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Everitt L, **Homer CSE**, Fenwick J. (2017). Working with vulnerable pregnant women who are at risk of having their babies removed by the Child Protection Agency in NSW Australia. *Child Abuse Review*. 26 (5), 351 - 363

## **Working with vulnerable pregnant women who are at risk of having their babies removed by the Child Protection Agency in NSW Australia**

### **ABSTRACT**

In this paper midwives experiences of working with vulnerable pregnant women who were subject to child protection orders in New South Wales, Australia and faced the possible removal of their baby at birth, known as 'assumption of care', are described. A qualitative descriptive approach was used to explore the experiences of ten midwives who had been involved in some 91 episodes of assumption of care. In-depth interviews were undertaken and thematic analysis was used to analyse the data set. Four themes were elicited that demonstrated how midwives worked with vulnerable women and Community Services during the antenatal period. These were labelled; Reporting- Taking the first step; The woman-midwife relationship remains a priority; Jumping through the 'community service' hoops; and Crunch time: the decision... sometimes justifiable sometimes not? Even though the three-way relationship between woman-midwife-community services could be confronting it was essential that midwives worked in positive way with Community Services to improve outcomes for the woman and her unborn child.

### **Key Practitioner Messages**

- Working effectively with community services is essential. Sharing information and developing multidisciplinary approaches and pathways will produce the best outcomes for vulnerable newborns and their mothers whilst at the same supporting health and community workers to work in a cohesive manner to provide quality care.
- Midwives need to be supported to stay 'woman centred'. Keeping the woman engaged in the system will help ensure the health of the fetus (baby)
- Further research is needed to explore the perspective of all those involved in assumption of care.

**Four keywords**

Child protection; midwives; pregnancy; vulnerable women

**Word length:** 4400

## **INTRODUCTION**

Supporting families to ensure the health and wellbeing of children is a major responsibility for most governments around the world. The protection of children is embedded within the United Nations Convention on the Rights of the Child of which Australia is a signatory country (Sanson & Wise, 2001). Enacting child protection legislation is one of a number of major strategies undertaken to achieve this goal. Child protection is thus the responsibility of every state and territory government in Australia (Commonwealth of Australian Governments, 2009).

The New South Wales (NSW) Community Services Agency is the largest child protection service in Australia. The service aims to provide support and assistance to vulnerable families and as a result reduce and/or prevent the need for the involvement of statutory child protection services. The agency works closely with community, government and non-government organisations. In serious cases of abuse and neglect the statutory child protection services are involved and manage the situation; often removing the child (referred to as assumption of care) (NSW Department of Community Services, 2006).

Statistics indicate that the number of reports relating to child protection issues is increasing in Australia (Goldsworthy, 2015). Infants are over-represented in these reports. The rate of reporting children aged less than one year is higher than any other age group (Australian Institute of Family Studies, 2012; Goldsworthy, 2015). Notifications of suspected child abuse or neglect are made most frequently by police, school personnel and health/hospital staff (Mathews & Scott, 2014). Reports related to children under one year most commonly originate from health care reporters, which includes midwives (Zhou & Chilvers, 2010).

Despite the fact that midwives are the predominant workforce providing care to childbearing women and their newborns, and therefore work in the child protection space, there is very limited research exploring their experiences. One of the few midwives to publish in this area of practice is Gaynor Wood (2008). Wood's qualitative work undertaken with midwives in the United Kingdom (UK) identified the importance of midwifery involvement, identification and collaboration in child protection services during pregnancy. However, earlier related work exploring midwives' experiences of their health promotion role found that midwives were challenged when working with pregnant women in domestic violence situations and/or with alcohol and substance abuse issues (Lavender, Bennett, Blundell, & Malpass, 2001). In this UK study, midwives recognised the need to assess for and recognise risk factors and subsequently involve child protection agencies. However, the midwives reported feeling anxious and worried that doing this would impact on, and undermine, their ability to form effective professional relationships with the women.

The tension midwives potentially face when needing to prioritise the unborn/newborn over the woman has been previously identified by Chapman (2002; 2003). Midwives described feeling stressed and anxious in situations where getting to know women might reveal child protection concerns. Chapman (2003) used the analogy of 'walking a tightrope' to describe how midwives worked to maintain a woman-centred approach to care whilst identifying the unborn child at risk of harm. Working with vulnerable families and child protection services in the best interests of everyone was a challenging space for midwives to find themselves in. This was especially so knowing that removal of the baby may be a possible outcome.

Midwives have a unique role in providing quality maternity care to vulnerable and disadvantaged families and ultimately in protecting children (Australian Nursing & Midwifery Council, 2006; Schmied et al., 2008). As such, developing the role of the midwife in

prevention, early intervention and collaboration is vital to improving positive outcomes for vulnerable families and ultimately reducing the need for statutory intervention to remove children. However, there remains very limited national or international research to inform best practice for midwives in the area of assumption of care of newborns.

The findings presented in this paper focus on midwives' experiences of working with vulnerable pregnant women who are subject to child protection orders and face the possible removal of their baby at birth. This work is part of a study that aimed to explore and describe midwives experiences of assumption of care (Everitt, Fenwick, Homer 2015).

## **METHOD**

A qualitative descriptive approach was used to describe midwives experiences of assumption of care of newborns. Qualitative research seeks to explore real life situations, complex social interactions, opinions, experiences and behaviours and how people themselves view these (Baker, 2006; Marshall & Rossman, 2006; Sandelowski, 2000, 2010). This method is especially useful in circumstances where little evidence exists (Whitehead, 2007).

### **Participants, recruitment and data collection**

Ethical approval for the study was granted by the University of Technology Sydney. Midwives were recruited using an advertisement in the local professional journal. To participate in the study, midwives needed to have been involved with an assumption of care within the last three years. Upon contact with the research team, midwives were provided with information about the study. Once midwives confirmed their willingness to participate a convenient time and location was organised to conduct the one off face to face interview (see Everitt et al 2015 for a more detailed description of the research design).

Interviews were digitally recorded and lasted approximately 60 minutes. A set of broad questions, informed by the literature and clinical experience, were used as prompts (see Box 1). However, the interviews remained flexible and participants were encouraged to talk freely about their experiences. As the study progressed questions were introduced based on the developing analysis framework.

Five midwives contacted the research team via telephone or email. A further four midwives were recruited through snowball sampling (Llewellyn, Sullivan, & Minichiello, 2004). Following nine interviews data saturation was reached. One further interview was conducted with no further emergent themes. This brought the number of participants to ten (Daly et al., 2007; Higginbottom, 2004). The ten participants had experienced approximately 91 episodes of assumption of care of a newborn. Midwifery experience ranged from two to 30 years. Six midwives held midwifery consultant positions, two were midwifery managers and two were clinical midwives.

### **Data analysis**

Thematic analysis and the techniques associated with constant comparison were used to analyse the data. The work of Braun and Clarke (2006) guided the process. Initially, analysis commenced by 'immersion' within the data set. In reality, this was a process of familiarisation whereby transcripts were read and re-read. Copious notes were taken to capture the researchers' thoughts and the questions 'asked' of the data. The process of generating initial codes then commenced. This is referred to as line-by-line coding (Polit & Beck 2014). As the process continued, similar codes were clustered together. As more interviews were analysed these clusters grew and were continually compared and revised against each other. In this way, themes and/subthemes started to emerge. Relationships or links between themes were identified by comparing themes against each other. Finally, writing up the findings helped

crystallise the patterns in the data that represented the midwives experiences of assumption of care (Streubert & Carpenter 2011).

During the analysis process there was a constant dialogue between the researchers which helped to clarify ideas and thinking. Placing grouped data into word tables enabled the researchers to keep track of the decisions made around emerging themes and subthemes (Annells & Whitehead, 2007; Grove, Burns & Gray 2014, Jootun, McGhee, & Marland, 2009). Presenting the preliminary findings at numerous conferences was also used to 'test out' the credibility and 'fit' of the themes with a diverse audience of midwives.

## **FINDINGS**

Four themes were elicited that demonstrated how midwives worked with vulnerable women and Community Services during the antenatal period. These were labelled; Reporting- Taking the first step; The woman-midwife relationship remains a priority; Jumping through the 'community service' hoops; and Crunch time: the decision... sometimes justifiable sometimes not?

### **Reporting: Taking the first step**

In the first instance, midwives felt it was important that they be '*up front*' about their role as 'mandatory' reporters with woman perceived to be at risk. In NSW, midwives are required by law to report to Community Services if they suspect (using their professional judgment and training), on reasonable grounds, that a child or young person is at risk of significant harm. At the same time, midwives said it was imperative that they shared with women their concerns around the woman's ability to adequately keep and care for her baby. Those midwives with extensive experience in this area expressed how vital it was they were '*open and honest*' with women and did not give women cause to perceive that they might '*go behind her back*'. While

the midwives acknowledged how difficult these conversations could be, they were seen as fundamental in keeping women engaged with the health care system and thus providing the midwife with some capacity to assist women work through their issues.

*I outline my role and say that I am the mandatory reporter, and if I'm concerned about the safety of your baby I need to report it, but I tell them that I'll talk to her about it. A couple of times I've had the woman with me when I've rung up, so that she hears what I'm saying. (Midwife 4)*

Another midwife put it this way:

*I would also consult with the parents first. Even if I thought it was absolutely completely 'dire straits' stuff I would still say to them "I really need to talk to Community Services. They need to know the situation. I am really concerned". (Midwife 1)*

Ignoring or failing to address issues with women was considered a potential barrier to establishing a healthy three-way working relationship between woman, midwife and whoever was representing Community Services:

*The conversation that we try and have, you address it (involvement of Community Services) because it's the elephant in the room and to pretend it's not there is going to get you nowhere, so you have to address it, but you have to dance, not wrestle. (Midwife 7)*

However, it was not always easy. As the midwife in the above extract went on to say, 'We're midwives! We don't 'dob' people in to this big, bad, scary agency (Community Services)! That's not what I did midwifery to do'. (Midwife 7)

## **The woman-midwife relationship remains a priority**

The midwives felt that building trusting relationships with women, through open and honest communication, was essential if they were to provide them with the support they needed as well as the skills and strategies required to alter their circumstance or *'turn their situation around'*. Establishing and sustaining trust was a tool midwives used to not only engage and influence women at risk but to protect the unborn baby regardless of whether a removal occurred or not.

*With trust ... and then if you have got a rapport you could say, "Look, this is where you are at it's not looking good this is what's happening or let's do this and this and this and we can change this before we have the baby".(Midwife 2)*

The midwives made it clear that they wanted to advocate for the women. They saw their role as *'being with'* the woman. As one midwife said of her experience; *'I think by the end of the day they felt that we'd supported them. We'd given them every support, that we weren't the bad guys'*. (Midwife 5)

Sometimes in an effort to manage potential conflict and maintain their position *'beside'* the women, midwives very deliberately made sure that the social workers took responsibility for certain aspects of care. In essence, doing this protected the midwives from some of the *'woman versus baby'* tensions.

*So I try to be her ally so that I am like the good guy for her and try to paint Community Services as being a really valuable helpful service, not the bad guy either. If anyone is going to be the bad guy we try and make it be the social workers. They are happy to take that role, like we actually say, if someone is going to be the bad guy it shouldn't be the midwife. (Midwife 9)*

## **Jumping through the 'community service' hoops**

Once a relationship was established midwives started encouraging women to engage in a positive manner with Community Services. This was a strategy that midwives perceived would indicate the woman's commitment to keeping her baby and preparing a safe and caring environment once born.

*You're trying to engage and to make a plan and trying to do everything possible to see that with enough support these parents can take their child home and care for them safely, which is what midwifery is supposed to be about. (Midwife 5)*

Generally, midwives considered this was important and the right thing to do as it gave women 'some hope'. Part of this strategy included 'urging' women to undertake all the activities or suggestions Community Services requested of them.

*You've got to work with Community Services, not against them. Everything that they are asking you (the woman) to do, every hoop that they put there, you've got to jump through it. You've got to work with them. Really encouraging them (woman) to engage with them (community services) is really vital. Sometimes we had really lovely outcomes where at the beginning of the pregnancy you thought there was no way they will keep the baby, and the women have actually come through in the end. They did everything that Community Services asked of them and it's been a really good outcome. (Midwife 9)*

At the same time midwives also expended considerable energy to ensure they were successful in establishing clear and effective communication channels with Community Services. Midwives acknowledged the three way nature of the relationship and were very 'mindful' that they did everything in their power to make sure this worked to the woman's benefit. For

example, midwives worked hard to set up planning meetings with Community Services where information around decision making could be openly shared. Identifying a primary contact with community services was also vital. Bringing together all those involved in a woman's care to ensure effective communication and liaison happened was considered essential. So too was ensuring proceeding, decisions and plans were clearly documented.

*So Community Services attend that meeting and they'll share information with us and on different families that they know are in the pipeline, in the next nine months having a baby, and we'll also share with them information of known reported cases. (Midwife 6)*

The complexity of women's cases meant that planning management and possible removal took a considerable amount of time and energy from all involved. For example, one midwife commented, *'Hours and hours and hours of meetings and planning and liaising and one patient can probably take your whole day'*. (Midwife 8)

Despite the work that went into ensuring effective communication with Community Services, there were examples where this did not always occur. For instance, some midwives described being unsuccessful in their *'desperate'* attempts to get Community Services involved in a woman's care during pregnancy. Having no specific Community Service case worker involved in a woman's pregnancy meant that an assumption may take place immediately after birth without, what the midwives perceived was, a *'detailed proper assessment'*. As one midwife described; *'In previous cases it's been like banging your head against a brick wall to get Community Services and then you get this flurry after the birth and they come in swoop in and take the baby'*. (Midwife 5) Midwives felt this was very unfair and unreasonable. Situations like this left midwives feeling like they had *'failed'* the woman and that in some way they had

*'negated their responsibility'* of ensuring all that could be done was done to keep woman and their baby together.

### **Crunch time: the decision... sometimes justifiable sometimes not?**

One of the midwives, whose primary role was to work with vulnerable families, described how some of her experiences to prevent assumption had been satisfying. This midwife articulated; *'It's been a really good outcome. That's been incredibly rewarding but I guess they are few and far between'*. She went on to say, *'It's amazing. There's little kind of pearls in there that sustain you (helping prevent an assumption of care), so you don't go completely mad. It is gruelling work'*. (Midwife 9)

Comments such as these, however, were uncommon in the data set. There were a number of examples where midwives perceived that despite women *'doing everything'* Community Services requested of them they still faced an assumption of care. No matter how many *'hoops'* the woman and her midwife *'jumped through'* sometimes it was to no avail and the baby was still removed. Midwives talked about feeling *'distressed'*, *'frustrated'* and *'betrayed'* in these circumstances. For example, one midwife said:

*The woman herself, she jumped through hoops during the pregnancy. Went to three or four different courses, the Triple P (Positive Parenting Program) and had some counselling. She worked with Community Services and she had a case worker. They still took the baby into care.* (Midwife 8)

Midwives said they were often *'confused'* as to how decisions around assumption of care actually occurred. As a result of their past experiences most thought they could anticipate the decision Community Services would make about the removal of a baby. However, midwives were often left *'bemused'* and *'wondering'* why a similar circumstance resulted in a completely

different decision. One midwife described how it would be easier to live with the decision if she didn't feel like the end result was based on a *'flip of a coin'*; *'This one will go this one might not'*.

Midwives hinted at the *'power'* of Community Services stating that they had the *'final say'* and *'the authority'* to use the information they received in *'whatever way they deemed fit'*. Having said this, there were also examples whereby the midwives agreed with the decision and/or recognised that perhaps Community Services was privy to additional information that was not known to themselves; *'things like criminality and domestic violence'*. Midwives recognised that some babies should *'just not go home with their mother'*. In these circumstances, midwives talked about being not only *'relieved'* that a decision had been made but that it was *'clear cut'*. As one experienced midwife said:

*Working with a family where the mother or the father has a serious mental illness and where there is just no way that they can ever take care of a baby... For some reason, they are not quite as painful, because it's so overt to everyone that they are unable to take care of the baby and because of their mental illness is so unstable. (Midwife 9)*

Others, while in total agreement, still struggled emotionally with the concept that a baby was going to be removed from their mother; *'Even when I know that it is for the best reason, it's still hard as there is still a woman with dreams'*.(Midwife 4)

## **DISCUSSION**

This paper describes how midwives worked with vulnerable pregnant women who were subject to child protection orders and faced the possible removal of their baby at birth. The findings are part of a qualitative study that explored ten Australian midwives' experiences' of a newborn being removed from his/her mother commonly referred to as an assumption of care

(Everitt et al 2015). The study addresses a significant gap in both the Australian and international literature.

### **Being 'with woman' also means being child-focused**

There is little argument that midwives, like other health professionals, need to report suspicious behaviours and/or vulnerable women at risk of harming their infants to child protection services (Chapman, 2002; Dimond, 2003; Nayda, 2002; Raman, Holdgate, & Torrens, 2012). In this study, the majority of midwives were able to clearly articulate their role in mandatory reporting and understood the need for them to engage in this activity. However, like others have identified (Bennett, Blundell, Malpass, & Lavender, 2001; Henderson, 2002; Lazenbatt, 2010), these conversations were not always easy. Midwives often questioned their role and worried that their decisions and actions may be seen by the woman as an act of betrayal.

Unborn babies who are assessed to be at significant risk of harm pose a fundamental dilemma for the midwife. Although there was evidence that midwives walked a fine line balancing the needs of both the unborn baby and woman, as others have suggested (Chapman 2003; Fraser & Nolan 2004), it was clear that midwives were committed to ensuring pregnant women were given every possible chance to demonstrate how they could change their circumstances. Unlike child protection workers, midwives actually need to work in partnership with pregnant woman keeping them at the centre of their care. It is this way of working that gives midwives the best opportunity to support maternal health and lifestyle behaviours that ensure the unborn baby is given every opportunity to grow and be born healthy (ANMC, 2006; Marsh, Browne, Taylor, & Davis, 2015; Pairman, Pincombe, Thorogood, & Tracy, 2006). Prioritising child protection for the individual baby can only happen after the birth. Whilst multidisciplinary and interagency services may be involved during the woman's pregnancy (for

example adult mental health or child protection services), it is the midwife who bridges the gap until the baby is born.

### **Community Services: A powerful third person in the relationship**

The involvement of Community Services in the woman's maternity care meant that the midwives were accountable not only to the women but also to Community Services. Thus the midwives were required to have a dual role of advocacy and support as well as surveillance and reporting. The conflict and potential inequalities of professional power imbalances have been recognised as an important issue for those working in child protection (Davies, 2011; Glennie, 2007; O'Neill, 2005; Wickham, 2009). The statutory power carried by Community Services was daunting for some midwives. Midwives work towards equality with women which means overt power is a challenging concept and not one that usually underpins a partnership model of care (Pairman & McAra-Couper, 2006, Marsh et al., 2015). Power inequities or feelings of powerlessness amongst both parents and workers has been highlighted in both the midwifery and child protection literature (Davies, 2011; Leap, 2010; Pairman & McAra-Couper, 2006; Rouf, Larkin, & Lowe, 2011; Wickham, 2009). In addition, midwives often experienced a sense of conflict between their expectations of Community Services, the decision making processes around assumption of care and their own beliefs about what was best for the woman and her newborn. At times, this increased the midwives' emotional response to the situation which had the potential to foster ill feelings and lead midwives to be critical of Community Services. Scott (2010) also acknowledged the potential for disharmony in the context of interagency work. She went on to caution against telling 'atrocious stories' and the tendency to perpetuate the notion of a 'common enemy'. Scott (2010) argued strongly that this behavior only increases any dysfunction that may exist between agencies and ultimately splits services who are trying to work together for the common good of the child.

One strategy that more experienced midwives used to ameliorate the potential to feel disempowered was to ensure they had an in-depth understanding of processes and procedures. As Wood (2008) similarly identified, it was important for midwives to have a good working knowledge of the system. Likewise, streamlining communication between the different agency caseworkers and health care professionals was considered fundamental to providing quality service provision. The bottom line for midwives was that they really wanted to make a positive contribution. Like others, they wanted to reduce the potential for harm whilst ensuring a good outcome for the woman and the baby (Buckley, Carr, & Whelan, 2011; Bunting, Lazenbatt, & Wallace, 2010; Dale, 2004; Devaney, 2008; Wood, 2008).

The challenging question, however, is how best to educate midwives and share information in relation to this complex area. The literature relating to improving skills and training in child protection consistently recommends an interagency approach (Bunting et al., 2010; Paavilainen, Åstedt-Kurki, Paunonen-Ilmonen, & Laippala, 2002; Reder & Duncan, 2003). The common aim of these programs is to improve communication and collaboration between agencies and promote an understanding of the differing roles and responsibilities of professionals involved with child protection issues (Baverstock, Bartle, Boyd, & Finlay, 2008). The impact of attitudes, values, core professional and personal beliefs as well as status and power of organisations need to be acknowledged and should underpin any interagency training (Glennie, 2007; Keys, 2005). In addition, education and training needs to include an acknowledgement of the anxieties that midwives face in their dual role of support and surveillance (Keys, 2005, Halsall & Marks-Maran, 2014). Responsibilities to both the pregnant woman as well as the unborn child place the midwife in a unique position which at times contributes to the professional dilemma expressed by midwives in this study.

## **Limitations**

The findings of this research need to be contextualised within the study's limitations. Firstly, legislation in each state and territory of Australia varies (Australian Institute of Health and Welfare, 2013 ). This means that the processes and legal requirements for midwives and other health professions differ. Secondly, the perspective and the responses of the women, hospital social workers and Community Service workers were discussed by the midwives from their standpoint. The study would have been strengthened had these alternate viewpoints been explored. Thirdly, only a small number of midwives, from one state in Australia, participated. In addition, the authors acknowledge it was beyond the scope of this study to discuss the removal of children from Australian Aboriginal and Torres Strait Islander families, appropriately and sensitively. The history of the Stolen Generation and the profound subsequent intergenerational impacts mean Indigenous children remain over-represented in the child protection system (Kojan & Lonne, 2012; Zhou & Chilvers, 2010). Despite these limitations, the study does contribute understanding of how midwives experience this important but potential distressing aspect of their practice.

## **CONCLUSION**

Midwives enact their care through the relationships they share with women. Prioritising the concept of child protection or being solely baby focused before the actual birth is a conundrum for midwives. This is because keeping the unborn baby well means ensuring the pregnant woman stays engaged with the service and is able to access all the resources required to support a healthy pregnancy, lifestyle and birth. For midwives, there was little choice but to remain woman focused.

Although small, this study highlighted the importance of well-developed referral pathways and communication channels between child protection and health care professionals such as midwives. Further research needs to focus on improving interagency collaboration. Developing

multidisciplinary approaches and pathways is likely to produce the best outcomes for vulnerable newborns and their mothers whilst at the same supporting health and community workers to work in a cohesive manner to provide high quality care.

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