in planning how the removal will take place, and provide psychosocial support, support for breastfeeding where appropriate and contact arrangements between the mother and the newborn. Removal must occur with minimal disruption for other patients and staff.

King Edward Hospital estimates anecdotally that 10% of removals are recurrent. A multi-disciplinary team forms around the most complex cases and the social work team performs an advocacy role and will engage legal and other services when necessary. They can follow up post-natally for three months, although the team is unable to do any outreach work. WA is currently designing residential mother and baby support for those at severe risk of removal, with a focus on Aboriginal women.

The WA schedule was adopted by NSW and is currently offered at two hospitals in Sydney District. There have been positive outcomes, with rates of removal decreasing. Other health districts in NSW are in the process of designing and implementing their own programs.

Sydney District is now developing an enhanced Pregnancy Family Conferencing Program with the goal of restoration and support for any future pregnancy. It entails developing Family Action Plans which include wraparound supports for families and ongoing connections with birth families in a more considered way post birth. This will address some of the difficulties with engagement and absence of an assertive service system working with vulnerable pregnant women. The approach will be assisted by the introduction of flexible packaging allowing the purchase of both mainstream and private therapeutic, substance use and mental health services as required. The model will be finalised and implemented by July 2018.

5.3.3 FAMILY DRUG AND ALCOHOL COURTS (FDACS)

Problem solving courts can acknowledge the underlying issues that lead to a court appearance and attempt to address the problem and work to change behaviour rather than simply processing cases. Yet family courts have rarely been used to promote change or intercept in cycles of harm by engaging directly with parents.

The high incidence of parental substance use in care proceedings and poor outcomes has driven the development of Family Drug and Alcohol Courts. FDACs work with parents who have substance use issues and are at risk of having children removed as a 'last chance'. They have specialist judges who maintain continuous engagement with each case and are backed by a multi-disciplinary treatment and support team, who engage parents in tackling problems that put children at risk of harm. They work through fortnightly judge-led review hearings and intensive treatment and support for parents. The close monitoring of progress means cases are dealt with in a collaborative rather than an adversarial manner.

An FDAC was developed and piloted in London from 2008-2012. An independent evaluation of the pilot in 2014 tracked the progress of 200 families and a comparison group over five years. It found statistically significant better outcomes for parents and for children (Reeder & Whitehead 2014). Compared with the comparison group, a higher proportion of parents ceased substance use by the end of the proceedings, the likelihood of reunification increased and lower proportions of families experienced relapse. The evaluation concluded that FDAC should be embedded into the Family Court and mainstreamed.

A further evaluation in 2016 (Tunnard et al. 2016; Harwin et al. 2016) tracked 240 families up to five years after the end of proceedings and found mothers had better short and longer term outcomes, including reunification. Two years after proceedings was identified as the time of maximum risk for the recurrence of substance use issues, neglect of children and a return to court. This suggested that two-year post proceedings support is required which is intensive, ongoing and multi-agency. The evaluation concluded that FDACs are more successful than ordinary services in minimising risk, keeping families together and helping parents to sustain their recovery. An estimation of the cost savings generated across London by FDACs found that in 2014/15 operational costs of £560,000 had led to estimated gross savings of £1.29 million to public sector bodies over five years. For each £1 spent, £2.30 is saved to the public purse due to fewer children entering the OOHC system, fewer families returning to court and less substance misuse (Reeder & Whitehead 2014).

Across the UK there are now a growing number of courts operating the FDAC model. Many judges are keen to expand this approach to care proceedings more generally and not just when substance use is involved, to give parents a voice in court and the best chance of turning their lives around.

In 2014 a FDAC was established in Victoria as a three-year pilot based on the London model. It is supported by a multi-disciplinary team of alcohol and drug clinicians and a dedicated social worker. Eligible parents must have at least one child aged 0-3 in OOHC, be seeking reunification, committed to ceasing their substance use and willing to participate in the program for 12 months. Participation requires regular court attendance, drug testing three times a week, attending treatment appointments and working towards achieving the goals of a Family Recovery Plan. At the end of the program the magistrate can order reunification, an extension of the program or a return to the Children's Court if no progress has been made.

5.3.4 COMBINING SUPPORT WITH LEGAL ADVOCACY

It is well established that the quality of the relationship parents have with CSS can determine outcomes and is key to mitigating the negative aspects of being involved with CSS. CSWs trying to foster a collaborative working relationship with parents continually complain of a lack of engagement. At the same time parents complain of not being respected or treated fairly, disagreeing about safety concerns and not feeling part of any decision-making process. These barriers to engagement have been attributed to the imbalance of power between the parent and the system, which prevents establishing a productive working relationship.

Social worker/lawyer teams have the potential to resolve strained relationships and improve their quality by better balancing the power between CSS and families. Increasingly a number of programs in the US are offering social work services directly to each court-involved parent in collaboration with a legal representative.

Evaluation has demonstrated an improvement in outcomes (Pott 2017) including:

- a better balancing of power when social workers focused on the interests of parents build trust and a better identification of problems and solutions tailored to the individual. This counters the current situation where any exposure of vulnerabilities is used against parents to argue for removal;
- the resolution of conflicts of interest where workers are better able to balance the needs of children and of parents; and
- a more efficient use of resources where earlier resolution of issues saves court time, prevents removal, preserves children's connections to their birth families and gives parents access to the support they need.

Whilst the child welfare system continues to be responsible for investigating reports, once an application for an Order has been made their role is to monitor, document and report on the family's progress in court and to facilitate access to services which have been ordered by the court. They are not responsible for identifying the needs of parents or formulating service plans.

The Healthy Mothers, Healthy Babies Project (HMHB) in New York was established in 2013 to 'break the cycle' by providing support combined with advocacy and legal representation during the peri-natal period. It was developed in response to the implementation of Child Safety Alert 14 (Ketteringham 2016). This policy outlined the protocol to be used when an 'at-risk' pregnancy is identified. The protocol highlighted prior child protection involvement as the primary safety concern alongside the level of compliance with the original safety plan to address the neglect of older children. The weight placed on the mother's history rather than current circumstances or progress made in addressing safety concerns led to low levels of support and high rates of removal at birth.

HMHB is located in the Public Defender Office and provides client-centred holistic advocacy from the moment a system-involved woman identifies as pregnant. She is connected to a dedicated social worker and a parent advocate who work collaboratively with her attorney as part of a legal team. The social worker helps her to access services and the parent advocate provides emotional support and encourages her to engage with and participate in services. The team helps her to identify what supports she needs to prepare for a newborn and avoid removal and is loyal only to the expectant mother, offering complete confidentiality. This allows her to voice her anxieties and problems without fear of reprisal or it being reported in court.

HMHB offers a weekly support group for pregnant system-involved women and many remain connected to the group after the birth. Rather than prescribing generic solutions like parenting or anger management programs, HMHB can address individual problems and poverty-related concerns like housing, income and unemployment. They can provide direct material assistance through a client emergency fund, such as help with baby equipment and clothing, groceries, breast pumps, transportation and whatever is required to facilitate access to their children in OOHC. The team provides

support without judgement and includes access to high quality legal defence and representation.

Since its inception the team has worked with 224 pregnant women and 54 parents of children aged 0 to 3 years. The result has been that 86% of newborns were not removed, and of those that were only 14% went into foster as opposed to kinship care. The team approach and effective representation engaged parents, supported the safety of their children and reduced entry to the OOHC system.

In Australia a recent review of the **Victorian Child Protection Legal Aid Service** aimed to establish a system of child protection legal services that were timely, appropriate, better at supporting children and parents, of higher quality and consistent across the state (VLA 2017). The review found that for parents involved in CSS there was not enough help available at the right time, and they required higher levels of legal and non-legal support before, during and after court processes. For pregnant women with CSS involvement there is currently no service providing advice about CSS issues and often little engagement with CSS during pregnancy to put support in place. This means they face a CPO shortly after birth when they may not be able to attend court and are therefore unable to participate in proceedings.

The review has resulted in a framework for the rebuilding of VLA's Child Protection Program. It uses a client-focused design which will target those families at greater risk of longer term engagement in the legal system and establish services directed at reducing that risk. The design recognises the need to empower clients at all stages of the child protection system to understand what is happening and participate in the process. It prioritises young parents, especially those who have been in the OOHC system themselves, and Aboriginal families. The Program will give a greater voice to clients in planning and designing services, encourage more interaction between clients and lawyers outside the court environment and support legal practitioners to acquire the specialist skills to better meet clients' needs. VLA is now establishing two pilots:

- a new Early Intervention Unit staffed by non-legal advocates to support families from their first contact with CSS, provide legal advice about their case and deal with matters before they go to court. The unit will prioritise parents with an intellectual disability and Aboriginal families.
- a health justice partnership to provide early advice and legal representation to pregnant women who are or may be the subject of an UBA. The partnership will involve staff from community legal centres, co-located in maternity hospitals, and accept self-referrals and referrals through the UBA process. It will be integrated with hospital social workers and support programs for pregnant and/or new mothers.

Preliminary evaluation of the pilot Early Intervention Unit demonstrated significant cost savings to the Legal Aid Fund and better support to parents. Full implementation is expected by 2021.

5.3.5 ADDRESSING GRIEF AND TRAUMA

Without addressing some of the emotional and practical issues which led to removal or resulted from removal, parents are not ready to reflect on their parenting or make any changes, and they require support to deal with complex emotions and trauma (Battle et al. 2014). A recognition of these intense emotions and of the importance of fostering positive ongoing links between parents and children in OOHC to improve outcomes has led to the development of group programs for parents post-removal. The past few years have seen a number of organisations offering programs targeted at those who have experienced removal, including Doorways to Parenting in Tasmania.

Kids in Care Group - Relationships Australia NSW was established in 2013 and runs over a three month period using a trauma-informed practice approach. It builds trust between members and facilitators to address shame, guilt, grief and anger, using the group as a vehicle for healing and learning. Facilitators challenge parents to consider how to constructively redirect their anger to achieve their goals and develop emotional regulation skills. The focus is not confronting neglectful or abusive behavior, but rather identifying strengths and allowing parents to engage in more reflective parenting. Individual counselling is offered to deal with trauma issues. It is made very clear that doing the program is not a pathway to having children returned, although it can demonstrate a commitment to getting support.

A key outcome from attending the program is finding better ways to manage the relationship with CSS and making it easier for parents to engage with other support services such as counselling and ongoing therapeutic work. It provides a soft entry point into other services and has been described as 'a feeder group', assisting parents who have never accessed services before or sought help to engage with a range of support services.

The program is offered every second term. Parents engage with it shortly after removal or, more typically, some months later. It is not unusual for parents to attend once and then come back six months later. It provides for those experiencing recurrent removal; a typical parent might describe how their children had been removed some years ago and they had now experienced the removal of a new baby.

The program is now manualised and an ongoing qualitative evaluation is being conducted by the University of Sydney.

Catholic Care NSW have developed a similar program, **My Kids and Me**, which is available across Sydney, Wollongong, Newcastle, the Hunter and parts of Victoria. The program runs for seven weeks both for parents with children permanently in OOHC and for those with reunification plans. Most participants also have a history of abuse and trauma. It is primarily viewed as a springboard for parents to access other services and promote identity reconstruction. It was positively evaluated in 2013 by University of South Australia (Gibson & Parkinson 2013).

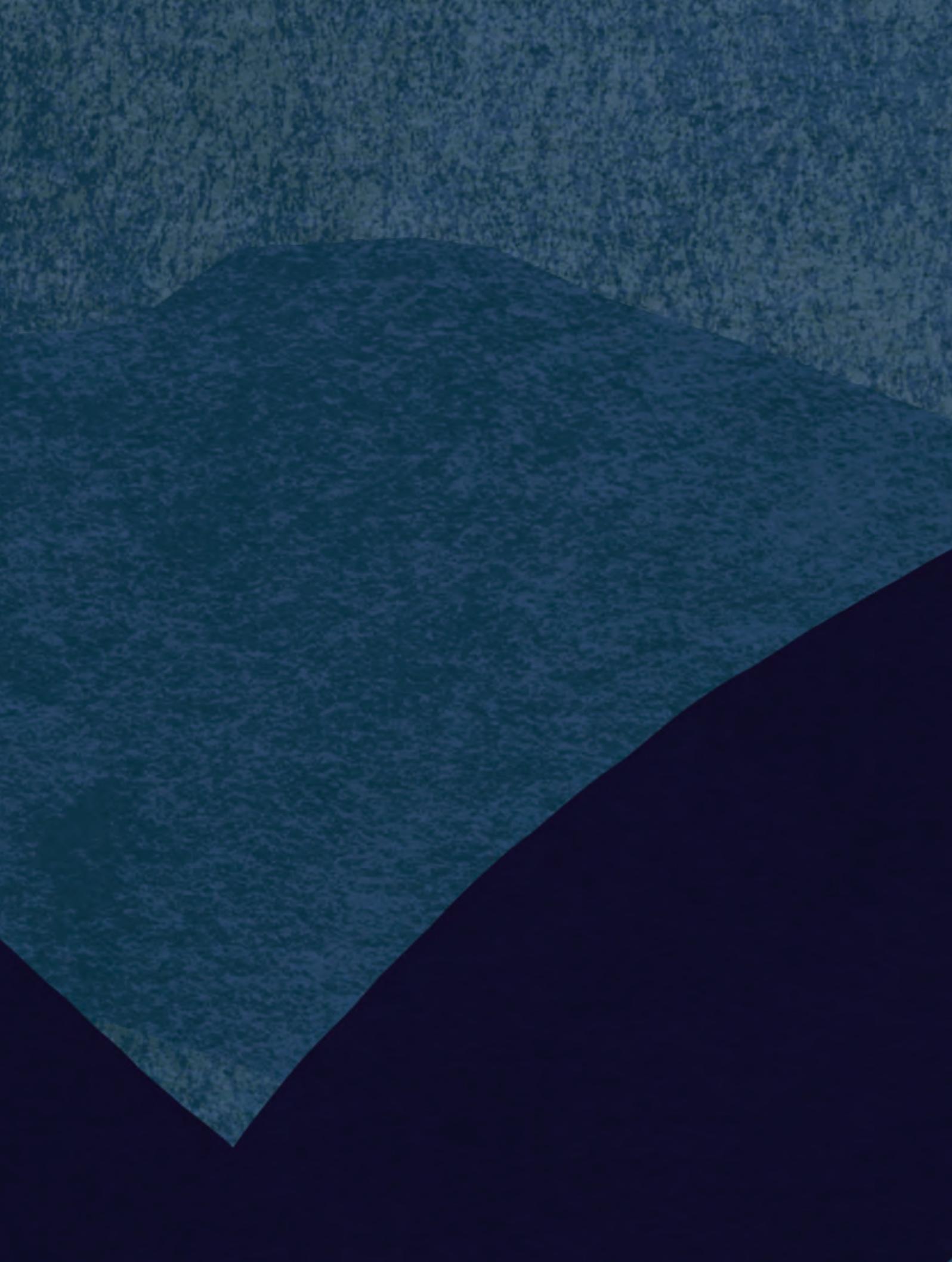
5.4 In summary

There is a consensus among parents and the services working with them about what is required to break the cycle of recurrent removal. It requires:

- Intensive support to assist parents to deal with the collateral consequences of removal, both practical and emotional, and provide a firmer base for reunification and/or the parenting of any future children. This should also extend to working with vulnerable pregnant women at risk of losing their unborn child. Key elements of support are:
 - case management to provide flexible, wraparound holistic support tailored to the circumstances of individual families and able to address multiple and complex need;
 - delivery by skilled, well-resourced professionals who are able to engage and build positive working relationships with families, walk alongside them and refer them into any specialist services they might require; and
 - a service network which offers appropriate assistance to this cohort and does not exclude parents by eligibility criteria, service capacity or service inappropriateness.
- A cultural shift within CSS to reduce system-induced trauma and promote better working relationships between parents and CSS staff. Two key elements of this are introducing trauma-informed practice across CSS and fully embedding a Signs of Safety Framework to standardise procedures and risk assessment and better engage parents in addressing any safety concerns.
- Revised decision-making processes within CSS which can focus on current circumstances rather than past events and allow for the possibility of change

A number of jurisdictions globally are exploring, piloting and evaluating how best to break the cycle. Although differing in design, cost and intensity, all interventions have at their core intensive and holistic support for parents post-removal, and in some cases pre-removal. The most developed of these models, PAUSE UK, can demonstrate significant cost savings in terms of reducing entry to OOHC and improving child and parent wellbeing.

Tasmania is a small jurisdiction ideally placed to work differently and build its own innovative response in this area. It is not a one size fits all model and any response must be integrated into the current redesign and tailored for the needs of specific cohorts, particularly young mothers, Aboriginal families and parents with intellectual disability.



CHAPTER SIX

Conclusions and
recommendations

6.1 Conclusions

Multiple removals from a significant number of vulnerable birth parents is a real problem in Tasmania. When one in five birth mothers who experience removal will go on to experience recurrent removal, this becomes a systemic failure where the system is unable to respond appropriately to parents as vulnerable adults who require support in their own right. For those birth mothers who have children removed when they are in their teens, well over a third (38%) will go on to experience recurrent removal. So many parents in the research described overcoming incredible odds and personal challenges only to lose their children to CSS.

Typically the vulnerability of parents is a consequence of histories of abuse, neglect, living in OOHC, early parenthood and a complex mix of high rates of mental health and substance use issues, experience of abusive relationships and low levels of education. Yet parents come to the attention of services not because of their own vulnerability but because of parenting issues or the risk they might pose to their unborn child. Removal leads to a 'perfect storm' of collateral consequences which compound the social, economic and personal challenges which led to the removal, and adds moral injury and system-induced trauma to their deteriorating circumstances.

Despite this vulnerability, once children are removed it is no one's mandate to actively support the parent. The serious downturn in functioning post-removal and the increasing risk of a further pregnancy are seen as evidence of irresponsibility, dysfunction and inability to parent rather than a need for support. Any supports are offered on a discretionary basis, and access to services is sporadic and often limited to tackling one area of their life, not the root causes of the challenges they face. With a Child Safety System focused on the needs of the child the needs of parents become less visible. In addition the lack of trauma-aware practice within CSS results in responses which are inappropriate, damage the ability of parents to address safety concerns and risk triggering trauma responses which further limit any chances of reunification. The consequence of not offering appropriate support to parents when children are removed are increased rates of entry to OOHC and life-long impacts on an already highly vulnerable group of people.

The current redesign of the Tasmanian Child Safety System aims to build a system which can improve the access struggling families have to support at a level of intensity that they require to avoid removal. However there remain systemic difficulties in responding to a vulnerable mother in need of support while witnessing the harm done to the child through neglect or abuse. The conflicts inherent in the drive to remain child-focused are played out in the response to vulnerable pregnant women, which so often results in monitoring rather than support. It raises questions about how to manage the complications of two sets of interests and where the duty of care for vulnerable parents lies.

Recurrent removal is an issue common to all jurisdictions and has led to pockets of innovative practice to reduce the likelihood of children entering care, particularly when there is a history of intergenerational disadvantage, neglect and abuse. Many parents have overcome enormous odds to survive their own histories and embark on parenthood only to have their efforts remain unsupported and to witness their own children entering OOHC, not once but a number of times. At the core of these interventions is intense relationship-based work and individually tailored responses which can provide wraparound support for parents. This not only improves their chances of avoiding further removal, but also supports them to maintain positive relationships with their children in OOHC and any subsequent children they may have. These interventions may be seen as costly. However given the risk of subsequent pregnancy, they can also be regarded as early intervention to reduce the numbers entering OOHC and an investment in improving current and future parenting capacity which impacts on the next generation.

6.2 Recommendations

There is a moral imperative to help families avoid the tragedy of recurrent removal. As the United Nations Convention on the Rights of the Child (UN 1989) states, children have a right of access to a healthy and functioning family and, if they are separated from their family, a right to stay in contact with both their parents. In the best interests of the child, governments must make every effort to support families to provide a safe and nurturing environment for their children whether or not they are in their care, and reduce the costs to society of children growing up in out-of-home care and the poor outcomes they can experience.

Based on these principles, the following recommendations combine the research findings about the prevalence and needs of vulnerable parents with current thinking taking place in a number of jurisdictions about how these issues might be best addressed. They identify different points in a parent's pathway through the Child Safety System where interventions must be made, and reimagine the landscape of legislation and practice in order to clarify where the duty of care to parents lies.

6.2.1 LEGISLATIVE AND POLICY FRAMEWORK

RECOMMENDATION 1: That the Department of Communities develop a policy framework to clarify where the duty of care for parents lies and how their needs should be met.

There is currently no strategic response to the needs of parents post-removal at either a micro or macro level and an absence of strategic thinking about how to meet their needs and the consequences of not meeting their needs. The *Children, Young Persons and Their Families Act 2013* states that a child's family is 'the preferred environment for care and upbringing', that the best outcome for the child

is to remain with their family of origin and that families should be strengthened and supported to provide a safe environment for their children. Child Safety Services has a duty of care to the child and seeks to maximise a child's best interests. However despite the push in the Act to keep children with their birth families whenever possible, there is no matching duty of care to support parents to provide a safe and nurturing environment. There is a strong disconnect between the intent in legislation and practice which reduces the chances of reunification and increases the risk of recurrent removal. A policy framework is required which recognises the interdependence of parent and child and the necessity to respond to the needs of parents in order to promote the best interests of the child.

RECOMMENDATION 2: That the Department of Justice and Children and Youth Services review current court processes and access to legal advice and representation for parents involved in the Child Safety System.

The research found that parents' experiences in the Tasmanian legal and court system can be fraught. This includes struggling to understand legal processes, gain appropriate levels of legal aid and representation and be able to challenge Orders or hold the court accountable for the conditions attached to Orders. There are particular concerns about the evidence which is used to justify removal and the significant amounts of money being spent on gathering and testing it. This evidence gathering can compound parents' problems and undermine their parenting confidence and capacity whilst failing to offer a pathway to support. High quality legal representation should be the right of all those accused of wrongdoing by the State. There is a need to review and improve parents' experiences in the legal system and adopt a problem-solving approach when decisions about permanency are being made.

RECOMMENDATION 3: That the Department of Communities ensure that parents with children in OOHC are proactively assisted to maintain the parent/child relationship and improve parenting capacity whether or not children are returned.

When children are in out-of-home care parents commonly continue to have parenting relationships with them, if not with the removed child then with subsequent birth children, step-children and extended family. Many young people will also self-place back with their birth families during adolescence or when they exit the out-of-home care system. The *Children, Young Persons and Their Families Act 2013* is strongly based on the United Nations Convention on the Rights of the Child, where the child has a right of access to a healthy family. Given the scale and complexity of the needs of parents experiencing recurrent removal and the implication for any children they have or will care for in the future, it is crucial they are supported to improve their parenting skills and are given opportunities to address any underlying issues which led to the removal of their children.

6.2.2 ENGAGING AND SUPPORTING PARENTS

RECOMMENDATION 4: That Children and Youth Services develop a clear framework to respond to and support those in out-of-home care and care leavers through early pregnancy and parenthood.

The strong link between maternal age, care histories and recurrent removal indicates the need to strengthen support for young mothers in or exiting the out-of-home care system. However young pregnant women and/or young parents in or exiting out-of-home care are in many cases standing on their own and struggling to access the support that they need. The research suggests an urgent need to clarify where the duty of care to this cohort lies and to review the supports available to them in Tasmania.

RECOMMENDATION 5: That the Department of Communities and the Department of Health ensure that intensive support is available during pregnancy to proactively engage vulnerable women and assist them to prevent removal.

Pregnancy is a window of opportunity and a powerful motivator of change. However, despite a range of procedures in place to identify at-risk pregnancies and support women to address safety concerns, parents and services report surveillance and voluntary agreement to removal being sought rather than any more proactive assistance to engage and work with support services to avert removal. The current support architecture should be strengthened to include specialist services available prenatally with the capacity to proactively engage with women and prevent further removal. This might include an automatic referral to specialist support services when an unborn baby alert is received.

RECOMMENDATION 6: That the Department of Communities ensure that skilled post-removal support be available to all parents who experience removal of their children.

Past trauma and the collateral consequences of child removal mean that when parents lose their children to the care system they face a perfect storm. Their ability to ride the storm and improve their chances of reunification or their ability to parent in the longer term, and whether or not their children are returned, can be dependent on the kind of support they have access to. There is a consensus amongst parents, services, researchers and policy makers both in Australia and globally that the most appropriate support offers a case management model tailored to the needs of individual parents and delivered at arms' length from Child Safety, by workers who can build a trusting relationship, address underlying issues and smooth pathways through the system. Ideally any intervention should be delivered at varying levels of intensity, be responsive to the differing needs of Aboriginal parents, young parents and parents with disability and be co-designed with birth parents who have experienced removal.

6.2.3 ADDRESSING TRAUMA

RECOMMENDATION 7: That the State Government ensure that trauma-informed practice becomes the norm across sectors working with vulnerable parents who have had their children removed.

Parents experiencing recurrent removal have trauma histories compounded by system-induced trauma and moral injury which undermine their parenting capacity, their ability to work productively with CSS and their future life chances. Parents complain of not being respected, being treated unfairly and not being listened to or involved in decision-making. Child Safety Workers complain of a lack of insight among parents about safety concerns, a failure to recognise children's needs and dealing with angry and aggressive parents who will not engage with Child Safety processes. Service providers complain of being trauma-aware but unable to provide a trauma-informed response because of funding criteria and under-resourcing. Any intervention for parents experiencing recurrent removal must recognise parents' exposure to trauma, understand the symptoms and the survival responses required to cope and be able to provide an environment which addresses trauma and protects against re-traumatisation. This report supports an argument for trauma-informed contracting of services to enable them to work in a trauma-informed way and provide the intensive, long-term support which parents need.

RECOMMENDATION 8: That the Department of Health and the Department of Communities ensure that parents have access to intensive therapeutic support which can address the underlying causes of the challenges parents face in parenting their children.

There is limited access to therapeutic support to address attachment issues and unresolved childhood trauma during pregnancy and after removal. This can require intensive adult and infant/child psychotherapy to begin to address ingrained patterns of behaviour, mother/child interactions and loss. There have been calls for mental health of child removal to be a substantive field of service delivery. But currently few services can provide the accessible and affordable long-term intensive therapy which parents need, and there is a significant gap in the therapeutic response for those with a past history in the Child Safety System and exposure to trauma who are experiencing child removal.

RECOMMENDATION 9: That Children and Youth Services ensure full implementation of the Signs of Safety Framework across the Child Safety System.

Parents describe being neglected and abused by the Child Safety System. The current Child Safety System redesign and embedding the Signs of Safety Framework across Child Safety is already having a positive impact on family-inclusive practice and the engagement of families with Child Safety processes. The Framework has the ability to reduce system-induced harm and trauma and nurture a 'do no harm' culture which can acknowledge and respect the circumstances parents endure and promote more positive working relationships with them. Full implementation of the Signs of Safety Framework would allow for a more productive balance between the identification of need and the assessment of risk, especially when there is a history of intergenerational disadvantage or previous removal.

RECOMMENDATION 10: That the Department of Communities develop good practice guidelines for the removal of children and specifically for the removal of babies at or shortly after birth.

Removal is often reported as traumatic for both parents and children. This trauma can be long-lasting and have a significant and ongoing impact on parent/child relationships and outcomes. This is especially the case when children are removed at or near to birth. A national toolkit is required to foster good practice in the process of removal. This must acknowledge the distress of those who are doing the removing so that they can better provide a more therapeutic response. This will promote a more humane approach and ensure emotional and practical support for parents pre-, during and post-removal.

6.2.4 MONITORING AND REVIEW**RECOMMENDATION 11: That the Department of Communities develop the capacity to collect data about the incidence and characteristics of recurrent removal, including trends over time.**

Any changes to policy and practice, and assessing how far they are responsible for a diverse range of outcomes, requires evidence. Data systems need to be fit for purpose. Data about the prevalence and characteristics of parents experiencing recurrent removal should be routinely collected in order to inform policy-makers and practitioners about the impact of any interventions and to evaluate the outcomes.



Appendix

Appendix: Themes from the research and policy literature

The serial removal of children from the same mother is reported in Australia, Canada, the United Kingdom and the USA. To date, however, little research has examined the experiences of those caught in this cycle to build an evidence base and inform any prevention agenda. This Appendix provides a brief overview of research and good practice literature which throws light on the cycle of recurrent removal. It is not exhaustive but rather identifies the major themes in the literature and what they tell us about the consequences of child removal and possible points for intervention.

A.1 The collateral consequences of removal

Research about child protection has focused on risk assessment and supporting families to address safety concerns and avoid removal. However there is an increasing volume of work describing the trauma of removal, what happens post-removal and its negative impact on birth parents and their families (Hinton 1999, 2013; Novac 2006; Harries 2008; Ross et al. 2017; Broadhurst et al. 2015, 2017a, 2017b).

A study in Canada explored the issues and service gaps for young homeless women who had lost custody of their children to the care system (Novac et al. 2006). More recently research in Western Australia and in Tasmania (Harries 2008; Hinton 2013) documented the experiences of families in the child protection system. A study in NSW (Ross et al. 2017) explored how far a policy of family inclusion and reunification is reflected in parents' accounts of their contact with the child protection system. These studies have highlighted a number of common themes in parents' experiences of removal and their relationship with child protection systems. These experiences have been identified as generating 'system-induced trauma' which is characterised by:

- **An absence of attention to and understanding of grief reactions** to removal. These reactions can persist and lead to chronic unresolved grief exacerbated by social stigma related to loss of child custody and parents' own experiences of childhood trauma. International literature reports long term physical, psychological and social damage for those who have lost their children, generating a future demand for mental health, substance use and homelessness services.
- **Difficulties in accessing support** and a loss of support services on removal. This includes significant drops in income and resulting housing instability, as well as problems in accessing quality legal representation.
- **High levels of disempowerment** in working relationships with the child protection system, in engaging with legal processes and in managing

relationships with carers. Hindered by unresolved trauma, many parents mistrust services, are reluctant to engage, lack clarity about service expectations and feel judged, stigmatised, tricked and unsupported.

- **A series of 'catch 22s'** throughout the child protection system where parents are 'dammed if they do and damned if they don't'. They are labelled as not asking for help/asking for too much help, reacting emotionally/not being emotional enough, in employment/not in employment (Ross et al. 2017). If they identify as in need of support they are then considered to be a risk to their children.
- **A deficit focus in risk assessment**, with parents being labelled as 'hard to reach', untreatable, unresponsive and unworthy. Decisions are controlled by child safety workers, largely unstandardised and often guided more by moral and political judgments rather than empirical research.
- **Difficulties in maintaining positive contact with children in OOHC**. Despite still identifying as parents and needing parenting help and support, systems do not currently acknowledge or assist parents to stay involved post-removal. There are many obstacles to maintaining and improving relationships with children in OOHC and retaining an identity as 'mother' or 'parent'.

Broadhurst et al. (2013, 2015, 2017a, 2017b) identified a series of 'collateral consequences' for parents of court-ordered removal which include:

- unresolved grief, anger and emotional damage;
- stigma and isolation;
- a deterioration in mental health, including increased drug and alcohol use and risk of suicide;
- a deterioration in material circumstances, including loss of income, housing insecurity, poverty and homelessness;
- a negative impact on relationships between the removed child(ren), their parents, siblings and extended family;
- a high risk of rapid repeat pregnancy and further removal; and
- a significant negative impact on a young mother's journey into and through adulthood.

In addition to the psychological and emotional issues faced by parents, the financial impact has been described in a number of studies (Hinton 2013; Fidler 2018). The strong relationship between social disadvantage, child protection intervention and, particularly, neglect has been well documented (Davidson et al. 2017; Bywaters et al. 2018), and economic hardship increases the odds of children entering OOHC (JinChoi et al. 2017). Poverty can induce stress and exhaustion as parents struggle to manage and they become increasingly visible to the child protection system due

to their interactions with government services (Ketteringham et al.). Poverty is also exacerbated when families already struggling financially experience immediate and dramatic drops in income as parenting payments and family tax benefits are withdrawn as children enter OOHHC. For many this is combined with the acquisition of substantial Centrelink debts. This can mean difficulties in meeting costs involved in maintaining housing, complying with any conditions imposed by CSS and maintaining contact with their children.

One under-researched area is the actual process of removal and how it is undertaken. Badly planned and implemented removals can compound the grief and loss and traumatise both parents and children. Although the literature resonates with descriptions about the removal of children from their birth parents, there has been little systematic work about the way in which removals are conducted. Children can be removed from school and day care, from a parent's home or on CSS premises. When a newborn is removed, until recently it was often considered kinder and easier for mothers not to see their baby in order to minimise emotional pain by removing any opportunity for attachment and bonding. Today, however, newborns are usually removed from hospital with parents being given hours or days to form attachment and/or establish breastfeeding. A Canadian study (Novac 2006) documenting the circumstances of removal at birth found:

- pre-natal services helping women to prepare for removal by involving them in planning how and when it should occur;
- an acceptance that time for attachment/bonding, however painful, is crucial so that parents can work through loss and have memories of the child and an identity as a parent;
- virtually no empirically validated guidelines for practice with birth parents about the process of removal; and
- an absence of emotional support. The compassion shown by hospital staff may be the only emotional support mothers receive.

Broadhurst (2017a, 2017b) has called for the development of good practice guidelines for removal, particularly when babies are removed at birth. An international task group is now being developed to look at good practice when mothers and infants need to be separated at or close to birth with a view to producing an international guideline.

A.2 Recurrent removal

Although recurrent removal and its high costs have long been recognised by practitioners working with families, to date they have received little legislative or policy attention or discussion about why history repeats itself and what can be done to prevent this negative cycle. A major catalyst for this research has been pioneering research conducted in the UK which, for the first time, focused attention on birth mothers who experience repeat court-ordered removal of children (Broadhurst et al. 2013, 2015, 2017a, 2017b). The research measured the scale of women's repeat removal using data sets held by the Children and Family Court Advisory and Support Service (CAFCASS) in England. The research looked at 43,541 birth mothers during a 2007-2014 window. It profiled recurrent cases, estimated the probability and timing of recurrence and explored the relationship between maternal age and recurrence. An accompanying qualitative study collated insights into why women return to court and what can be done to break the negative cycle.

What the study revealed is a sizeable population of birth mothers (24%) experiencing recurrent removal of infants and children, with one in four women becoming repeat clients of the family court within seven years. The time between proceedings was typically short with little opportunity to make any changes, and certainly not the time required to deal with serious problems like mental health or substance use issues. Typically women had troubled histories with multiple significant adverse experiences in their own childhoods. This history of trauma affects their ability to engage with services and change their behaviour to avoid further removal. Young women are most at risk, especially those who become mothers during adolescence and have a background in OOHC. Here removal rates for any subsequent births increase from one in four to one in three women. The absence of any post-removal protocols meant that accessing any support was ad hoc and often determined by the lack of appropriate services which could address women's needs. Without services a significant number who experience removal will go on to have further children who are also likely to be removed, with the length of time between each removal shortening.

The qualitative study examined how successive removals can compound the collateral consequences of removal, yet parents receive little support until the next pregnancy and a pre-birth assessment indicating a risk to the unborn child. Birth mothers who have changed partners and built a new family find themselves being re-investigated by CSS and potentially facing further removals. Given the risk of repeat removal and its longer term impact on the lives of individual parents, the research argues for a fundamental reappraisal of responses following removal to fit with parents' histories of disadvantage and a better understanding of how parents can salvage productive lives after removal.

The research demonstrated how recurrent removal can mean short interval pregnancies resulting in the removal of a newborn or an infant under 12 months.

Pregnancy is seen as a crucial period for preparing for motherhood and addressing any conflicts women may experience between their capacity to nurture and their need to rework their own early histories to be able to parent effectively (Judd et al. 2018). As a result any interventions which might prevent or delay a future pregnancy or intervene during pregnancy have become a key focus for thinking about how to break the cycle of recurrent removal. However, there is a lack of information about what happens in the gap between a first removal and subsequent pregnancy and few studies have explored women's motivations for a subsequent pregnancy post-removal in any depth. Novac et al. (2006) noted that, beyond unintended pregnancy possibly driven by the 'perfect storm' of the initial removal, a subsequent pregnancy could be motivated by a number of factors including:

- new hope for the future, choosing life;
- an opportunity for redemption from past failure;
- a chance to reclaim a socially acceptable and respectable identity;
- someone to love or to be loved by;
- cementing a relationship with the father;
- proving capacity to parent in the hope of having other children returned; and
- reluctance to terminate a pregnancy.

Other studies have looked at motivations to continue with a pregnancy among young women both in the OOHC system and exiting OOHC (Fairhurst et al. 2015). Here pregnancy can provide a pathway to seeking a stable relationship, an avenue for unconditional love, a sense of choice and control, a chance to mature and settle down, a potential source of healing from past experiences and a meaningful way of moving forwards and acquiring adult status as a mother.

What we do know is that the number of newborns and infants being removed is increasing across Australia, with Aboriginal children forming a growing proportion of this population (AIHW 2018). In the last ten years all jurisdictions have changed legislation and developed guidelines to enable pre-natal reporting of pregnant women to CSS, with a stated goal of providing more opportunity to work with pregnancies considered to be at risk and of maximising access to intervention and support to avoid removal at or near birth. The interface between maternity hospitals and CSS has become crucial in thinking about how they might effectively work together to promote early identification of problems and potential interventions (Harrison 2015). Maternity services now have routine systems for the screening and assessment of psycho-social needs prenatally, which alongside pre-natal reporting trigger CSS involvement. However there is little information about the impact of pre-natal reporting on removal rates or its effectiveness in eliciting the support women might need to avoid removal.

Two studies have examined the link between prenatal reporting, access to support and rates of removal. A review of the legislation and policies across Australia related to maternal screening for alcohol and drug use during pregnancy (Taplin et al. 2014) found a lack of data on prenatal reporting and removal at birth. It also found that although prenatal reporting focused on early identification of risk and the provision of services and supports, the extent to which this was realised in practice was unclear. There was some evidence to suggest that early engagement and strategies like case conferencing were providing promising mechanisms for developing sustainable plans to support women. However, unless that support continued into the post-natal period, women were experiencing removal as the supports fell away. There was also evidence to suggest a weakening of the supportive focus and a leaning towards more punitive responses by child protection services. This meant that the consequences of prenatal reporting could be maternal disengagement, avoidance, later presentations and increased involvement with child protection.

A later study examined administrative data and the casefiles of women reported prenatally to child protection in one Australian jurisdiction (Taplin 2017). It looked at the timing and reasons for reporting, service responses and their impact. The study concluded that although two-thirds of those reported had received some kind of pre-natal support - for example a referral to maternal and child health services, supported residential accommodation and housing assistance, parenting and family support - it was generally of limited duration and there was little evidence that it led to better outcomes. Despite a high motivation to change during pregnancy, reporting could mean surveillance rather than support.

Harrison et al. (2015) examined seven years of data on removals in Western Australia and the key policies which guide practice in maternity health settings, in child safety and in working with vulnerable pregnant women. In particular the research looked at the issues for pregnant women when their circumstances or their history was seen as a risk to their unborn child. The study found a population characterised by clinically significant levels of mental health issues, which spiralled down after removal, and high levels of grief, which was likened to experiencing a stillbirth. Word of mouth information about UBAs and early removal could lead to reduced usage of antenatal care. Importantly, engagement with services was primarily in relation to the safety of the child, rather than the mother as a recipient of services in her own right in order to facilitate change. Mothers felt their problems were decontextualised, including their own difficult childhoods, poverty and their need for help, and they were put under surveillance rather than supported. The research concluded that the needs of mother and child are interdependent and should be the unit of attention in policy and practice frameworks in order to promote the best interests of the child.

Research to better understand the intergenerational nature of women's involvement with CSS (ACCPCF 2015) reviewed a sample of those subject to UBAs in 2014 in South Australia. It found:

- ninety percent were either first time parents with their own histories of childhood abuse and neglect (21%) or parents with at least one child already known to CSS (66%). A quarter of these also had a history of abuse and neglect;
- high levels of domestic violence across the sample, and the majority of reports including substance use; and
- a quarter of those subject to a UBA had infants removed before they were two years old.

The research concluded that traditional assessment and referral was unlikely to work with these families. To ensure any intervention is timely and effective, services and systems must be aligned to the needs of those suffering from trauma, high levels of domestic violence and significant substance use. It also concluded that intervening before or during pregnancy could prevent substantial numbers of children entering the OOHC system. The research is now examining a series of sub groups to trial models of working, including first time teenage parents with a history in OOHC, parents with other resident children known to child protection and parents who have had previous children removed.

Perinatal psychiatry is beginning to explore how best to identify and work with high risk mothers during pregnancy with histories of trauma, abuse and attachment disruption (Judd et al. 2018). This includes pregnant women with psychoses, learning difficulties, borderline personality disorder, substance use, depression and anxiety and a history of contact with the child protection system. Working effectively in this area requires interventions which can move beyond improving practical parenting capacity to considering the mother's ability to engage with an infant and attach. As Judd et al. point out, it requires a move from short term goal-orientated psychological strategies to longer term psychological therapies which can support the mother with the resolution of past trauma and reduce the repetition of maltreatment. Effective models of clinical perinatal intervention must focus on the needs of both mother and child so that the relationship can be reparative and preventative and break the transgenerational cycle of problems. At present there is little support for this work at either a policy or a resourcing level.

Funded by the Australian Research Council, research is now being progressed in NSW and WA by the Australian Catholic University in partnership with the University of Lancaster to explore rates of infant and newborn removals, rates of prenatal reporting and recurrent removals. The research will examine services and interventions during pregnancy and provided on removal and identify best practice and strategies to reduce the need to remove babies. The research will report in 2020.

A.3 Working with trauma

It is increasingly recognised that many users of welfare services, including parents subject to recurrent removal, are likely to have experienced traumatic life events. This means that trauma and the service response to it is becoming an important concept in the delivery of human services.

When children are removed and parents are left to deal with the collateral consequences, they can experience system-induced trauma. This is associated with the loss of the role and status of parent, a loss of reputation and a loss of relationships with family and extended family. As well as grief parents can experience shame, guilt and stigma. If their parenting has been judged unsafe they lose the right to be treated equally or with respect (Battle et al. 2014), either in their own minds or in the beliefs of others.

The concept of 'moral injury' is useful in understanding a parent's response to removal. Moral injury refers to the lasting psychological, spiritual and social harm caused by one's own or another's actions that transgress deeply held moral beliefs and expectations about right and wrong (Haight et al. 2017a). It is a concept which was developed while supporting Vietnam veterans suffering distress which was not fully explained by post-traumatic stress disorder (PTSD). The mismatch between core beliefs and actions can lead to a breakdown in an individual's sense of integrity and persistent distress. Parents in CSS can experience moral injury due to harm inflicted by themselves or others on their children, their failure to protect or to provide basic necessities and when social systems which should be helping them are instead harmful. This contributes to feelings of guilt, shame, rage, depression, betrayal and loss of trust in their own or others' capacity to behave in an ethical manner. If unaddressed it can lead to acute emotional distress which can persist for years, undermining efforts to move forwards with life or constructively engage with CSS. Parents experience moral injury and/or 'system-induced trauma' due to:

- professionals' behaviour - an adversarial stance, unethical/dishonest behaviour, a lack of compassion, harming and neglecting the family, or attacking and shaming it;
- problematic services which are not relevant to a family's needs, such as inappropriate referrals and poor quality foster care;
- an adversarial system which allows attacks on parents already under stress, puts them always in the wrong, takes behaviour out of context and distorts it, or uses normal human responses like grief and anger against them;
- their own actions - living with other addicts, harming their children, failing to protect them from an abusive partner; and
- problematic laws, policies, procedures - automatic child protection involvement even when circumstances have changed or cultural issues in relation to Aboriginal families.

As Haight points out, the guiding principle for many parents is working to avoid doing what their parents did to them. However, under stress it can become a significant challenge not to reproduce their own traumatic childhood experiences when raising their children. This in turn raises the risk of suffering from moral injury.

The system-induced trauma and moral injury experienced by parents can be compounded by the impact of trauma from their own childhoods. Although individual responses to traumatic life events vary widely, evidence suggests that exposure to abuse, neglect and domestic violence in childhood is associated with a broad range of negative outcomes including mental and physical ill health, social and relationship difficulties, and poor academic and employment outcomes in adolescence and adulthood. Multiple developmental and ongoing trauma is called complex trauma. SAMHSA²¹ (2014) described the causes and consequences of trauma:

Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing.

Complex trauma can have a major impact on an individual's ability to manage internal states and can result in problems with mood regulation, impulse control, self-perception, attention and memory disorders (Battle et al. 2014). Complex trauma symptoms include dissociation, elevated emotional reactivity, anxiety, a diagnosis of borderline personality disorder or dissociative identity disorder, substance use and self-harm (Battle et al. 2014). It can leave people seven times more likely to get into difficulties with alcohol and five times more likely to have problems with drugs. They also carry twelve times the risk of suicide (Aynsley et al. 2017)). Some Aboriginal communities experience trans-generational trauma where trauma is transmitted across a number of generations. Parents who are experiencing trauma have trouble with developing positive working relationships with CSS and will regularly present with anger, defensiveness, mistrust and difficulties in engaging with identified safety concerns (Battle et al. 2014).

There is an increasing body of work which explores the impact of trauma and how human services should tailor their responses to those who have experienced it through trauma-informed models of care (Wall et al. 2016). These models include an acknowledgement that unless clients' presentation to services is understood in the context of their trauma history, there is a risk of re-traumatising them and adding system-induced trauma. Although Australia currently lacks an overarching

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21 SAMHSA - Substance Abuse and Mental Health Services Administration has been leading efforts to incorporate trauma theory into service delivery in the USA. SAMHSA funds the National Center for Trauma-Informed Care and the National Child Traumatic Stress Initiative in the USA.

framework for trauma-informed practice, there is a consensus that policies and service delivery must address and respond to trauma appropriately to promote better outcomes (Wall et al. 2016). This is especially true in the child protection setting where dealing with crisis and risk can lead to misunderstanding parents' responses to trauma and deprioritising trauma-informed responses to parents.

Kenny (2015) outlined the key elements of trauma-informed service delivery:

- a safe, supportive environment which protects against re-traumatisation;
- understanding clients and their symptoms in relation to their history, experiences and culture;
- ongoing collaborations through all stages of delivery and treatment;
- an emphasis on skill building rather than managing symptoms;
- an understanding of the symptoms and survival responses required to cope;
- a view of trauma as a fundamental experience that influences an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with them.

Practitioners can also experience moral injury or system-induced trauma as a result of under-resourced systems, high caseloads, laws and policies they see as unfair, abusive parents and an adversarial system (Haight 2017b). Their reactions are similar to those of parents – anger, sadness, emotional numbing, guilt and shame. Continuing to work in a moral and ethical manner becomes problematic in a system which is viewed as deeply flawed. Coping mechanisms can include acceptance, or seeking employment elsewhere. The study concludes that more thinking is required about how professionals should respond to moral injury, but suggest the problem lies within the system itself.

A.4 Longer term outcomes

What happens to parents who lose children permanently to the care system? The longer term impact of child removal on parents has been hard to assess and represents a significant gap in the literature (Hinton 2013). This is partly attributable to the reluctance of parents to remain visible within the service system once their children have been returned or permanently removed from their care.

There are clues about outcomes from talking to those who experienced OOHC themselves and how it impacted on relationships with their own parents and extended family. Accounts reveal a spectrum of experiences from irreparable, broken and fractured relationships to those where attachments remain strong and supportive. What is clear is that after removal most parents maintain their identity as a parent. Many adolescents will also self-restore and return to their birth families

either during their time in OOHC or on leaving OOHC. There is evidence to suggest that up to 57% of children in care seek out their birth families on exiting OOHC in their late teens (Kenrick et al. 2006; Salveron et al. 2010). These experiences are highlighted in the forced adoption literature, which recognises that family ties are for life and that the trauma of interrupting the parent/child bond can have lasting negative effects for all involved (Higgins 2014). A UK study exploring the experiences of homeless mothers who lost their children, often years previously, identified the overwhelming negative and destructive impacts on their lives and their chances of rehabilitation (Hinton 1999).

The importance of continuing contact between parents and children in OOHC has long been recognised and indeed enshrined in the United Nations Convention on Rights of the Child (UN 1989). Removing children is not a final solution and without supporting positive contact between child and birth family there are concerns that young people return to parents still struggling with the mental, physical and social issues which led to removal. Parents go on to have other children or become step-parents of their partner's children. It therefore makes sense to continue to support them to have a meaningful relationship with their children and improve their parenting capacity. There is a consensus that good quality contact promotes positive outcomes including placement stability and a sense of identity for children. This has led to a range of programs designed to improve contact, involve parents in decision-making, improve relationships between parent and carer and promote the quality of access visits (Ivec 2013).

Most parents continue to see their children once they enter OOHC. There are various forms of contact including face-to-face visits, supervised or unsupervised, in the home of the foster or kinship carer, the parent's home, a child protection office, a neutral space or a contact centre. There is also indirect contact through telephone calls, texts, social media and the swapping of gifts and photographs. Indeed one of the main collateral consequences when children are removed is the struggle many parents experience to maintain what they consider to be adequate access to their children, which can gradually reduce as long term orders are granted. At completion of care proceedings 94% have face-to-face contact. This reduces to 42% after 5 years (Bullen 2015).

In Australia contact is commonly supervised with a worker appointed to monitor interactions between parent and child and in some cases be more proactively involved in supporting the development of parenting skills. However, as a literature review identified (Bullen et al. 2015), there is no common understanding of the concept, definition or purpose of contact among providers and little is known about the benefits of or best practice in managing contact. Generally guidance on delivering and managing contact is lacking (Bullen et al. 2015, 2016). It is usually done on a case-by-case basis depending on the child's age, parent/carer relationships and parent/child attachment. When done well it performs a number of functions including supporting the parent/child relationship, supporting

reunification, maintaining identities and promoting attachment with carers. However poorly planned and managed contact can be harmful, disruptive and prevent a sense of permanence, especially when there is a bad relationship between parents and carers or parents are unreliable, disinterested or rejecting (Chateauneuf et al. 2017).

Research concludes that the value of positive contact is undisputed. Given its paramount importance to both those in OOHC and their parents, research in this area should be given a high priority by government so that decisions about how and when it occurs and how it is managed are made on the best available evidence (Chateauneuf et al. 2017).

A.5 The needs of particular groups

Particularly at risk of removal and recurrent removal are women with disabilities, Aboriginal women and young women, especially those who have had experience of OOHC.

A.5.1 WOMEN WITH DISABILITY

Although there are no exact figures available, international estimates suggest that birth mothers with intellectual disability are disproportionately represented in child protection systems. Although only 1-2% of all families have a parent with a disability, a high proportion of families where a parent has an intellectual disability come to the attention of child protection and support agencies (Lamont & Bromfield 2009), and estimates suggest they have a 40-60% chance of having a child removed (Frohman 2009). In Australia 8.8% of applications for child protection orders involved parents with intellectual disability (Llewellyn et al. 2003). In NSW one in ten cases before the Children's Court in 2009 involved a parent with an intellectual disability (Mayes & Llewellyn 2012). Although there are no accurate figures in Tasmania, a review did suggest that about 10% of birth mothers with children in OOHC in Tasmania have an intellectual disability (Vargas 2014). It is suggested that prevalence rates are fuelled by a lack of understanding among CSS staff about intellectual disability, discrimination and an absence of support services.

The primary reason why women with disability enter CSS is child neglect and risk factors associated with social isolation, poor support networks, a reliance on benefits, social disadvantage and experience of maltreatment as children. A survey of 297 child protection workers in three countries (Tefre 2017) indicated that intellectual disability acted as a 'red flag'. They were likely to assume that parents with intellectual disability are unable to change, do not understand the need for change and are incapable of learning the necessary skills. However they also recognised the lack of appropriate support services to enable parents to keep their children.

It is unclear whether parents with intellectual disability have a heightened risk of recurrent removal, although anecdotally that appears to be the case. However those who do have their children removed suffer from the same grief, loss, anger and sadness as other parents and the same range of collateral consequences. These include difficulties in dealing with child protection, retaining contact with their children and accessing support to deal with their issues, all of which may be compounded by their disability. The birth of subsequent children can herald a new cycle of grief and highlight a systematic failure to provide adequate support to mothers when their first child is removed (Mayes & Llewellyn 2012).

Services are finding innovative ways to support parents with disability to keep their children. There has been some success in using a parent's National Disability Insurance Agency (NDIA) package to fund 24-hour supported respite to enable a mother with intellectual disability to learn the skills necessary to care for her baby and avoid removal. This has included input from a disability organisation skilled in teaching people with intellectual disability. Currently there is a push to develop a Memorandum of Understanding between NDIA and child protection systems nationally and at a state level to address these issues.

A.5.2 YOUNG WOMEN

The strong correlation between recurrent removal, intergenerational disadvantage and young mothers has focused attention on early parenthood and care leavers (Fairhurst et al. 2016; Campo et al. 2016; Mendes 2009). This is reinforced by concerns about the moral obligation of the state to take responsibility as a grandparent and to deal differently with this cohort by giving them every opportunity to break the cycle of removal.

However there are no accurate figures available in Australia about the scale of this issue. The Child Protection National Minimum Data Set (CPNMDS) does not include information about the number of pregnancies or births in OOHC either at a whole population level or for particular jurisdictions. Research conducted by the CREATE Foundation (McDowall 2009) found that 28% of care leavers were already parents. International work suggests between one-third and half of leavers are either parents on exiting OOHC or become parents shortly afterwards and face a higher risk of rapid repeat pregnancy and removal (Fallon & Broadhurst et al. 2015; Broadhurst et al. 2017a). Their circumstances are compounded by trauma and attachment issues, poor educational attainment, a lack of appropriate parenting models, housing instability, social isolation, few family supports and poverty (Mendes 2009; Farber 2014).

A study conducted by Anglicare Victoria (Fairhurst et al. 2015) explored the experience of early pregnancy and parenthood for those in and exiting OOHC. The study found a vulnerable population struggling with the compounding effects of trauma and adverse childhood experiences, and an absence of services specifically targeted to their needs despite their perceived heightened vulnerability. This means

they are more likely to come to the attention of CSS during pregnancy, birth and early motherhood and transfer their disadvantage to the next generation.

A literature review about improving preparation for parenthood among care-experienced young people noted many calls to action in the research but little reporting of interventions which have been developed to address it (Fallon et al. 2015). The absence of data about the scale of the issue has contributed towards a lack of policy and supports relating to early parenthood among care leavers.

A.5.3 ABORIGINAL WOMEN

It has long been recognised that Aboriginal people are over-represented among families in contact with child protection systems. In Tasmania 27.3 per 1,000 children in OOHC identify as Aboriginal compared to 8.1 per 1,000 amongst the non-Indigenous population (AIHW 2017).

The policy of the forcible removal of Aboriginal children known as the Stolen Generation and the long term impacts on those affected means that Aboriginal families have become a specific focus for research about child protection. All jurisdictions in Australia have adopted the Aboriginal Child Placement principle which requires that when children are removed they should be placed with extended family, the Aboriginal community or other Aboriginal Australians in order of preference.

There is a large literature which explores the experiences of Aboriginal families in working with child protection systems. One of the underlying issues that has led to their over-representation in the system is cultural differences between Aboriginal communities and welfare agencies in their understandings of family relationships and child-rearing practices, with Aboriginal families perceived as unstable or dysfunctional (CFCA 2017b).

In order to address the over-representation of Aboriginal families the National Framework for Protecting Australia's Children (DSS 2009) takes a public health approach to improving outcomes by addressing disadvantage, recognising and promoting family, community and cultural strengths and addressing specific risk factors like alcohol or substance use and domestic violence. This national drive promotes a more culturally appropriate response including policy, practice and interventions which are accountable to Aboriginal and Torres Strait Islander people.

A.6. In summary

There is a limited but growing body of research and policy literature about the prevalence, characteristics and experiences of birth parents who are subject to the recurrent removal of their children. Typically studies reveal a significant population of birth mothers with adverse experiences in their own childhoods and a lack of

services available post-removal which are appropriate to their needs and/or able to reduce the chances of recurrent removal.

There is a consensus among studies about the collateral consequences of child removal and its negative impact on mental and physical health, material circumstances, support networks and the chances of reunification. Of particular concern is the system-induced trauma generated by parents' contact with child protection systems, which exacerbates pre-existing difficulties and further undermines the ability of parents to provide a safe environment for their children.

Although the conduct of a removal can mean the difference between traumatised parents and children and capacity to accept the situation and work to redress it, the practice of removal is under-researched. This has led to a push for evidence about good practice and the development of international good practice guidelines for how removals should be undertaken.

The longer term outcomes for parents of child removal are less well researched but indicate a continuing wish to maintain the identity of 'parent' and to sustain a positive relationship between parent and child whether or not children return to their birth families. Research in this area identifies a growing concern that there is both a moral and practical imperative to provide services to support parents who have lost children to find a meaningful life, feed the parent/child bond, prevent recurrent removal and build a more solid foundation for parenting any future children.

The emerging field of trauma-informed practice is highly relevant to both families and professionals involved in child protection systems. It explains the behaviours of parents, fosters understanding and contributes towards the development of services which can engage with and respond to parents effectively. As Wall et al. (2016) have stipulated, trauma awareness must be translated into concrete policy statements and frameworks that can be applied when working with traumatised populations across different service systems.

The high rates of removal of newborns and infants have focused research attention on what happens during pregnancy and how far pre-natal reporting impacts on removal rates. Although pregnancy can present a window of opportunity to intervene to avert removal, research has consistently demonstrated that current practices and a focus on 'the best interests of the child' marginalise questions about parents and their support needs, make arbitrary distinctions between risk and need and fail to fully exploit the window and provide the intensity of support that vulnerable pregnant women require.

The research suggests that the needs and rights of both the mother and the unborn child are critically important and interdependent. As Harrison et al. (2016) have identified, this means that the mother/child unit should be the focus for attention in policy and practice frameworks. This requires a positive focus on pregnancy, pre-birth assessments and planning rather than the primacy given to the 'best interests of the child'.

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