The experiences of midwives working with removal of newborns for child protection concerns in NSW, Australia: Being in the headspace and heart space.

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Certificate of Original Authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student:

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Abstract

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The experiences of midwives working with removal of newborns for child protection concerns in NSW, Australia: Being in the headspace and heart space.

Background

The aim of this study was to explore the experiences of midwives who had been involved in the assumption of care of a newborn baby at birth or the early postnatal period. An assumption of care occurs when, on reasonable suspicion, by NSW Community Services, a newborn is at risk of serious harm and it is not in the best interests of the infant to go home with their parent(s) or carer(s) and the child is removed into care. Assumption of care of a newborn is a challenging professional activity for all involved. This is particularly so, for midwives, who by the very nature of their role, work in partnership with the woman. There is no Australian and very limited international research to inform midwives in this area of practice.

Method

A qualitative descriptive approach was used to explore the experiences of ten midwives who had been involved with the assumption of care of a newborn. In-depth interviews were undertaken using semi-structured questions. Thematic analysis was undertaken to identify themes.

Findings

Three overarching themes were elicited. The first 'Being in the Headspace' represented the activities, tasks and/or processes the midwives had to engage in when involved in an assumption of care. Main themes included; *An outsider in the relationship: Working with Community Services*; and The *actual assumption of care*. The second overarching theme, 'Being in the Heart space' described the emotional impact on midwives, as well as their perceptions on how women were affected. Main themes included; *Seeing it though the woman's eyes: How the midwives perceived women feel*; and, *Sharing the emotional roller coaster: How the midwives feel*. The final overarching theme, titled 'Helping make a difference to the head and heart space', described what midwives considered helped negotiate the actual processes and emotional impact of their involvement in an assumption of care.

Conclusions and Implications

This research highlights the need to better prepare midwives for the complex and potentially traumatic experience of being involved in the assumption of care of a newborn. Midwives described feeling unprepared and unsupported, in both the processes involved, as well as the highly charged emotional impact of experiencing an assumption of care. Midwives were confronted by this profound emotional work and described experiencing professional grief, similar to that felt when caring for a woman having a stillbirth. Specifically designed ways of educating and improving support mechanisms for midwives around assumption of care need to be established and evaluated.

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Chapter One – Introduction and Background

Introduction

The aim of this study was to explore midwives experiences of the event, referred to as 'assumption of care of the newborn'. This is the removal of a newborn baby from its mother and/or family on the grounds that the infant is at risk of significant harm. Assumption of care of the newborn is one of a range of child protection strategies. By the very nature of the event removing a newborn from his/her mother is a potentially intrusive and emotionally charged event. Anecdotally, midwives talk of their distress at having to witness, and/or be part of, this type of care. Although practices such as assumption of care have been around for sometime, there has been very little research undertaken investigating how midwives experience this area of their practice. My study goes some way to filling this gap in the literature.

Whilst assumption of care is one important strategy in child protection, it is not the intention of the thesis to debate the actual practice. However, some of the literature and findings do question the current models of child protection and if the actual procedures associated with an assumption of care of a newborn are in the best interest of the parents and the infants.

As I read the literature and interviewed the midwives for this study, the overarching message is that promoting child wellbeing and child protection is a shared responsibility. From holistic primary health care models, to early intervention and prevention strategies, through to responding at the statutory child protection level, all stakeholders have a responsibility to ensure vulnerable children and young people have their physical, social, emotional, mental and spiritual needs met, to adequately develop and flourish (Hart, Lee & Wernham 2011; NSW Health 2013)

The importance of everyone working together to promote the needs of children is summed up in the following extract taken from a recent NSW Health policy directive from:

> 'All stakeholders – government, non-government, community, families and parents/ carers are expected to work together to support vulnerable children and young people to ensure a co-ordinated and comprehensive response to their needs. No individual worker, agency, service, program or profession has the complete knowledge, skills or mandate to work unilaterally to ensure the safety, welfare and wellbeing of children and young people. An integrated system involves individual agencies and professionals working in collaboration with others in the

> service system to help identify and address the often complex needs of vulnerable children and young people and their families and carers' (NSW Health 2013, p. 1).

Knowing when a family and/or children are vulnerable however can be complex, as labelling 'vulnerability' is influenced by multifaceted factors. Vulnerability and resilience are a continuum of changing phenomena and how health care workers and child protection agencies measure their response to the families may differ. This may depend on the stages of instability or strengths of families as they may move forward or back along the continuum depending on changing circumstances (Appleton 1994; Arney & Scott 2010; NSW Department of Health 2009). At the high risk end of the scale, vulnerable families can move from a perceived concern to legitimated child abuse or neglect. Early identification and intervention can help prevent short or long term adverse effects on children's health or wellbeing and the need for statutory child protection intervention (Arney & Scott 2010; Higgins & Katz 2008).

Midwives, by the nature of their work, are one of the key stakeholders involved in identifying vulnerable or at risk families. Midwives work in partnership with women. Open communication, choice, trust, respect and informed decision making are just some of the underlying tenants of the midwifery profession. So too is the provision of safe competent clinical care, that is aimed at securing the best possible outcomes for both the woman and her newborn. Part of this means recognising existing or developing vulnerabilities in the lives of women, as they journey through the changes and challenges of childbearing and parenthood. Leap's (2010) phrase 'embracing uncertainty together' perhaps best describes this process. Inherent in the role of the midwife therefore is the promotion of child wellbeing and child protection. The removal of a baby from the mother at birth because of significant risk of harm for child protection reasons, is often very confronting for midwives, even though it may be in the best interest of the newborn. The challenge of working with vulnerable women, families and newborns at this statutory child protection level, requiring an assumption of care at birth, has promoted this study.

What is assumption of care?

In New South Wales (NSW), the state legislation Children and Young Persons (Care and Protection) Act 1998, defines when an assumption of care of a child or young person can occur. Specific to this study, removal of a child or young person on hospital or other premises is defined in Section 44 emergency removal ('Children and Young Persons (Care and

Protection) Act 1998'). Based on the Act, the following NSW Health Policy Directive, released in 2011, clearly defines when and why an assumption of care can occur on health premises.

> An assumption of care order may be issued where Community Services suspects, on reasonable grounds, that the child or young person is at risk of serious harm and is satisfied that it is not in the best interests of the child or young person to be removed from the Health premises by their parent(s)/carer(s). In these circumstances the Chief Executive Community Services may assume the care responsibility of a child or young person by means of an order in writing served on the person who can reasonably be assumed to be in charge of the Health premises at the time. (NSW Health 2011, p. 1)

The NSW Health Policy Directive outlines the mandatory and legal requirements of the health services, the health staff roles and responsibilities prior and post the official serving of assumption of care orders by Community Services in this state (NSW Health 2011).

Assumption of care of a newborn is a challenging professional responsibility for all involved. This is particularly so for midwives, who by the very nature of their role, work in partnership with the women during their pregnancy, labour and birth, and postnatal period. The NSW Interagency Guidelines for Child Protection Intervention (NSW Department of Community Services 2006) set out processes for agencies to work together and provide broad instructions on the procedures surrounding assumption of care, however they are silent on how best to support the health care professionals including midwives and other workers through the experience. More recently the NSW Health Policy Directive does aim to ensure that an 'assumption of care occurs in a way that the safety and wellbeing of the child or young person, parents/carers and staff is maximised' (NSW Health 2011, p. cover page).

As primary providers of antenatal care, midwives have a unique opportunity to recognise vulnerable families during pregnancy and work with them to optimise health and wellbeing and reduce risk of serious harm to the unborn child (Bull 2008). If, however, after working with women/families, little or no change to parental behaviours, or vulnerable circumstances occur and evidence of risk of serious harm to an infant is deemed to exist and immediate response is required, then involuntary assumption of care may be the only course of action. In these situations, the Department of Community Services (DoCS) [1] in NSW applies for an order to 'assume care and responsibility' for the newborn immediately post birth (NSW Department of

[1] The Department of Community Services (DoCS) in NSW changed its name to Community Services in 2009 and for the purpose of this document will be known as Community Services unless referred to in referenced text.

Community Services 2006). Assumption of care is an extremely invasive action as it means separation of mother and baby. This is the most intrusive statuary intervention in child protection (Tomison 2001).

Midwives have often attempted to deal with the complex emotions elicited when caring for new mothers and their families during the assumption of care and immediately after by supporting each other (Wood 2008a). Fraser and Nolan (2004) identified that midwives in the United Kingdom (UK) found working with parents with child protection issues, upsetting and unsettling. Likewise, Australian researchers have found that midwives can feel overwhelmed by some women's complex family situations (Mollart, Newing & Foureur 2009). The disclosure of social and emotional risk factors that occur during antenatal screening interviews can leave midwives feeling distressed and unsure of how to best help the woman. However, there is no Australian work and very limited international research to inform best practice for midwives in the area of assumption of care of newborns. The research presented in this thesis was undertaken to address this significant gap in the evidence.

Question, Aims and Objectives

The research question to address this gap was: What is the experience of midwives who are involved in the assumption of care of a newborn baby at birth or in the early postnatal period?

The overall aim of this qualitative study was to explore and describe the experiences of midwives who have been involved in the assumption of care of a newborn baby at birth or in the early postnatal period.

The specific objectives of this study were to:

- Describe the processes and activities undertaken by midwives, when providing care to a childbearing woman whose newborns were, or were at risk of being, subjects of an assumption of care
- Explore the emotional aspect of undertaking this work for midwives
- Identify strategies the midwives themselves used and/or considered to be of assistance in working with women whose newborns are the subject of an assumption of care.

Deciding to study this topic

I have a personal and professional interest in this topic. I was a midwife for more than 20 years before I was involved in an assumption of care of a newborn. At the time I was working in a caseload model of care where I was responsible for the care of a defined number of women across pregnancy, labour and birth and early parenting period. The majority of women in the caseload were those deemed to be vulnerable, requiring additional care and support. Two other midwives worked with me in this small caseload model. During this particular experience, Community Services had been involved during the woman's pregnancy but neither the woman, myself or any of the other midwives knew the baby would be removed from her care immediately in the postnatal ward. We, as midwives, did not know what was expected of us and how to be 'with a women' during what was to become an intrusive and distressing experience. I had no formal preparation or education for undertaking or being involved in the process. When it happened I was left feeling bewildered and uncertain of my role and responses in the process. This experience lit a fire to develop a better understanding of the practice and today I am committed to researching and assisting midwives with assumption of care experiences.

My current position as a clinical midwifery consultant, involves providing care to vulnerable women with complex family situations as part of a multidisciplinary team in a public metropolitan Sydney hospital. As a result of caring for this vulnerable group of women, we are often dealing with significant child protection issues that require the involvement of Community Services. Increasingly over the past five years, I have cared for many women during the assumption of care of their newborns. I now have an extensive understanding of the terminology and the procedures required around the processes involved in this area of practice, despite my lack of formal education. Part of my role now involves supporting less experienced midwives. This has lead me to investigate how best to do this. However in trying to do this I was surprised at the lack of literature from which I could draw on. In 2008 one of my colleagues, similarly interested and experienced in this area of practice, showed me an article by Gaynor Wood (2008a) describing midwives experiences of removing babies at birth for safeguarding and child protection requirements in the United Kingdom (UK). After reading Wood's work, further exploring the available evidence (which remained limited) and some robust discussion I decided that this was an important topic for me to consider researching. And so my journey as a researcher commenced.

Background

In this next section of the chapter I provide a brief background description, including definitions of child protection and an explanation of maternity services in the Australian context. The purpose is to provide a background for the study.

Protecting and supporting children

Supporting families to ensure the health and wellbeing of children is a major responsibility of most governments and individuals 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, ratified in 1995 (Sanson & Wise 2001). Enacting child protection legislation is one major strategy adopted by countries, such as Australia, to achieve this goal. Child protection is the responsibility of every state and territory government in Australia.

Community Services NSW, work closely with the community, government and non-government organisations to keep children safe and support vulnerable families. The service aims to provide support and strategies to help families and prevent the need for the involvement of statutory child protection services. The NSW Community Services agency is the largest child protection service in Australia. In 2009, the NSW government developed a five year Action Plan 'Keep Them Safe: A Shared Approach to Child Wellbeing' (NSW Government 2009) in response to a report by the Special Commission of Inquiry into Child Protection Services in NSW (Wood 2008c). The commission was initially set up by the NSW government in response to the tragic deaths of two children in late 2007. The brief of the commission was to investigate the child protection system and to identify changes in how services could better meet a growing demand in notifications.

The aim of the 'Keep Them Safe' action plan was to reform child protection services in NSW (Zhou & Chilvers 2010). In this plan, child protection was articulated as everyone's shared responsibility, both from a community and a government perspective. The goal of Keep Them Safe is that 'all children in NSW are healthy, happy and safe, and grow up belonging to families and communities where they have opportunities to reach their full potential' (NSW Government 2009, p. II). Increasingly, health professionals, including midwives, are required to identify, report and assist in prevention of risk of harm for infants and children. As such, this poses significant professional responsibilities on all health care professionals (Australian Nursing & Midwifery Council 2006; NSW Department of Community Services 2006).

Today the activities, services and programs of Community Services are based on the goals of the 'Keep Them Safe' action plan (Department of Family Housing Community Services and Indigenous 2012). Examples of services provided include integrated domestic and family violence program, Aboriginal child and family centres, specialist homelessness services, early intervention programs and strategies aimed at preventing need for children to enter child protection system. The statutory child protection services manage the most serious cases of abuse and neglect. These services include a 24 hour, seven day a week helpline to receive reports of significant risk of harm and an after hours crisis response team. There are also joint investigation response teams (JIRT) that include Community Services, NSW Police and NSW Health providing integrated services related to criminal activities and intensive case management and support from child protection workers. Children who are deemed to be unsafe at home due to risk of serious abuse and neglect may be placed in Out of Home Care (OOHC) which may include being placed with relatives, kinship care[2] or foster care (Department of Family Housing Community Services and Indigenous 2012). The aim of Community Services is to provide support and strategies to help families and prevent the need for statutory child protection services involvement.

Protecting children is seen as everyone's business and shared responsibility (Commonwealth of Australian Governments 2009; NSW Government 2009). The National Framework for Protecting Australia's Children 2009-2020 developed by the Council of Australian Governments (COAG), comprised of all State and Territory, as well as Commonwealth Governments (Commonwealth of Australian Governments 2009) emphasises the need for building capacity for parents and communities through early intervention and prevention programs to protect Australia's children. The prevention of abuse and neglect of children is seen as the best way to protect children. In the United Kingdom (UK), the term 'safeguarding' is often used to describe this broader concept, not only protecting children from harm, but improving the welfare and wellbeing of all children (McDougall 2008).

Protecting and nurturing children is an essential part of childrearing. This is especially true for newborns and infants under one year of care, who are entirely dependent on their parents/primary carers for their growth and development. Parenting behaviour and

[2] Relative or kinship care is a type of care that places a child or young person with a relative or someone they already know. Caring by relatives is a common practice across cultures, but the term kinship care can have different meanings for different cultural groups. In Australian Indigenous communities, kin may be a relative of the child or young person or someone who shares a cultural or community connection.

interaction shapes current and future behaviours of infants (Swain et al. 2007). There is a growing body of evidence that neurobiological and socio-emotional development of an infant during the first few years of life can be affected by the quality of attachment, relationships and parenting styles (Barlow & Calam 2012; NSW Department of Health 2009). The work of John Bowlby and Mary Ainsworth in the 1950s related to maternal-child relationships, influences much of the practice today about the value and need for attachment of infants and maternal bonding (Sanson & Wise 2001). The consequences of interactions of parents and carers with infants to sensitively identify needs and respond appropriately to behaviours is highlighted in attachment theory. These interactions are essential for brain development, developing self-confidence, coping strategies and social interactions later in life (Barlow & Calam 2012; NSW Department of Health 2009). The principles of attachment theory underpin child protection services. Therefore, child protection workers require an understanding of the how their knowledge of attachment theory influences their clinical decisions when working with families (Bacon & Richardson 2001). Attachment is significantly challenged when an assumption of care occurs.

Child maltreatment and protection

Child maltreatment has occurred throughout the centuries. Definitions of child maltreatment are usually divided into five subtypes: physical abuse, sexual abuse; emotional maltreatment; neglect, and the witnessing of family violence (Price-Robertson 2012). These definitions describe the circumstances by which each Australian state and territory is mandated to intervene to protect children (Holzer & Bromfield 2010). Though, not all families reported to child protection agencies require statutory intervention of the removal of children or assumption of care.

Child protection in Australia is complex as relevant legislation varies in each state and territory and definitions of what constitutes abuse and neglect are different. However, the guiding principles from the United Nations Convention on the Rights of a Child are embedded within all Australian legislation (Bromfield & Irenyi 2009; Holzer & Bromfield 2010; Tomison 2001). In NSW, section 71 of the Children and Young Persons (Care and Protection) Act, 1998 (NSW) outlines the reasons for a child to be in need of care and protection orders, the most extreme measure of child protection. These include a child that is at risk of being physically or sexually abused or ill-treated, is suffering or likely to suffer serious developmental impairment or psychological harm, and/or basic physical, psychological or educational needs are not being met (Holzer & Bromfield 2010). Amendments to this legislation in 2009 changed the

mandatory reporting threshold to 'significant' risk of harm and added that the cumulative impact of a series of acts or omissions may indicate a pattern of risk of significant harm (NSW Government 2009). There have been concerns raised about the child protection agency's ability to cope with the increasing number of notifications and appropriate investigations of high risk families in the system (O'Donnell, Scott & Stanley 2008).

Assessment procedures by child protection agencies have developed and changed over the past three decades. During the 1970s and 1980s in Australia, an increased professionalism for child protection workers occurred in investigating and responding to child protection reports using risk assessment tools to assess if a child should be removed from his/her family (Tomison 2001). However, these standardised risk assessment tools have been criticised as utilising a prediction of future risk focus and should always be used in conjunction with sound clinical practice and knowledge, as no one tool can effectively assess concerns in child protection (Price-Robertson & Bromfield 2011). In the 1990s, the emphasis changed to prevention and supporting families focusing on the multitude of issues that impact on child abuse and neglect (Tomison 2001). This led to a focus on early intervention through universal and secondary services to support parents and children moving away from what is often considered an overburdened ineffective tertiary statutory invention model (Barlow & Calam 2012; Humphreys et al. 2009).

Despite this refocus, several Australian authors have challenged the child protection focus arguing that to reduce child abuse in the community, public health models of child protection should be funded, implemented and evaluated (Holzer 2007; Jordan & Sketchey 2009; O'Donnell, Scott & Stanley 2008; Scott 2006). Models of this nature aim to provide universal support and education for everyone to prevent the problems occurring. Secondary interventions are aimed at supporting vulnerable families with early intervention programs and the involvement of tertiary statutory services of child protection occurs only when maltreatment of children has been identified (Holzer 2007; Hunter 2011). Midwives have a strong role in public health and primary care especially in relation to vulnerable and disadvantaged families and 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 may assist in the reduction of the need for statutory intervention of removal of children.

Specific issues for Aboriginal and Torres Strait Islander children

Within the Australian historical context of child protection legislation, it is important to recognise and acknowledge policies that specifically related to Aboriginal and Torres Strait Islander communities and resulted in the 'stolen generation' (Human Rights and Equal Opportunities Commission 1997). These past policies had intergenerational consequences and caused extreme distress and anguish to many families and children (Human Rights and Equal Opportunities Commission 1997; Koolmatrie & Williams 2000; Sanson & Wise 2001; Tomison 2001; Zhou & Chilvers 2010). The 'stolen generation' refers to the forcible removal of thousands of Aboriginal and Torres Strait Islander children from their families and communities from the beginning of the twentieth century to the 1970s, some for child protection concerns but also just for being 'half caste' (Human Rights and Equal Opportunities Commission 1997). It is recognised that the current level of over-representation of Aboriginal children in child protection and OOHC experienced by Indigenous people possibly results from the associated disadvantage, trauma and disengagement from their families affected by these policies (Humphreys et al. 2009; Zhou & Chilvers 2010). The national rate of OOHC placement of Aboriginal Children in 2011 is almost ten times higher than other Australian children (Price-Robertson 2012). The Aboriginal Child Placement Principle which prioritises the placement of Indigenous children with kinship or extended families has now been adopted by all Australian States and Territories (Zhou & Chilvers 2010). Everyone involved in child protection needs to be aware of the impact of these historical policies and ensure they are aware of the cultural background of families in their care. It is likely to have even deeper ramifications for these families, although it is beyond the scope of this thesis to examine this area.

Frequency of child protection reports in Australia

The number of reports related to child protection issues has increased substantially nationally, each year over the past decade, however in NSW with the introduction of Keep Them Safe reforms in 2009 there appears to be a decrease in notifications (Australian Institute of Health and Welfare 2013). Infants are over-represented in these reports, with the rate of reporting children aged less than one year old being higher than any other age group (Hopkins & Smoothy 2007). Notifications of suspected child abuse or neglect are made most frequently by police, school personnel and health/hospital staff (Bromfield & Irenyi 2009). Reports related to children under one year of age, more commonly originate from health care reporters, of which midwives are one group (Zhou & Chilvers 2010).

The number of notifications and worker investigations differs from the confirmed total number of substantiated cases of abuse and neglect requiring statutory involvement and that at times necessitate removal of children. In Australia, from state and territory authorities in 2010-2011, the total number of notifications of suspected child abuse and neglect equalled 237,273 (Price-Robertson 2012). This number had decreased from previous years, however an important change had occurred in NSW mandatory reporting requirement increasing the threshold to 'significant risk of harm'. The total number of final investigations from these reports was 127,759, with 40,466 total substantiated cases concerning 31,527 children. Significantly, most likely to be subject of a substantiated report of abuse or neglect, are children aged less than one year (12.0 per 1000 children) (Australian Institute of Family Studies 2012). Some of these infants are removed from their homes into out of home based care with foster care or relative/kinship care the main types of placements (Bromfield & Irenyi 2009). In NSW the largest numbers of children entering OOHC are under the age of one (Zhou & Chilvers 2010). This is not unexpected as child protection agencies need to immediately respond to concerns related to infants due to their inherent vulnerabilities and risk to physical and emotional development (Jordan & Sketchey 2009). Infants involved in these statistics are the group midwives will most likely be involved with during assumption of care at birth or in the early postnatal period.

The statistics of assumption of care of newborns on NSW Health premises are not readily available. Personal correspondence from Cathy Peters, Senior Analyst, Child Protection and Wellbeing Unit, NSW Kids and Families, and the contact of the NSW Health policy directive on assumption of care order by Community Services on NSW Health premises (NSW Health 2011) indicated that Community Services do not differentiate in their data about place of removal of infants (Peters 2013, pers.comm.,2 April). The need for the creation of a policy directive to guide staff in NSW Health premises clearly indicates the practice is occurring in NSW hospitals. The work by Zhou and Chilvers (2010) from the Economics, Statistics and Research Directorate in the NSW Department of Community Services (DoCS), Australia, state newborns cannot be identified in the data of children less than one year old in OOHC. A more recent analysis of statistics comparing outcomes Australian and Norwegian child protection system also only identiies data for infants less than one year of age (Kojan & Lonne 2012). Personal correspondence with Professor Robert Lonne who works at Queensland University of Technology, Social Work and Human Services, Brisbane, Australia, states that, anecdotally, an increase in newborn infants is occurring around Australia but the statistics are not readily available perhaps due to the sensitivity of the issue (Lonne 2012, pers.comm.,7 August). These

reports confirm my personal experience as a midwife that the frequency of removal of newborns is escalating, thus prompting this study.

In NSW, the policy of prenatal reporting exists not only to identify risks of harm and concerns related to the unborn child, but also provides the pregnant woman with assistance to reduce the possibility of removal of a newborn infant at birth (Zhou & Chilvers 2010). The most common cause for concern and removal of children under one year is related to vulnerable families with issues resulting from mental health problems and/or drug and alcohol/substance misuse and/or domestic violence (Zhou & Chilvers 2010). While removal of infants to OOHC for child protection is usually considered the 'last resort', in some situations of significant risk, it may be considered the 'first resort' (Jordan & Sketchey 2009).

The consequences of removal of infants from their families are enormous as research demonstrates that infants removed to OOHC are more likely to have a longer duration of stay than other children placed in care (Zhou & Chilvers 2010). According to O'Donnell and colleagues (2008), child protection agencies need to be mindful that while they have an obligation to prevent harm they must also ensure the intervention does not cause further harm. Health care models and primary prevention that support vulnerable families and provide optimal outcomes for infants' wellbeing and development should be promoted and supported in an effort to reduce the need of tertiary intervention of removal of infants (Jordan & Sketchey 2009; O'Donnell, Scott & Stanley 2008). Health care workers have a role to play in child protection through prevention strategies, promoting health and early intervention strategies to support families. Midwives are one important part of this health care team.

The maternity care system in Australia

Midwives provide antenatal, labour and birth and postnatal care either in hospitals or the community. Midwives may work providing continuity of care in models known as caseload or midwifery group practices (Homer, Brodie & Leap 2008). These models mean a small group of four to six midwives who are each allocated approximately four women per month to provide their entire care including antenatal visits, labour and birth and postnatal follow up to six weeks. Some of this care may be based in community settings or in the woman's home. In NSW, publicly funded homebirth has become an option more recently, as historically homebirth in Australia meant contracting an independent midwife with minimal funding rebate for the woman (Catling-Paull, Foureur & Homer 2012). Some public hospitals have a birth centre available offering women a more homelike environment based within the hospital

facilities. These centres usually have a natural birth philosophy and with midwives providing continuity of care to low risk women.

In Australia, the primary maternity care professionals include obstetricians, general practitioners and midwives. Other professionals involved in maternity services include nurses, anaesthetists, paediatricians, Aboriginal Health Workers, allied health professionals, (for example, mental health and social workers) and lactation consultants. Today, midwives in Australia are qualified via tertiary education, as either through a Bachelor of Midwifery undergraduate program or a postgraduate qualification for registered nurses. Midwives must maintain their registration annually via the Australian Health Professionals Regulation Agency (AHPRA).

The statistics in NSW from NSW Health, Mothers and Babies Report (Centre for Epidemiology and Evidence 2012), showed 96,489 women gave birth in 2010, the majority in a hospital labour ward, with 3-4% in a birth centre and planned home births totalling only 246 women. The vaginal birth rate was 57.7% with a caesarean section rate of 30.5%. Instrumental births accounted for 11.5%. Of concern both nationally and locally in NSW are the poorer maternal and perinatal outcomes for Aboriginal and Torres Strait islander women. In 2010 in NSW, 3138 Aboriginal and Torres Strait islander women gave birth. The report shows improved outcomes in commencing antenatal care earlier, decreased rate of teenage pregnancy and smoking, however low birth weight, premature births and perinatal mortality were still higher than non-Aboriginal and Torres Strait islander women (Centre for Epidemiology and Evidence 2012). Several cultural appropriate initiatives have been developed in an attempt to improve these poor outcomes amongst this community. These include Aboriginal Maternal and Infant Health Strategy (AMIHS) in NSW, with midwives working in partnership with Aboriginal health care workers to provide care to pregnant Aboriginal women, new mothers and their babies in a culturally safe environment. (Commonwealth of Australia 2009).

Other socially vulnerable groups in the Australian community include migrant and refugee women. In NSW, in 2010 25.3% of the women giving birth were born in non-English speaking countries (Centre for Epidemiology and Evidence 2012). Examples of specific vulnerable groups of women with complex maternity care clinical needs include adolescent mothers; women using substances including cigarettes, alcohol and illicit drug; women experiencing mental illness; women experiencing domestic violence; and women in prisons. These women may require additional strategies and initiatives in comparison to the general population, to prevent poorer maternity outcomes (Commonwealth of Australia 2011). These specific groups

of vulnerable woman, including some Aboriginal and Torres Strait islander women, and culturally and linguistically diverse women characterise many of those who may present child protection concerns for midwives.

Midwives work under a framework of woman centred-care. This concept is imbedded in the Code of Professional Conduct for Midwives in Australia (Australian Nursing & Midwifery Council 2008b) and the Code of Ethics for Midwives in Australia (Australian Nursing & Midwifery Council 2008a). Midwives work 'with women' in a partnership model concentrating on a woman's individual needs to strengthen and empower her, her family and in turn her community and society (Pairman & McAra-Couper 2006). Woman centred-care encompasses the needs and expectations of the woman, her baby, her partner and family addressing the social, emotional, physical, psychological, spiritual and cultural aspects of pregnancy, childbirth and early parenting (Leap 2009). The midwife has a primary relationship with the woman and does not separate the needs of the baby, viewing them as a unified whole. The woman decides who from her family and friends will be involved in the journey (Leap 2009; Pairman & McAra-Couper 2006).

Building a trusting relationship is fundamental to how midwives interact and work with women (Kennedy et al. 2004; Kirkham 2010; Leinweber & Rowe 2010). Some elements of a trusting relationship include factors of providing individual care, building rapport, getting to know the woman, listening, making time and being accessible (Homer et al. 2009; Pairman & McAra-Couper 2006). The study by Homer et al. (2009) interviewed midwives and women to gain an understanding of the role of a midwife in Australia from their perspective. These findings were consistent with international literature with key elements of midwife-mother relationship identified as being woman centred; providing safe and supportive care; and working in collaboration with others when necessary.

The National Maternity Services Plan 2010 by the Commonwealth Government of Australia is to provide a strategic national framework to guide policy and program development in maternity services across Australia over the next five years for state and territory governments (Commonwealth of Australia 2011). The five year vision is that:

> Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health

> outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women (Commonwealth of Australia 2011, p. 3).

The development of models of care to provide improved access and choice for women and their families is a priority of the National Maternity Services Plan (Commonwealth of Australia 2011). Decreasing fragmented care and improving continuity of care and carer with increased collaboration of maternity services workforce is seen as an optimal outcome. Challenging issues for maternity care in Australia include access to services for women in regional, rural and remote areas; public and private systems; services are divided into three levels primary, secondary and tertiary and distribution of appropriately trained maternity care professionals (Commonwealth of Australia 2011). These differing aspects of care provision can impact on outcomes and this may have even greater impacts on vulnerable women and families.

Australian College of Midwives (ACM) Philosophy for midwifery

Midwife means 'with woman'. This meaning shapes midwifery's philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society. Midwifery is a woman centred, political, primary health care discipline founded on the relationships between women and their midwives (Australian College of Midwives 2001). The philosophy of a midwife states:

Midwifery

- Focuses on a woman's health needs, her expectations and aspirations,
- Encompasses the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the woman herself,
- Is holistic in its approach and recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself,
- Recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers,
- Recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals,
- Is informed by scientific evidence, by collective and individual experience and by intuition,
- Aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems; the focus is on the woman, not on the institutions or the professionals involved,
- Includes collaboration and consultation between health professionals

(Australian College of Midwives 2001).

This philosophy is important to consider within the context of the interviews of the midwives, related to the challenges they faced being women centred during to their experiences of assumption of care of newborns.

Thesis Outline

This thesis has six chapters. The chapters are organised as follows: Introduction and Background, Literature Review, Methods, the Findings presented in two chapters and the Discussion and Conclusion. A brief overview of each chapter follows:

Chapter One - Introduction and Background

Chapter One has provided the introduction to the research study incorporating the aim, objectives and background. The aim and objectives were followed by a brief overview of why I decided to study this topic and my personal involvement in assumption of care of newborns. The definitions and explanations of assumption of care of a newborn were provided within the context of NSW statutory child protection requirements and how this impacts midwives. A brief overview of child protection in Australia was provided highlighting some of the government strategies, definitions and historical context. The chapter concluded with an

outline of Australian maternity services that contextualises woman centred care for midwives in Australia which is the philosophy that underpins this research.

Chapter Two - Literature Review

Chapter Two explores the relevant and current literature related to the research topic of midwives experiences of assumption of care. Literature related to child protection experiences of midwives, nurses and other health professionals has been included. The perspective of social workers and child protection has also been examined. The literature review highlights some of the complexities and challenges faced in this area of practice and the lack of research exploring experiences of professionals associated with removal of infants or children from their parents.

Chapter Three - Methods

Chapter Three explains how descriptive qualitative explorative methodology was used in this study. The particulars of the setting, sample size, participant's selections and demographic details are included. Data collection and thematic analysis is described in detail to provide the reader with the audit trail of the development of themes. The reflective processes used during this stage by myself are also incorporated describing my location within the study. Finally, the ethical considerations and challenges are addressed.

Chapter Four and Five - The Findings

Chapters Four and Five present the findings. The three overarching themes are described in two chapters. Due to the length of the first overarching theme it was decided to divide the findings into two chapters, however, the themes continually influence each other and cannot be separated. Chapter Four describes the 'Being in the Headspace' representing the activities, tasks and/or processes the midwives had to engage in when involved in the removal of a baby. Chapter Five 'Being in the Heart space' describes the emotional impact on midwives as well as their perceptions on how women are affected. This chapter concludes with a final overarching theme, titled 'Helping make a difference to the head and heart space', describing what helped midwives negotiate the processes and emotional impact of their involvement in an assumption of care.

Chapter Six - Discussion and Conclusion

Chapter Six discusses the findings of the midwives' experiences of assumption of care in relation to the relevant literature. A brief overview of the findings is presented. The current literature was reviewed to explore common or different themes to support the findings of the research question and are discussed in this chapter. The key challenges for the midwives, of the processes and impact of being involved in an assumption of care are addressed. The limitations of the study, implications for practice and recommendations for future research conclude this chapter.

Conclusion

Involvement in the prevention of child abuse and neglect is the responsibility of everyone. Assumption of care of a newborn at birth is one of the most intrusive forms of statutory child protection. It is a challenging professional activity for all involved, particularly for midwives who work in partnership with women. Midwives require knowledge and support surrounding their involvement in the process and the emotional impact of an assumption of care. The limited amount of research surrounding this topic highlighted the importance of this study.

This chapter has provided an introduction and background to the research question. The aims and objectives including the decision to study this topic were discussed. A brief overview of child protection systems and maternity models of care in Australia was provided. A review of the literature applicable to this study is provided in the next chapter.

Chapter Two – Literature Review

Introduction

In this chapter, I situate the study outlined in this thesis within the available and relevant literature. I do this by firstly discussing the only published research that could be found that specially set out to describe midwives' experience of the removal of babies at birth. As previously alluded to, this work by Gaynor Wood (Wood 2008a) was instrumental in the development of this study. I follow on from here by presenting work that explores midwives and child protection. The review subsequently broadens to describe the role and experiences of other health care professionals such as nurses and doctors with child protection in a variety of health settings. The viewpoint of the child protection workers and social workers involved in the child protection system is then canvassed, providing a different perspective.

The main concepts explored in the literature include the conflict of roles between woman centred care for midwives or client centred care for adult health professionals and child centred care focus of child protection. The role of mandatory reporting is described and includes issues around reasons for non-reporting, exploring why health professionals make these choices and the challenges faced in reporting requirements. The education and training needs of health professionals in relation to their child protection roles and requirements is discussed, as there is a constant challenge to ensure confidence and competence in identification and responding to child abuse and neglect. Child protection is a key component of health professions' responsibilities and the literature review highlights some of the complexities and challenges faced in this area of practice.

Search strategy

A search strategy of the literature was undertaken using the databases of Academic Search Complete (EBSCO), CINHAL, Medline (OVID), ProQuest Health and Medicine (ProQuest), Maternity and Infant Care (OVID), Wiley Interscience (Wiley online) and Google Scholar. The words, assumption of care or removal of baby did not result in any publications, except the one written by Gaynor Wood (2008a) on which my study was based. Broad search terms were used including child protection, safeguarding children (a UK terminology for child protection), child abuse and neglect, vulnerable families and mandatory reporting. These were combined with professions including midwives, nurses, doctors, child protection workers and social workers to review research related to health workers experiences with removal of children

from their parents. Terms searched specifically related to midwifery included continuity of care, woman centred care, role conflict, emotional work and collaboration. The search continued throughout the research project, with additional articles sourced through reference lists of the papers being reviewed and opportunistically while searching data bases by using search terms in specific journals.

Child protection literature, reports and policies were also sourced from Australian Government websites. The National Child Protection Clearinghouse (NCPC) was used to source research and discussion papers about child protection. In March 2012 the NCPC was amalgamated into the Child Family Community Australia (CFCA) information exchange which is hosted by the Australian Institute of Family Studies (AIFS) and funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. Child Family Community Australia is an amalgamation of three previous AIFS clearinghouses: National Child Protection Clearinghouse, Australian Family Relationships Clearinghouse, and Communities and Families Clearinghouse Australia. The aim of the CFCA is to be a primary source of quality, evidence-based information, resources and interactive support for professionals in the child, family and community welfare sectors. Australian and NSW government websites provided access to the state legislation, policies and guidelines related to child protection including the Special Commission of Inquiry into Child Protection Services in NSW (Wood 2008c).

The literature search, whilst extensive, exposed a lack of research about experiences of midwives or health workers in general, related to removal of babies and or children from their parents. Whilst the government documents assisted in the history, definitions, policy and procedures, the large amount of literature related to child protection was not specifically relevant to health professional experiences about removal of babies especially at birth. The examination of the child protection workers' and social workers' literature provides the perspective of their experiences of working with families before and after removal of children from their care but still no specific studies were found related to being involved at the actual removal process. Decisions on what articles to include in the review were based on relevance to the research question, qualitative studies exploring experiences and what were relevant to health professionals or health settings.

Research examining midwives' experience of assumption of care

An extensive search of the literature identified only one study from the United Kingdom (UK) related to midwives' experience of the removal of babies at birth in relation to child protection

(Wood 2008a). Wood, who was the Named Midwife for Child Protection in Whittington Hospital National Health Service Trust, conducted a small qualitative study, informed by phenomenology, she interviewed nine midwives about their experiences in child protection and working with vulnerable families. Wood identified four main themes from the research, namely: identification of vulnerable families; gut feelings and instincts; understanding the role of the midwife; collaborative working and support. The study was developed as part of a Master's thesis by Wood (2007, 2008b) following an extensive literature search exploring the role of midwife in safeguarding children and child protection issues exposing a dearth of relevant research in this area.

Much of the data collected by Wood (2008a) related to child protection issues resulted in multiple in-depth disclosures of their experience of removal of babies at risk from their mothers at birth. Midwives discussed how they recognised their part in protecting babies and removing them at birth but found this a difficult part of their role. The midwives commented that everyone needs to know their responsibility at the time of a removal of baby but felt it was not actually the role of the midwife to physically remove the infant from the mother. At times, the midwives felt there was a lack of appropriate collaboration, communication and support. The midwives also expressed feeling threatened and were fearful of being attacked by volatile families. The midwives compared the experience of being involved in the removal of a newborn as akin to the grief and loss felt with working with a woman and her family after a stillbirth. Wood advocates the importance of finding ways to support midwives during these rare but emotional and distressing situations.

Work by Chapman (2003) provides some additional and earlier insight to the impact on midwives of involvement in removal of newborns. A two part series of commentary articles were written by Chapman, a consultant midwife, exploring the implications on midwifery practice of government policy related to child protection frameworks in the United Kingdom (Chapman 2002, 2003). In the second part of the series, the author describes the removal of newborns at birth as the most forceful statutory intervention of the State into a family life. Chapman describes how a midwife five years after she was involved in the removal of a newborn at birth, continued to be affected both professionally and personally because of the psychological and emotional impact of the event. Midwives often feel powerless and vulnerable themselves in caring for women during the removal of her baby with the tension of woman centred care and a child protection focus, creating a conflict for the midwife with the mother versus fetus dynamic. At the time, as ways of supporting midwives, Chapman (2003)

argued for the need for standard approaches for assessments that could assist midwives to make professional objective judgements and conclusions related to families in their care combined with providing opportunities for clinical supervision and counselling.

Whilst limited work is available specific to midwives caring for a woman during the assumption of care of a newborn, it is evident involvement can be a distressing event. Leinweber and Rowe (2010) undertook a literature review addressing secondary traumatic stress in health care professionals. The six main empirical articles reviewed highlighted how the effect of empathetic relationships can increase the potential traumatic stress. This is important as the basic role of a midwife 'being with woman' has the potential to cause traumatic stress due to the high emotional involvement and empathetic relationships formed in midwifery care. Being involved in a traumatic event can place the midwife at risk of harmful consequences for his/her own mental health and may impact on their relationships with women and ability to care for women (Leinweber & Rowe 2010). More research is recommended to explore how midwives deal with the emotional content of their work and how midwives can be prepared to deal with this aspect of their role (Hunter 2001; Leinweber & Rowe 2010). My work aims to explore this area of need in the context of assumption of care of a newborn.

To develop further insights in this area the experiences of midwives' roles and involvement with child protection as part of their practice was explored.

Midwives' experiences with child protection

The role of the midwife involves 'being with woman' and this encompasses the care of the woman, her unborn or newborn child and her family and support people through their childbirth journey (Leap 2009). Midwives in Australia are required to meet National Competency Standards which have an overarching framework of woman centred care (Australian Nursing & Midwifery Council 2006). One of the four main domains of the National Competency Standards of the midwife is legal and professional practice. Within this domain midwives are required to function in accordance with legislation and common law affecting midwifery practice. Thus midwives must comply with relevant child protection legal requirements. As child protection issues increase in our society, the role of the midwife in safeguarding children is greater than ever.

While there is no published Australian work exploring the views of midwives of their role in child protection, Wood (2007), in her literature review, identified the importance of midwifery

involvement, identification and collaboration in child protection issues. Indeed pregnancy offers midwives a window of opportunity to promote safe parenting practices and healthier behaviours (Henderson 2002; Lavender et al. 2001). The earlier work of Bennet et al. (2001) found that most midwives believed they had a role to play in child protection. In this study Bennett and colleagues set out to explore midwives' views of different aspects of their public health and health promotion roles. Using a survey design, 735 questionnaires were administered with a response rate of 468 (66%) midwives from seven hospitals in the Mersey region in UK. Whilst 90% of the midwives either agreed or strongly agreed they definitely had a role in child protection, a small percentage felt an identified person for coordination of a child protection strategy should be available. It was noted that the system of training in child protection was seen as inadequate (Bennett et al. 2001).

The other part of this study reported by Lavender and associates (2001) reported the role of midwives in health promotion. The authors found that many midwives were challenged when working with women in domestic violence situations and/or with alcohol and substance abuse issues. 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 a relationship with the woman. Likewise, a small two part UK study that used focus groups followed by self-administered surveys to explore midwives (n=59) involvement in public health activities, found respondents agreed that health surveillance and problem identification, especially amongst vulnerable groups like drug users and teenage pregnancies, was an integral part of midwives public health role (Henderson 2002).

Chapman (2002, 2003) describes part of midwives' role as 'walking a tightrope', as they work to maintain woman centred approach to care whilst identifying the unborn child at risk of harm. Chapman (2003) argues that there is a tension between child centred care and woman centred care. As previously described, Chapman (2002, 2003) explored the implications for midwives of applying national child protection policy in the UK to midwifery practice and working with women. Women from vulnerable backgrounds presented the midwives with the challenge of making professional judgements related to the child protection risk factors for the unborn child during pregnancy and the newborn after birth whilst trying to stay woman centred. Fraser and Nolan (2004) in their book Child Protection: A guide for midwives, similarly acknowledge the challenge midwives face when trying to comply with the tenet of 'child protection' which means placing the child at the centre of care or having the infant or child as

the first priority (Fraser & Nolan 2004). Chapman (2003) argues that this tension between the two different foci is borne out in clinical practice. Midwives feel stressed and anxious as a result of being in a situation where being in the presence of women and getting to know them may in fact reveal attitudes and behaviours that subsequently mean they need to make decisions about involving chid protection.

There is little argument that midwives need to report suspicious behaviours and/or vulnerable women at risk of harming their infants to child protection services (Chapman 2002; Dimond 2003). However, these decisions and actions could be seen as a betrayal of trust between the woman and the midwife. Chapman argues that assessment needs to be an ongoing process in partnership with the woman and her family to ensure appropriate supports and actions are instigated (Chapman 2003).

A recent survey of midwives (n=488) undertaken in Northern Ireland confirmed that midwives believed that during a mother's pregnancy and /or postnatal period they had a significant role in identifying children at risk factors and were willing to be involved in reporting and addressing the issues (Lazenbatt 2010). Having said this, there was a discrepancy between what midwives said they would do and what they actually did do. For example while 12% of the community midwives reported that they had come across a definite case of child abuse only 2% reported the abuse to the appropriate authorities. The failure to report suggests a significant issue for midwives and the study suggests a need for more multidisciplinary education in relation to how to identify and report suspect child abuse whilst maintaining the support of the woman.

The work by Wood identifies that because of the need to identify and report at risk families, midwives have to engage in the role of surveillance and monitoring as well as the usual one of support (Wood 2008a). Surveillance has increased with the introduction of universal screening for psychosocial, drug and alcohol, domestic violence and mental health issues (Mollart, Newing & Foureur 2009). Surveillance of behaviours brings increased responsibilities that are more than monitoring physical wellbeing. While midwives may potentially consider 'surveillance' as a negative undertaking, this activity does offer midwives a window of opportunity to promote safe parenting practices and healthier behaviours (Henderson 2002; Lavender et al. 2001).

The tensions of the 'best interests of the child' and the 'best interests of the mother' require midwives to act in a sensitive and supportive role to best meet the needs of vulnerable

families (Fleck-Henderson 2000; Lazenbatt 2010). This tension can exist for midwives during the assumption of care of a newborn, prompting this study.

Nurses' experiences with child protection

Given the limited research examining midwives experiences of child protection and the associated issues, the literature search was extended to exploring nurses' experiences. Nurses are seen as another key professional group in identifying and protecting at risk children. For example, a sample of 1400 (return rate of 88%), Taiwanese paediatric, psychiatric and emergency nurses responded to a national questionnaire related to intention to report child abuse (Feng & Levine 2005). This survey identified a trend to under-report suspected child abuse. The registered nurses were required to be mandatory reporters' as part of their role but lacked knowledge of how to actually report. This was attributed to a lack of appropriate education (Feng & Levine 2005).

A small qualitative study by Fagan (1998) examined UK emergency nurses' (N=14) perceptions of their role in child abuse cases. The findings identified that nurses often lacked the skill and expertise to successfully identify cases of abuse. Participants with more years of experience felt their confidence and instincts increased due to exposure to potential cases of abuse over time (Fagan 1998). Regardless of the years of experience, all the nurses called for more training and education in child protection identification and reporting (Fagan 1998).

In Australia, similar findings are evident. Nurses in some states of Australia are legally mandated to report suspicion of child abuse and neglect. Nayda (2005) wrote a paper addressing some of the key practice issues for Australian nurses as mandated reporters. The paper highlighted losing or betraying the therapeutic relationship with their clients, concerns or questions pertaining to whether the children would indeed be safer or better off and worry around being personally confronted by an alleged reported abuser, as issues raised by the nurses. These fears or concerns meant that the nurses questioned their reporting role. In an earlier qualitative study, the same author (Nayda 2002) had interviewed ten South Australian community nurses, about their experiences of suspected child abuse and neglect. The findings identified that non-reporting occurred more frequently around the area of emotional abuse or identifying wilful neglect, where value judgements were more often involved. The nurses in this study, did not make a report if they thought the child protection service response would not be helpful to the family and their own efforts may be more beneficial (Nayda 2002).

In a more recent study of 930 registered nurses from clinical settings across Queensland, Australia, Fraser et al. (2010) used vignettes to examine the factors influencing recognition and reporting of child abuse and neglect. Like the international literature reports, this study found that whilst 42.6% of the nurses had reported suspected cases of child abuse or neglect, some 26.6% of this same cohort had at one time made a decision not to report when they had a suspected case. The negative attitudes that swayed the nurses not to report included not believing the report would benefit the family, negative views of child protection services and personal and organisational barriers. These findings were reported within the context of the nurses demonstrating sound knowledge and understanding of identifying and reporting suspected child abuse and neglect as a result of state wide training. Fraser et al. (2010) concluded that further education is required to address personal attitudes and the gap in awareness of just how serious the impact of abuse and neglect can have on children and families.

Other health care professionals experiences with child protection

Like midwives and nurses, there are a variety of health professions who can be considered frontline workers to identify suspected child abuse or neglect. Identifying and reporting circumstances where child protection may be needed, is a necessary but complex process for all health professionals.

Lazenbatt and Freeman (2006) surveyed 979 nurses, doctors, and dentists in Northern Ireland via a postal questionnaire with a response rate of 43% (n=419). While community nurses were the group most likely to identify and report suspected child abuse, doctors and dentists were the most reluctant. Once again, fear of misidentification of child abuse and damaging the relationship with the family was an issue for these practitioners. This group of health care workers also worried about fear of litigation and/or disciplinary action resulting from misreporting (Lazenbatt & Freeman 2006). These findings were similar to those reported by Vulliamy and Sullivan (2000) who asked doctors in Vancouver, Canada (n=50) via an anonymous survey questionnaire, about their experiences of the child protection system as well as views on reporting. In this study, the key reasons for non-reporting included dissatisfaction with child support services, loss of relationship with parents and a desire to avoid court proceedings (Vulliamy & Sullivan 2000).

In 2008, Soldani, Robertson and Foley, reported the findings of a small audit of 16 Scottish dentists and dental care professionals' knowledge and understanding of child protection. This

was considered an important issue for this group of professionals given that oro-facial signs and symptoms appear as common injuries in abused children. Dentists are therefore in a vital position to recognise and report these concerns. The results highlighted however a lack of ability to identify child abuse and/or neglect. The authors concluded that the inability to recognise suspected abuse and a reluctance or lack knowledge of reporting procedures was a result of limited education and training (Soldani, Robertson & Foley 2008).

Inadequate training and non-reporting of suspected child abuse and neglect are reoccurring themes that are also identifiable in Australian studies. Raman, Holdgate & Torrens (2012) used a validated Child Abuse and Neglect Questionnaire to explore child protection knowledge, practice and attitudes of general practitioners, practice nurses, emergency department doctors and nurses from Western Sydney. From the 320 questionaries distributed via post, 113 were returned (35%). The major findings were that there remained a lack of competence and confidence in identifying and reporting child abuse and neglect. While the response rate was low, this study's findings remain significant given the group of participants surveyed were frontline or primary health care professionals providing care in a low social economic area of NSW, Australia. The lack of education and training related to child protection, remains a concern, as repeatedly in the literature health care practitioners continue to appear inadequately prepared for their role and requirements in this area.

Child protection workers' experiences with child protection

Exploring the experiences of child protection in contrast to health care professionals was considered another aspect to explore. The roles of child protection staff differ to those of health workers as they are more likely to have a long term involvement with families through a case management approach. This group of allied health care professionals are involved in interagency communication and collaboration with health services and, in some circumstances, social workers and child protection teams based within health networks (Bennett, Plint & Clifford 2005; Wickham 2009).

The role of child protection workers is a complex and challenging aspect of professional work. The negative perception of child protection agencies in the community and by some health professionals does not help to build trust and effective working relationships (Harlow & Shardlow 2006). Kojan and Lonne (2012) explored child protection systems in Australia and Norway and concluded that child protection agencies were perceived as being under-resourced, having high staff turnover and inexperienced staff, resulting in pressure on the child

protection workers, poor interagency relationships and inadequate case management. In the United Kingdom, Devaney (2008) interviewed 28 experienced child protection workers, exploring their role with complex long term families raised similar issues stating that staff turnover staff can result in important loss of knowledge about the family, create difficulty engaging with parents and key professionals and can produce strain on relationships between organisations. In addition, lack of experience has been linked to poor skills around decision making and assessment of risk factors impacting on outcomes for families (Gillingham 2012; Harlow & Shardlow 2006). Gillingham (2012), in an ethnographic study of 46 child protection workers in Victoria, Australia, found that the more inexperienced workers relied heavily on organisational decision making tools which are not a replacement for expertise and professional judgement that more experienced practitioners incorporated into their work practices with child protection cases (Gillingham 2012). Given the impact of decision making and interagency relationships on families, support for child protection workers is essential to improve turnover and skill development.

A study providing some positive outcomes was published by an Australian researcher in 2002. In this study, Trotter (2002) interviewed 50 child protection workers and 282 clients and family members and identified key skills to improve outcomes for the families The findings of the study indicated child protection workers who made clear their role and expectations with the family, understood the problems from the client's viewpoint and worked in an honest supportive relationship, that included at times confrontation of concerns and problem solving techniques, resulted in more closed cases and satisfaction from families. Whilst there is no simple formula, the aim of child protection workers is to improve the long term outcomes for at risk families. Trotter's study described how child protection workers can incorporate a partnership type model into their practice.

Child protection and health care communication and collaboration

A common theme in articles accessed for this review raised issues and challenges related to ineffective interagency collaboration and communication between child protection services and health workers (Devaney 2008; Frost, Robinson & Anning 2005; Harlow & Shardlow 2006). Some of the broad issues identified by these authors included reluctance to share information, maintenance of confidentiality, organisational and professional role and values conflict, and fear that engagement with child protection services may harm relationships and engagement with the family with health and other services. Scott (2005, 2010) argues that a degree of

conflict should be expected and accepted in inter organisational collaboration and by identifying the areas of tension can provide possible solutions to these issues.

Some studies illustrate attempts to explore how the child protection services and health workers can work more effectively to benefit the families in their care. In the previously mentioned study by Devaney (2008), it became clear that the effective interagency communication and quality multidisciplinary relationships between professionals supported the development of more workable management plans and appropriate use of resources, resulting in improved parent engagement. Another well conducted review of the literature, policies, service users files and professional accounts was undertaken in the UK to explore the role of social workers in effectively working with other professionals in child protection (Harlow & Shardlow 2006). The results identified the importance of the recognition of roles and values of the professional groups and how this influences their assessments and opinions about child protection concerns. The authors argued that understanding the significance of these differences and recognising the potential for conflict may assist group dynamics to improve inter agency relationships and partnerships with parents and children at risk (Harlow & Shardlow 2006).

Another concept identified in the literature is the idea of joining-up services. An example of authors working in this space, such as Frost, Robinson and Anning (Frost & Robinson 2007; Frost, Robinson & Anning 2005) similarly stress the importance of working through relationship differences and agendas of various agencies to safeguard children. Their qualitative multi-method studies, involved three stages. Firstly they gathered relevant documents from the teams, then undertook interviews of teams, and followed with focus groups with team members responding to vignettes. Their studies aimed to explore the issues around joining-up children services teams. These studies highlighted that organisationally relocating teams together is only beneficial when combined with commitment from professional groups to strive to overcome conflicts and obstacles to effectively work with each other (Frost & Robinson 2007; Frost, Robinson & Anning 2005). Working with families in child protection situations is challenging and complex work, with long term consequences. The focus of individual practitioners and organisations is to find ways to work effectively together (Scott 2010).

Conclusion

The literature review presented in this chapter reveals a dearth of evidence pertaining specifically to midwives and their experiences of assumption of care of newborns. In fact, there is a general lack of evidence exploring health professions' experience of the removal of infants or children in any health settings. The importance of mandatory reporting is not in question and there is no doubt that the involvement of health professionals in mandatory reporting and working with vulnerable families to reduce risk of harm to infants and/or of abuse and neglect is essential. What literature is available however, demonstrates that health care professionals are challenged by the issues involved in child protection and often struggle with their role as mandatory reporters. The challenges and complexities of health professional roles and maintaining a child protection focus was evident. In addition, there appears to be ongoing educational and training deficits especially related to identifying, assessing and reporting suspected abuse and neglect of children.

Including the viewpoint of the child protection workers highlighted the challenges for workers in improving child protection systems and working collaboratively to improve outcomes for families. The gap in the literature to inform midwives in their role and practices during an assumption of care is evident and supports the priority of this study.

The next chapter will describe the research method and design. This includes details of recruitment, participants, data collection and analysis. The impact and reflection of my role within the research process is also discussed.

Chapter Three – Research Design and Methods

Introduction

In this chapter, an outline of the choice of a qualitative descriptive approach to explore midwives experiences of assumption of care is discussed. The chapter starts with an overview of qualitative descriptive design and a justification for the use in this study. The design of the study is described under headings of setting, sample, recruitment, participants and their demographic details. Details of the data collection and thematic analysis include reflectivity and location of myself in the study. Ethics approval was granted through the University of Technology, Sydney (UTS), Human Research Ethics Committee (HREC) - UTS HREC REF NO. 2010-223A. The ethical considerations and challenges are included at the end of this chapter.

Qualitative research

When commencing a research project, the researcher needs to make a decision about the best methodological approach for the topic. Qualitative methods best suit the purpose of addressing questions that have limited understanding of experiences or phenomena related to the complex real life situations (Marshall & Rossman 2006; Richards & Morse 2007). Working qualitatively allows for the participants' experiences to be explored and described from their perspective through various forms of data collection and analysis. The most common qualitative research methods used in health sciences include phenomenology, grounded theory and ethnography, each with distinct theoretical and philosophical underpinnings (Andrews, Sullivan & Minichiello 2004; Richards & Morse 2007; Whitehead 2007). Other methods include action research, feminist research, case study, historical and explorative descriptive design (Whitehead 2007). Qualitative descriptive approach was chosen to use to explore midwives' experiences of assumption of care. This method and why it has been chosen for this study are described in the following sections.

Research Design

This qualitative research study was undertaken as part of a Masters (Honours) degree. There was one study that could be found in the literature that addressed a similar issue. This was the phenomenological study undertaken by a UK midwife Gaynor Wood (2008a). Initially, I planned to replicate Wood's study. Replication of a study is encouraged by Burns and Grove (2005) for Master's degree research as a means to validate findings and generate new

information. However after discussion and debate, I decided to replicate one aspect of Wood's (2008a) study related to midwives' experiences of assumption of care. Given the dearth of evidence and the scope of a Masters' degree, using a qualitative descriptive approach was considered the most appropriate methodology.

Qualitative descriptive method aims to describe a phenomena in terms of who, what and where of events (Sandelowski 2000, 2010). The goal is to obtain a comprehensive summary of events in everyday terms, staying close to the data (Sandelowski 2000). Descriptive studies of this nature provide rich descriptions of complex situations that are unexplored in the literature and are searching for a deeper understanding of the experience of participants (Marshall & Rossman 2006). According to Annells (2007), qualitative descriptive studies are becoming a common approach in addressing questions pertaining to nursing and midwifery practice.

Qualitative research seeks to explore real life situations, complex social interactions, opinions, experiences and behaviours and how the people themselves view these (Baker 2006; Marshall & Rossman 2006). The aim is to describe and generate meaning within a practice or social context (Whitehead 2007). Qualitative research has increasingly been used to add to the body of knowledge within health sciences, nursing and midwifery professions as evidence to support best practice and develop theory (Burns & Grove 2005; Whitehead 2007).

Despite an increasing use, qualitative descriptive studies approaches have been criticised for a lack of philosophical underpinnings and sometimes considered inferior to well-known qualitative methods, such as ethnography, grounded theory and phenomenology (Annells 2007; Daly et al. 2007; Sandelowski 2000). However, authors such as Annells (2007) and Sandelowski (2000), argue that this approach can be used effectively to produce good quality research with outcomes applicable to practice. More recently Sandelowski (2010) published an article addressing her concerns related to misinterpretation of her original 2000 article to clarify that qualitative descriptive studies are not atheoretical. According to Sandelowski (2010), all research has a theoretical underpinning regardless whether the author acknowledges or recognises the theory applied to their work. She challenges authors to make it clear where they began and where they have moved away from the theory or framework within the study.

Current examples of published qualitative descriptive studies in midwifery include why woman request first caesarean birth in a normal healthy pregnancy (Fenwick et al. 2010), midwives' descriptions of postnatal experiences of women who use illicit substances (Dowdell et al. 2009)

and the experience of midwives who underwent a credentialling process (Smith 2010; Smith, Brodie & Homer 2012). All these studies explored a phenomenon where a lack of published literature was available for midwives to provide insight and guidance for practice. It is for these reasons that a qualitative descriptive approach has been chosen to explore midwives' experience of assumption of care.

Setting

Participants for this study were drawn solely from the Sydney metropolitan area of NSW. The rationale for this decision was based, firstly, on the fact that child protection laws and reporting notifications vary across Australia (Scott 2006). Recruiting and interviewing midwives from other states may have added a level of complexity in exploring and describing midwives experiences. Secondly, given the scope of the Masters' degree, access to participants was considered important. This restraint was due to the requirement of a face to face interview and my time and travel restrictions.

Participants

The participants for this study were registered midwives who had experience in working with an assumption of care of a newborn within the past three years. The requirement of experience in the past three years was to ensure involvement incorporated recent legislative changes surrounding child protection. The proposed number of participants to be interviewed was nine to twelve. The number of participants was eventually determined by theoretical saturation of data which is considered to have occurred when no new emergent themes or concepts are generated (Daly et al. 2007; Higginbottom 2004).

Process of recruitment

A half page advertisement about the study and an invitation to participate was placed in the Australian College of Midwives (ACM) - NSW Branch newsletter 'Midwifery Matters', September issue, 2010. The newsletter is distributed to approximately 1300 members of the ACM (NSW Branch). The advertisement provided a brief description of the aim of the research and how the study is part of UTS Master of Midwifery (Honours) degree. Other midwifery research students have used this approach in the past and it has been an effective method to recruit participants (Copeland 2011; Smith 2010). This participant selection is known as purposive sampling as the individuals would have experienced the event being studied with the aim of providing rich information on the research question (Burns & Grove 2005). This also

meant there was a possibility of a self-selection bias as midwives who have a concerned interested may volunteer for an interview.

A limitation of using the ACM newsletter is that only current members of the College in NSW receive the newsletter, restricting possible participants. It is likely the newsletter reaches about half the midwives in NSW. To overcome this issue, the technique of snowball sampling was also utilised (Llewellyn, Sullivan & Minichiello 2004). This is where participants identify other individuals who meet the sampling criteria and who may not be members of the ACM or who have not seen the advertisement. This is exactly what happened during the recruitment phase, several midwives responded to the advertisement then contacted colleagues who they thought may be willing to be interviewed due to their experience. These midwives then contacted me to register their interest participating.

Midwives who have been involved in an assumption of care and were interested in participating were asked to contact me via phone or email. The midwife was provided with a brief outline the project, their eligibility was then confirmed, they were made aware what their participation would involve and were invited to participate. A face to face interview was organised at a convenient time and place for the participant. The participating midwives were informed that the interview would be digitally recorded with their permission; the data would be transcribed verbatim and analysed for the purpose of the study. An explanation of how the midwives would not be identifiable in the research was provided. The participating midwives were made aware that confidentiality would be strictly adhered to, using the UTS Research Guidelines (National Health and Medical Research Council 2007). The midwives were able to withdraw from the project at any stage with no obligation. A pack containing the information letter, consent form and brief outline of the questions was forwarded to the participant prior to interview.

During my initial conversation with interested participants, I outlined the inclusion and exclusion criteria for the study. Any midwife who identified herself/himself as a colleague whom I work with on a regular basis was excluded. This decision was due to potential conflict of interest as most of the assumption of care experiences that occur in my own workplace I would be involved in. This did occur with one potential participant. I explained that this was a decision that has been made in their best interests. She was thanked for her interest and the offer made to inform her of the project outcomes.

After advice from UTS HREC, it was decided to ask each midwife who responded to the recruitment advertisement if they would identify themselves as an Aboriginal and Torres Strait Islander person. If the potential participants answered 'yes' to this question I was to explain to them, that given the sensitivity of the subject of removal of Indigenous children and the impact of the 'Stolen Generation' and risk of distress in the interview, that support numbers additional to those listed on the information letter would be available to them if they choose to participate in the research. NHMRC Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (National Health and Medical Research Council 2003) would be consulted throughout the research project if an Aboriginal and Torres Strait Islander midwife was recruited. No midwife who responded to the recruitment process identified as an Aboriginal and Torres Strait Islander.

Five midwives contacted me by telephone/email. A further four were recruited through snowball sampling. Following nine interviews I felt theoretical saturation had been reached. One further interview was conducted with no further emergent themes. This bought the number of participants to ten.

There was one other midwife that had responded and was keen to participate. However, this interview needed to be rescheduled on several occasions due to her workload commitments. Eventually the decision was made in consultation with my supervisors, not to conduct this last interview due to continued inability to reschedule and time restraints of the research project. The midwife was thanked for her willingness to participate and offered feedback about the results.

Demographic details of participants

Table 1 represents the demographic details of the participants. To maintain confidentiality of participants, the midwives were given an alphabetical code. The demographic details are correct for each participant however the order in which they were interviewed has been changed. In addition, when direct quotes appear in the body of text, midwives have been given a numeral to identify them.

Table 1 - Demographic details of participants

Midwife	A	B	C	D	E	F	G	H	I	J
Years of midwifery experience	27	2	30	16	17	11	30+	22	26	25
Registered Midwife (RM)	RM	RM	RM	RM	RM	RM	RM	RM	RM	RM
Registered Nurse (RN)	RN	-	RN	RN	RN	RN	RN	RN	RN	RN
Age range	50-59	40-49	50-59	30-39	40-49	30-39	50-59	50-59	40-49	40-49
Type of current position*	CMC	WM	CMC	MUM	CMC	MGP	CMC	CMC	MUM	CMC
Continuing education qualifications	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Number of assumption of care experiences	7	1	5	15	10	3	18	17	7	8

*Type of current position: CMC-Clinical Midwifery Consultant; WM-Ward Midwife working all areas of the maternity unit; MUM-Midwifery Unit Manager; MGP-Midwifery Group Practice.

The participants' ages ranged between 40 to 59 years. Nine of the participants were registered midwives who had completed their nursing qualification prior to their midwifery education. One participant had completed a direct entry Bachelor of Midwifery. All had completed some type of continuing education qualifications that included for example, management, education, masters of midwifery, counselling, women's health, child and family health, mental health, family planning and other health disciplines. Midwifery experience ranged from two years to 30 years with one midwife having only two years, three midwives between 10-20 years and the other six midwives with more than 20 years. In terms of employment, one midwife worked in a midwifery group practice as a caseload midwife, one worked as a registered midwife working in all areas of the maternity unit, two held midwifery manager positions and six were in current positions as clinical midwifery consultants (CMC). However,

the six CMCs each had a different focus to their roles, for example, specialising in drug and alcohol or mental health.

Eight of the midwives held positions in metropolitan Sydney public hospitals and two had positions in rural public hospitals. The study aimed to recruit midwives from metropolitan Sydney for logistical purposes. The two midwives with rural experience were based in Sydney at the time of the interview even though their assumptions of care experiences were during employment in rural hospitals. This was considered to add richness to the experiences. The midwives indicated they had been directly involved in between one and 18 occasions of assumption of care during the past three years. Collectively the 10 midwives were involved in a total of 91 experiences of assumption of care of a newborn. Some midwives' roles meant they had additional experiences working with Community Services during antenatal care or with the families and the newborns after assumption of care.

Data collection

In depth interviews were undertaken to collect data. These were digitally recorded and transcribed verbatim. In-depth interviews offer the opportunity to explore the meaning and experiences in the participants' own words (Marshall & Rossman 2006). As my research question related to the experiences of midwives, interviews were considered the best method to collect the data to uncover the participants' perspective of events. In addition, in face to face interviews, participants can share their experiences in detail and a large quantity of data can be collected quickly.

The interviews with midwives were conducted at a convenient location. The rooms were private to ensure confidentiality and avoid disruption. The interviews were conducted at a place and time suitable to the midwife. The locations varied from the participant's home, places of work and on one occasion a room booked at the University of Technology, Sydney (UTS) Broadway campus. The interviews lasted approximately 45 minutes to one hour.

The in-depth nature of the interviews allowed me to develop a relationship with the participant that assisted in building rapport and trust (Minichiello et al. 2004). The choice of face to face interaction allowed the midwives to share their accounts of the experiences with assumption of care with me, a researcher who had personal experience and knowledge of the research question. As this topic was complex and emotive, observing personal responses through watching body language and expressions was also an important consideration. This

allowed me to stop, pause or change the interview according to the participant's responses. A reflective journal was used to record these responses after the interview.

The experience or inexperience of the interviewer can impact on the interview and consequently the richness of the data. The types of interview skills required include building rapport, active listening, confidence, being mentally alert and concentrating, flexible and able to improvise (Minichiello et al. 2004). An inexperienced interviewer may miss opportunities to elaborate or prompt important issues (Jootun, McGhee & Marland 2009). As an experienced midwife, while I felt I had the skills to conduct interviews within my clinical practice, I was nervous about undertaking the role of a research interviewer especially within a complex emotive area. I also did not want to miss important perspectives the participants had to offer. Therefore, I undertook training in interviewing and did a practice interview.

Having a practice interview can assist in identification of issues and also offer valuable experience prior to the real interviews. This practice can help clarify the order of the interview guide, actual techniques of probing, observing interpersonal interactions and time frames (Burns & Grove 2005). Given my readings, I decided to conduct a practice interview with a colleague who was a midwife with experience of assumption of care and a researcher with experience in interviewing. This helped to identify issues like ensuring the opening question was not too broad for the participant to know where to start, how to best use the interview questions as a guide for discussion and check my ability to identify some of the themes raised during the interview and probe where appropriate. As the interviews were to be digitally recorded this was also an opportunity to test and become familiar with the equipment. The digital recorder was tested and placed in appropriate position to ensure effective recording. Undertaking the practice interview also helped me to recognise how, as a researcher you need to discuss with the participant, the guidelines for recording the interview and the ethical obligations with such recordings.

An interview guide was used to initiate discussion around a broad series of issues that I believed would assist in gaining data around the research aim and objectives. The list of questions or topics in the interview guide were developed from personal insight as well as from the current available literature (Minichiello et al. 2004). My questions were open ended and had a sequence but I remained flexible so that I could respond appropriately to the participant.

The broad questions around the topic of assumption of care were as follows:

- Could you describe your experiences in relation to assumption of care of a newborn?
- Could you describe the emotions you felt before and after the assumption of care?
- Could you share your thoughts on support for the midwives when involved in the assumption of care process?
- How did this experience influence your future practice when dealing with families who have child protection issues?
- How do you think the model of care you worked in during the assumption of care influenced and/or impacted on your experience/s?
- How did your midwifery education prepare you for being involved in the assumption of care process?

After the practice and first interview, an additional question was added to begin the interview, as the midwives required several prompts to start to describe their experiences. Part of the plan in the demographic data was to ask the midwives to tell me how many assumptions of care experiences they had been involved in during the past three years. So this question was included instead to begin the interview, for example:

- Could you tell me how often you have been involved in assumption of care of a newborn in the past three years? Has this increased or decreased?

Depending on the response to this question the midwives were then asked as initially planned to describe their experiences. The midwives who had been involved in numerous assumptions of care often chose at this point to discuss some of the cases that had the greatest impact on them. By adding this question from the start the interviews flowed better. As said previously, all the other questions were then used depending on the responses from this initial response about their actual experiences.

At the suggestion of the UTS HREC I included the interview questions in the information package sent to participants prior to the interview so they had an understanding of the type of questions I would ask. All participants received the same questions even as the data progressed. Initially in all the interviews, these broad promoting questions were used. As analysis progressed, concepts related to the emerging themes were added to the prompt questions. These were used to further clarify responses or investigate if the midwives had experienced some of the same experiences as the other participants. Although all the midwives had received the questions prior to the interview, not all had read them before the

interview. Participants were able to decline to answer any of the proposed questions, however none of the participants declined to answer any of the questions.

Data analysis

Thematic analysis was used to analyse the data. This approach identifies answers to research questions through identifying themes imbedded in the data. Thematic analysis involves identifying, analysing and reporting themes or patterns within the text (Braun & Clarke 2006). Line by line coding was used to identify concepts. This is achieved by examining the sentences, phrases and even words within the transcribed data that link to the research question and initially allocating a code to that piece of abstracted data (Annells & Whitehead 2007). These codes were linked into groups with tentative labels which developed and changed as the analysis process continued. Like concepts were clustered together to form themes and/or sub themes, then relationships and links between themes were identified**.** The overall pattern that emerged provided a valuable account of the analysis midwives experiences (Braun & Clarke 2006). Using thematic analysis resulted in an overall description of the entire data set allowing for a rich descriptive interpretation. As discussed, this technique is useful when investigating an under researched area or with participants whose views are not known on a specific topic (Braun & Clarke 2006). This was the case with my research.

Thematic analysis is a widely used method within qualitative research. However, some controversy exists about what researchers actually do when they state they use thematic analysis in their publications (Roberts & Taylor 2002). The themes can be determined by researcher judgement in relation to research question. The flexibility of rules applied to data analysis resulting in coding and development of themes require discernment by the researcher who must decide which piece of text is relevant or not to research question. Differing from quantitative research, the prevalence of a theme may not mean the concept is more crucial (Braun & Clarke 2006). Ideas and concepts of interest may become evident to the researcher during the interview. During my research, I kept a reflective journal that was completed immediately post interview to identify the initial thoughts and themes raised in regard to the interview. This was used in the initial phase of analysis of the transcript to help identify early concepts and themes.

Braun and Clarke (2006) provide an example of a detailed guide to help describe the phases of thematic analysis as there is no one way to conduct the process. The progression is flexible and

may not progress merely in this linear framework. These phases are used as a guide to explain the process of the thematic analysis used in my research:

1. Familiarising yourself with the data: This occurs through immersion of the data by repeatedly reading and re-reading while making initial notes of ideas. The interviews were checked by listening and correcting as required to the transcripts for accuracy. This phase allowed for the initial line by line coding and highlighting quotes that may be of relevance. A note book was used to record thoughts about each transcript. Listening to transcripts allowed identification of some non-verbal cues like silent pauses.

2. Generating initial codes: This phase involves coding interesting features of the raw data that provide information related to the research phenomenon. This was done manually. Notes were made on the typed printed transcripts to highlight emergent themes or even phrases used by the midwives. I did not use a computer program to assist in the coding of data and themes due to personal preference. Sections of text noting the midwife number and numerically recorded lines were cut and pasted as text into new word documents under developing ideas. This section generated lots of potential ideas with some extracts of data fitting into more than one heading. As more interviews were analysed, these themes grew, changed, and were re-named and even combined. Once all transcripts were read and codes identified, they were then re-read again. Ideas that developed in the latter interviews, were then reviewed in the earlier transcripts to ensure these concepts had not been missed.

3. Searching for themes: This next phase begins to analyse the codes into different broader overarching themes. This involved sorting and collating coded data into main themes, sub themes and even miscellaneous themes for data. This process was done with coloured paper on large sheets of paper posted all over the walls of my office. It allowed me to look at all the themes developed so far, using the colours to identify how some themes connected together or had been incorrectly allocated. This was an important aspect of the analysis process and assisted especially when data was allocated to multiple codes, as it provided an opportunity to move the data quote appropriately within one main theme.

4. Reviewing the themes: This involved checking the themes against the coded extracts of data and then against the entire data set. This was done by going back to the theme

word documents that had been created with codes and re reading quotes allocated to each section. This gave an opportunity to ensure the themes were correct and move any data within the themes. Codes were condensed at this stage and the order of how the codes and themes fitted together was more clearly identified.

5. Defining and naming the themes: This was about identifying the essence of what each theme was about. This step required writing a detailed analysis of each theme which included relevant quotes and describing why and what was important about them. At this stage, comments from my supervisors about the order and suggested names of the themes and sub themes were invaluable. Knowing that the names of themes were easily identifiable and concise for another reader was essential to the flow of the overall story.

6. Producing a report: This was the final step in the process of analysis and assisted in the completion of the themes. According to Braun and Clarke (2006) this part of the process tells an in depth story of your data in a way which convinces the reader of the merit and validity of your analysis. Selected pieces of quotes have been interwoven to provide evidence of the themes and the overall analysis of the data.

Ten interviews generated a lot of rich data for analysis. It was important to stay as true to the data as possible to answer the research question related to midwives' experience of assumption of care. Mauther and Doucet (1998) express how it can be difficult to cut up the stories of participants to condense into themes without losing complexity and ensuring the important aspect of each voice is represented. The thematic analysis was a very time consuming process and at times a challenging one. However, I believe the outcome has been worthwhile as it allowed the ten midwives' interviews to be combined into an overarching story about their assumption of care experiences.

Trustworthiness

Trustworthiness of the data occurred by discussing and debating emerging themes with my supervisors. An audit trail was kept of decisions made to support the main themes or sub themes and conclusions of the study (Annells & Whitehead 2007; Burns & Grove 2005; Jootun, McGhee & Marland 2009). This record is in the journals kept about my reflections about the interviews and the notes, and highlighted sections on the actual transcripts. A record of the development of themes with extracts of quotes is stored as word documents.

During the process of analysis, the data were presented at several midwifery and maternity related conferences (see Appendix 1). These presentations also form evidence of the emergent theme development and provided feedback from peers of the acceptability of the analysis and research process (Annells & Whitehead 2007).

Being reflective through the process

Reflectivity was a key process throughout the data collection and analysis. Being a midwife who had experience in assumption of care of newborns formed the basis of my interest in researching this topic. Throughout the research process, acknowledging my personal and professional values and changes of my position with the research progression was an important aspect to monitor. Allowing the participants to tell their stories which were sometimes painful and confronting to their, and my, expected role as a midwife was at times challenging. The midwives disclosed issues of personal safety for themselves or their colleagues, frustrations with communication systems, decision making processes, and distress of working with women during assumption of care. Often the midwives would say 'you know what I mean' acknowledging my perceived understanding of their experience and increasing the trust of sharing their own personal and professional experiences (Burns et al. 2012).

As a researcher, I tried to stay with the flow of the open ended questions and to not engage in discussions during the interviews about what may be separate agendas. Sometimes when reading transcripts of the interviews I questioned why I had not probed or prompted more over certain ideas raised by the midwives instead choosing to ask my next question. Alternatively, in some interviews there were long dialogues of text where I chose to allow the midwife to expand on her experiences without interruption. This was about recognising my own empathy for the recalling of traumatic experiences by the midwives beyond just being a research interviewer (Burns et al. 2012; Leslie & McAllister 2002). It is clear that while the findings were derived from the participants' accounts the interpretation of the data is influenced at each stage by my own personal experiences as midwife and a researcher (Jootun, McGhee & Marland 2009).

Location of the researcher in the study

Burns and Grove (2005) recommend that identifying your own position in the research to the participant is important to establish honesty between each other. This may assist the participants to feel more comfortable in sharing with someone who knows what they are

talking about. During the initial recruitment conversations with the participant, I identified that I had experiences with assumption of care as part of my role. I explained that my involvement had influenced my choice of research topic and was keen to hear about other midwives experiences and practices. I was careful prior to the interview to not disclose any of my personal experiences nor the themes from the literature or from the other interviews.

Being both the insider with experience of assumption of care and an outsider from a different organisation with a research objective was advantageous to my study. The challenge to find the middle ground being a midwife experienced in my research topic and being a research interviewer seeking to gain new understanding cannot be easily resolved (Burns et al. 2012; Dwyer & Buckle 2009; Else & Eva 2007; Leslie & McAllister 2002). This 'insider/outsider' knowledge has recently been described by Burns and colleagues (2012) during their observational study of the interaction between breastfeeding women and midwives. Whilst my study was not observational, some of the advantages of being a member of a group with insider knowledge had benefits in recruitment of participants, building trust and openness and during the interview process being able to relate to the complexity and the emotional sensitivity of the experiences of the midwives. Choosing to interview midwives from other hospitals also gave me the ability to be a researcher and distance myself more as an 'outsider' to hear the processes and impact experienced in different situations and sites.

However, as a researcher I needed to be aware of not missing opportunities to probe, prompt and explore important issues raised by the participants acknowledging my own potential biases (Jootun, McGhee & Marland 2009). It was important to be reflective as a researcher to acknowledge my own agenda, personal feelings and experiences and how this influenced the interview process. Keeping a journal of discussions at recruitment, and prior and post interviews helped me to recognise my pre-conceived ideas and identify the themes discussed by the participants. Discussions with my supervisors after the interviews helped to challenge my assumptions and identify areas for the following interviews that could be explored.

Data management and storage

Data were transformed from digitally recorded interviews to typed transcribed word documents by a professional transcriber. All identifying information was removed during the transcription process.

The data are stored securely in accordance with the NHMRC guidelines (National Health and Medical Research Council 2007) which includes:

- Stored in locked cabinet at the University of Technology, Sydney (UTS)
- Transcripts are kept separate from demographic details and coded with a pseudonyms as soon as they were transcribed
- Any identifying data about names of families, hospitals, local health districts or surrounding suburbs were removed from the transcribed word documents
- Transcripts are only accessible to myself and my supervisors.

Once the data were transcribed, each participant was not able to be identified by their name. Each transcript was given a code which was kept separate from the transcripts and only accessible by myself. The participants were not identifiable in the data. A pseudonym was used to de-identify the participants, the hospital sites and any names of women used in the interview process. Thematic analysis allowed for themes to be grouped and create composite stories in order to remove chance of identification of case recognition.

Ethical Considerations

Ethical approval for this research project was granted in August, 2010 through the University of Technology, Sydney (UTS) Human Research Ethics Committee (HREC)-UTS HREC REF NO. 2010-223A. The UTS HREC was chosen for approval as midwives were being recruited through the Australian College of Midwives NSW newsletter not NSW Health Local Health Districts. The UTS Jumbunna Indigenous House of Learning (IHL) Research Unit was consulted in relation to recruitment of Aboriginal or Torres Strait Islander midwives and disclosure of experiences in relation to removal of Aboriginal or Torres Strait Islander newborns. The HREC felt the issue of assumption of care of Indigenous newborns should be clarified within the ethics committee application and if the choice was made to exclude these experiences from the research, then this should be explained.

As described earlier a disproportionate number of Aboriginal and Torres Strait Islander babies and children are represented in removal statistics and specific policies and procedures have been developed to ensure appropriate placement and supports are provided if risk of significant harm is identified especially for these children (Koolmatrie & Williams 2000). After consultation between Mark McMillan and Jason De Santolo from Jumbunna House of Learning (IHL) Research Unit and my supervisors, the decision was made to include experiences of

midwives describing assumption of care of Indigenous children. The project aim is to focus on the midwives' perspective to improve their ability to provide care for women and families during this process. Non Indigenous midwives are involved in removal of Indigenous children and it was considered that their experiences would be sensitively considered as part of the research. However, the project was not specifically trying to recruit midwives with this experience. Finally, any publications will identify that Australia has had a long history of inappropriate policies that have resulted in removal of Indigenous children and the relevance of this issue was noted within the context of the study even if no experiences of removal of Indigenous children are described.

Confidentiality was addressed by reminding the midwife at the commencement of the interview that she should be careful not to identify the family or place of work whilst discussing her experience. Ethical guidelines for privacy and confidentiality were followed if they were removed from the transcripts.

Information sheets

The information sheets contained details about the study and the requirements of the participant. Details of assistance to explore and direct toward resources for counselling support were supplied. Additional support numbers were to be added if a midwife identified herself as an Aboriginal or Torres Strait Islander person (Appendix 2).

Consent

The participants were asked to read and sign a written consent form prior to the beginning of the interview. Opportunity to ask questions, discuss issues of consent and ability to withdraw from research at any time was discussed at that stage. The consent form detailed contact details of myself as the researcher, my supervisors and the UTS HERC Research Officer. Information about the study and the requirements of the participant were detailed on the consent form (Appendix 3).

Potential risks

The possibility of distress for the participant in recalling experiences of assumption of care of newborns in the interview process was highlighted as a potential risk. As the interviews surrounding assumptions of care were likely to raise sensitive and emotional issues related to what could or might be perceived as a traumatic event, it was important for me as the interviewer to acknowledge and be responsive to these emotions. The 'emotional work' in

midwifery is not well documented even though pregnancy and childbirth have the potential to be intimate and emotional in positive and negative aspects of care (Hunter 2001). How the midwives managed their emotions and were supported at work during assumptions of care was an important aspect to consider in the interview process. It was identified that it may be necessary to stop or pause the interview with immediate response to distress by providing appropriate support through active listening, allowing opportunity to explore personal distress and identify any risk or safety issues. Should crisis assistance be required, 24 hour counselling services were to be contacted immediately and strategies followed to ensure safety of the interviewee. Having said this, there is some evidence that midwives participating in studies like this may benefit by sharing their experience during the confidential interviews process (Hood, Fenwick & Butt 2010).

The possibility of ongoing distress from the interview process surrounding assumption of care was also likely, as the midwives may reflect more about the events of their experience of assumption of care of a newborn following the interview. The information letter provided options to explore future long term counselling support services available in the community. If the midwife was employed in a NSW Area Health District that offers an Employee Assistance Program (EPA), she could choose to access this service, especially if the concern was related to work practices or issues. Alternatively, referral pathways to their own general practitioner (GP), clinical psychologists or community mental health services were offered.

Only one midwife during the interview became distressed and began to cry as she recounted her experience. The digital recorder was turned off as planned and support offered. The midwife chose after a brief pause to continue the interview as she felt recounting her story was actually helpful to her ability to deal with her emotions in relation to her experience. With the midwife's permission I followed up with a phone call a few days after the interview to ensure her distress had not increased following the interview. The support services listed on the information sheet were highlighted to this midwife to use for further support, both at the time of the interview and at the follow up phone call. Following the interview I also discussed this midwife's response and my actions during the interview with my supervisors to ensure I had followed the ethical consideration requirements.

In addition, there was a possibility that issues of unsafe practice may be brought up during the interviews. Examples of unsafe practices to be considered during the interviews would have involved stories of assumption of care of newborns that had occurred prior to the interview process. It was thought that any disclosures of unsafe practice in relation to assumption of

care and/or child protection issues by a midwife were most likely to be a result of the midwife not following the policies and guidelines set out by NSW Department of Premier and Cabinet, Community Services and NSW Health before, during or after the removal (NSW Government 2009; NSW Health 2011).

Incidences of unsafe practice were to be discussed with the midwife and she was to be advised to discuss this formally through the relevant channels within the health service. If a midwife did disclose an unsafe practice the plan was to indicate the disclosure obligations of myself as primary researcher and follow up the issue in discussions with my supervisors. A risk assessment was to be undertaken and decision regarding the course of action made. However, no midwife during the interviews disclosed an unsafe practice in relation to child protection, mandatory reporting or assumption of care experiences.

As a researcher, in relation to unsafe practice disclosure, I would have discussed relevant policy requirements and assisted the midwife to become aware of how she may have accessed this information and current obligations. Fear for one's own safety and being involved in any legal proceeding are commonly cited reasons for not following polices (Bunting, Lazenbatt & Wallace 2010; Koritsas, Coles & Boyle 2010; Nayda 2005). As a researcher, I would have explored both these scenarios with the midwife providing all the relevant information and possible ways to move forward. If fear of safety was an issue, I would have ensured the appropriate notification of police, hospital security and management occurred. If disclosure during interview related to a current mandatory of risk of harm report I would have assisted in the immediate reporting of the situation to NSW Health Child Wellbeing Unit or Community Services Helpline as appropriate. During the interviews I made sure I had resources with me should a participant require them.

There was also risk of breach of confidentiality if the midwife identified the family or hospital within the interview. Possible breach of confidentiality was addressed by reminding the midwife at the commencement of the interview that she should be careful not to identify the family or place of work whilst discussing her experience. Ethical guidelines for privacy and confidentiality were followed. The names of some of the hospitals and surrounding services disclosed were removed by me as the researcher from the transcript prior to anyone else reading the transcripts.

Finally, there was a possible risk of distress to myself as the researcher hearing distressing stories related to an area of practice I have had personal experience in and am committed to

improve. Keeping the reflective journal after each interview helped me to acknowledge the impact of the experiences of the midwives on me personally. Re-reading the transcripts was also a time when I acknowledged how traumatic some of the experiences of the midwives had been during and following an assumption of care. I had regular sessions to debrief with my supervisors during data collection and analysis. I was also aware of my ability to contact UTS student counselling services to address issues if required.

Conclusion

This chapter has described the choice and use of qualitative descriptive approach to explore the ten midwives' experiences of assumption of care of newborns. As there was a dearth of literature related to this specific topic, the selection of qualitative descriptive approach allowed for the exploration of complex situations for the midwives to better understand their perspective. The chapter included the methods used for data collection and analysis with reflective perspective of the process.

The next two chapters present the findings of the study. The overarching themes, main and sub themes are presented with quotes from the midwives to describe and illustrate how the development of the analysis occurred.

Chapter Four – Findings Part 1

Introduction

This study aimed to investigate midwives' experiences of assumption of care of a newborn. Thematic analysis identified three overarching themes. The first, labelled 'Being in the Headspace', describes the activities, processes and ways of working, midwives engaged in when providing midwifery care to a childbearing woman who was at risk of having her newborn removed from her after birth. This overarching theme consists of two main themes; *An outsider in the relationship: Working with Community Services*; and, *The actual assumption of care*. The midwives learnt the importance of working with Community Services[3] even though they were not usually a part of the midwife-woman relationship. Understanding the processes and procedures involved in an assumption of care episode helped midwives come to terms with and deal with the decision to remove the newborn from their mother. Operating from ones 'head' rather than 'heart' worked to mitigate the emotional intensity of providing maternity care under such difficult conditions. 'Being in the Headspace' is the focus of Chapter Four; the first findings chapter.

'Being in the Heart space' is the second overarching theme and the focus of Chapter Five. This theme again consisted of two main themes; *Seeing it though the woman's eyes: How the midwives perceived women feel*; and, *Sharing the emotional roller coaster: How the midwives feel*. The midwives observed the impact on the women as they tried to come to terms with the news that their baby was to be removed from their care. The midwives were extremely accepting of the women's and their families' responses and reactions. An acknowledgement of the grief expressed by the women was reflected in the midwives knowing the removal of a baby from a mother was not something they wanted to experience either. The 'heart space' describes the emotional roller-coaster the midwives experienced including how it feels for the midwife during and after being involved in the removal of a baby.

Chapter Five concludes with an overarching final theme of 'Helping make a difference to the head and heart space'. Here the analysis brings together the ideas and suggestions midwives felt helped them negotiate the processes and the impact of their involvement in an

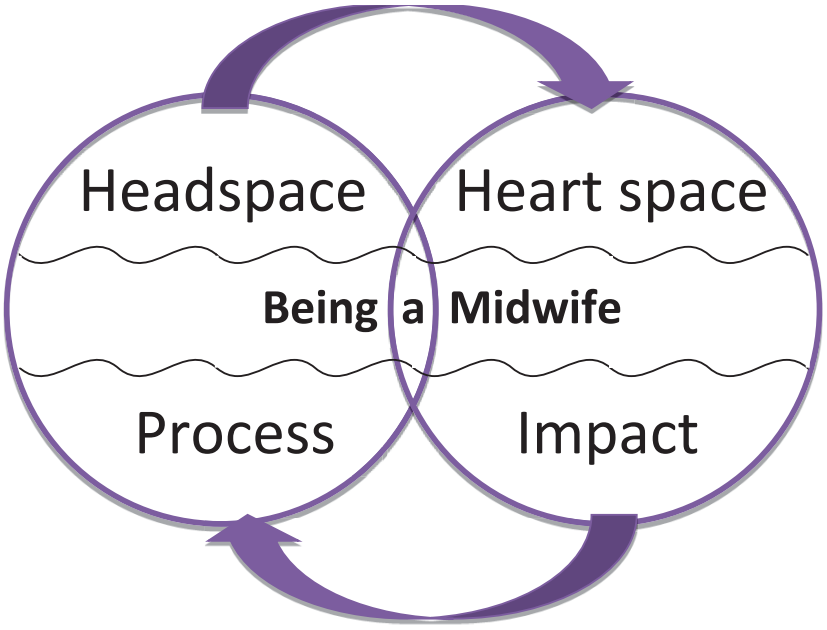
[3] Community Services will be used a generic term throughout the finding chapters for the NSW Department of Family and Community Services (FACS). The name has changed of the service throughout the research and the midwives used various abbreviations to discuss the services.

assumption of care. This section discusses models of care and the benefits or otherwise of the education they received.

The midwives who shared their stories had a range of experiences and roles in relation to preventing and being involved in the actual assumption of care of newborns. Some of the midwives had only a 'one off' experience to draw upon either antenatally or postnatally while for others their participation extended with the same woman across the childbirth continuum. For some of the midwives, their roles involved managing the assumption of care process as well as supporting other midwives during an assumption of care. There were also midwives who had roles that involved multiple episodes of involvement with vulnerable women and newborns at risk of significant harm.

The midwives' data has been interwoven in description of the themes and at times the level of expertise is identified to clarify their perspective. While the themes of 'being in the headspace' and 'being in the heart space' have been divided for ease of writing and presentation in reality they are not liner or separate from the other. The following diagram, Figure 1 aims to illustrate how the midwife continually moves between operating from her heart to operating from her head in order to manage the complex and emotional charged situation of working with a woman whose baby is at risk of, or will be removed.

Figure 1 - Diagrammatic representation of findings



The diagram in Figure 1 presents a diagrammatic representation of the findings of the study The 'headspace' is the midwives having the theoretical knowledge of the process, skill and ability to be involved in the procedures involved in an assumption of care. The 'heart space' is the impact on the midwives of the process. The process and the impact are described separately however, each both continually affect the other. 'Knowing' and 'doing' does not stop the feelings that the midwives have for the women and about their own role and involvement in an assumption of care. The wavy line represents how 'being a midwife' helps make a difference, characterised by how there is continual uneven flow of events for the midwife, negating the process and the emotional impact.

Being in the Headspace

The midwives described what they called 'Being in the Headspace' of an assumption of care. The headspace was defined as having the intellectual knowledge of the processes of how to care for the woman during the assumption of care and knowing the importance of child protection procedures. This included knowing what was required to work with women during pregnancy to try to prevent an assumption of care. Focus on the processes was often counter to the heart space which is where the emotions of the process dominated (the focus of

Chapter Five). Understanding and coming to terms with the fact that the newborn infant needed protection meant the midwives could rationalise the decision to remove the baby from their mother. The following quote from one midwife reflects the sentiments of all the midwives in the study:

> Most of the time, I can resolve it in my head and can make sense of it. It doesn't mean that you don't feel for the mother, but you know that the baby is probably better off not in that environment (Midwife 8).

This first overarching theme of 'Being in the Headspace' consists of two main themes each with a number of subthemes. An outsider in the relationship: 'Working with Community Services' is the first main theme. In situations where unborn babies were deemed at significant risk of harm, learning to work effectively with Community Services was considered an important part of the midwives' role to ensure the best outcome was achieved for both the woman and her baby. Six sub themes contribute to the key component of this theme described below.

The second main theme, the actual assumption of care processes, describes the practice of the actual removal of a baby. In this theme, the six subthemes describe the flow of events within the hospitals when a newborn was actually removed from their mother at birth or in the early postnatal period.

The more experience that a midwife had with the procedural implications of an assumption of care event, which included working with Community Services, the better prepared she felt to assist women and ultimately maintain child safety. The following extract from Midwife 5 perhaps best sums up what the concept of being in the headspace is:

> The head space is just about knowing, that you've done everything that you can. That the woman's challenges or issues have been identified early, that you've put stuff into place, that you've got a team together to try and support them, and that it's not just an automatic…'you're losing the baby'. So that's the headspace, that you've done everything that you can while protecting the baby's safety, and sometimes that becomes the dilemma, you have to choose, and ... you can't be prepared for that except to be educated that the child safety is paramount.

An outsider in the relationship: Working with Community Services

An outsider in the relationship: Working with Community Services is the first main theme under the overarching theme 'being in the head space'. Here the analysis shows how midwives worked hard to positively engage Community Services in an effort to achieve the best possible outcomes for the woman and her baby. Midwives described the processes and procedures of working with Community Services related to a potential removal of a baby. Community Services were seen as an outsider to the 'with woman' philosophy as both the midwives and the women often found their involvement in the relationship foreign. Six sub themes were identified. These were labelled;

- Reporting: Taking the first step
- Jumping through hoops
- Pushing for streamlined communication
- Developing management plans
- Crunch time: the decision making process around assumption of care
- The challenge of non-disclosure: being forced to keep secrets.

Reporting: Taking the first step

Midwives who worked with vulnerable women in the antenatal period used a number of strategies to either, assist them have the best possible chance of keeping their baby or, alternatively prepare the woman for the removal of her baby. The midwives were able to describe the various circumstances that would lead Community Services to assume care of a newborn. While the stories and reasons varied, Midwife 9 summed up the common reasons where they anticipated the baby would be removed and would lead them to make a report to Community Services:

> But mostly, if we know beforehand, like if there's a major drug and alcohol issue. If we suspect, because the woman's situation hasn't changed, either her mental illness is not been managed well, she is still homeless, she's still using drugs and alcohol or hasn't left a violent relationship where we just know that Community Services will be removing the baby.

First and foremost was the need for midwives to be 'up front' with the woman about their role as mandatory reporters[4] and their concerns around the woman's ability to adequately keep and care for their baby. Those with experience in this area considered it vital that they were not perceived by a woman as 'going behind her back'. These were not easy conversations to have but were considered vital if the midwife was to have continued engagement with the woman and some capacity to assist the woman work through her issues. For example:

> Yes, I tell the women when I see them, 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 you 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).

Midwives talked about having to 'walk a fine line' or 'do a dance' when making the decisions to report. While on the whole involving the woman was considered the best approach, there were examples when midwives perceived that it was best that they did not let women know that there had been a report made. For example, one midwife said:

> Sometimes you know there is a report gone in, you might have done it yourself. If I made a report the majority of the time I will tell them. There is the occasion that I don't because I am really concerned that they (the women) will disengage (Midwife 8).

Within these difficult conversations, midwives said they had to be able to articulate exactly what their concerns were to the woman. Talking openly and honestly with a woman about her situation and capacity to mother her baby was considered an important strategy. Similarly, midwives described being open and honest with the women that there was always a chance the woman may not take her baby home. Ignoring issues was not an option and considered to be a potential barrier to establishing a healthy three-way working relationship between woman, midwife and whoever was representing Community Services, for example:

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[4] 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.

> 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).

Once the reporting requirements had taken place midwives put every effort into helping prevent an assumption of care outcome.

Jumping through hoops

Establishing and maintaining a positive relationship with the women was considered one of the best ways to assist them to stay engaged in the system and ensure they had the resources they needed to turn their situation around. Generally midwives considered this was important and the right thing to do as it gave women 'some hope'. One midwife said:

> You're trying to engage and trying 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).

The midwives next strategy was to urge women to 'jump through the hoops' that Community Services requested. Encouraging the woman to positively engage with Community Services was seen as another strategy that would indicate the woman's commitment to keeping her baby and preparing a safe and caring environment for her baby. One midwife explained this in the following way:

> 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 to engage with them is really vital and sometimes we have had really lovely outcomes where at the beginning of the pregnancy you thought there was no way will they keep the baby, and women have actually come through in the end. They did everything that Community Services have asked them and been a really good outcome (Midwife 9).

A midwife's close involvement with an identified vulnerable woman and baby at risk of significant harm, also meant she could advocate on the woman's behalf. Documenting and sharing with Community Services the woman's commitment and willingness to prepare for parenting was one way to help. As one midwife stated:

> I am always honest and say that there is a possibility that you won't be taking the baby home, but we need to prepare in case you are. So you need to be bringing your urines in[5] and come to all your appointments and come to all your assessments because then I can tell Community Services how well you are doing (Midwife 9).

In some cases, midwives cared for women in the antenatal period where the decision to remove the baby was made very early in the pregnancy by Community Services. In these circumstances, midwives worked to keep the women engaged in the system and hoped to help them prepare for this event. As one midwife explained:

> So some of the clients we get are planned assumption of care antenatally, so they're the easier ones to do. Community Services normally have a relationship with that family already because there's been a previous assumption of care, so in that case the mother will be well prepared antenatally (Midwife 6).

The woman's effort to change and engagement in services was communicated to Community Services by the midwives in a hope to positively influence the decisions around removal of a newborn.

Pushing for streamlined communication

Women identified as at risk of having their baby removed, often had a multidisciplinary team caring for them in the hospital with various forms of communication networks. In some cases, several Community Services case workers may have also been involved. Midwives expressed how important it was to establish clear and effective communication channels between the woman, the midwife and Community Services and this was an essential aspect of working together in an attempt to achieve the best outcome for the mother and baby. Establishing and holding planning meetings which included sharing information around the decision to remove a baby, ensuring effective liaison between agencies and nominating a 'primary contact person' were all considered important strategies to be enacted during the care episode. One midwife described how important it was to have 'one person steering the ship'. This midwife went on to say:

[5] Women were required to bring urine samples for drug screens. Either the drug and alcohol workers usually caring for women on Methadone or Community Services request to perform urine drug screening.

> In terms with liaising with other people you need one person which I was able to be, I guess it's a social worker role in some instances to have all the people together and inform every one of changes (Midwife 2).

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 comments: 'Hours and hours and hours of meetings and planning and liaising and one patient can probably take your whole day' (Midwife 8).

In some cases, it was Community Services who identified the baby at risk of harm during the pregnancy to the midwife or health service. For example, some of the midwives described how their services often instigated regular meetings to discuss upcoming cases of pregnant women in the area. This was a two way process and helped the hospital staff know what the expectations of Community Services were and prepare for possible assumptions of care. This midwife explained:

> 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).

Despite the work that went into ensuring effective communication with Community Services, there were examples that suggested this did not always occur. For instance, there were a couple of instances where midwives described trying desperately to get Community Services involved in a woman's care before the birth but 'to no avail'. Having no Community Service case worker involved before the birth meant that it was possible for an assumption of care to take place, without what the midwives perceived to be a detailed proper assessment, before the woman was discharged home from hospital. 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).

These conversations often lead midwives to postulate what was actually happening within Community Services and question how well resourced they were to actually be able to assist vulnerable women in the antenatal period. One midwife expressed a strong belief that unless Community Services already knew the family they would not engage and assess women during

the antenatal period: 'I think it doesn't' have to be like that but that's really hard they are under resourced and they won't come antenatally unless they already know the family' (Midwife 5).

Another commented:

> I think a big part of it is lack of resourcing. Community Services is really under-resourced and I think it is a political issue. I think we all need to get political about it if we're serious about keeping mothers and babies together (Midwife 4).

In addition, there were times when midwives said Community Services did not make a decision about removing a baby until after the birth. For those working closely with women in the antenatal period this could be annoying and distressing. The comment from the following midwife is reflective of others working with woman and Community Services during antenatal period is 'one of the most frustrating points about an assumption of care is that often Community Services don't make a decision until the baby is born' (Midwife 8). Another said, 'often their decision isn't made until the baby is born and they assess the situation again, which is pretty black and white I think, before the baby is born' (Midwife 6).

The midwives felt proper planning and preparation with the families they were concerned about could have occurred better if Community Services were involved with the woman and her family prior to the birth.

Developing management plans

Midwives who were involved with vulnerable pregnant women antenatally, were responsible for writing management plans. The aim of developing a documented management plan in a woman's health record was to ensure that all staff involved in the woman's care would know the process and procedure to be followed when Community Services attended to assume care of the baby. 'Being all on the same page' (Midwife 5) was particularly important given the reality that an assumption of care may occur at any time and not necessarily during 'office hours' when those regularly involved with the woman's care were more likely to be available. For example, as one midwife described:

> It was all in place, the staff knew what the process was to follow, the after-hours hospital managers knew what was to happen, the postnatal ward knew. So everybody was pretty much filled in, briefed on what was to happen (Midwife 6).

The management plans provided a brief overview of the woman's circumstances and defined the roles of those potentially involved at the actual assumption of care. This midwife discussed if a 'birth alert'[6] had been issued by Community Services that this was also routinely documented. Commonly, this alert warned the hospital of the woman and her partner's risk factors and required notification of the birth to their service. This midwife explained:

> If there's a birth alert on a woman that means they (Community Services) probably are going to assume care at birth ... so we would have a birth plan and if there is a problem with the partner, for instance, then security will be called (Midwife 10).

The management plan also helped staff think about and identify 'others' who may be impacted by an assumption of care, for example, other women in the ward or the partners. This midwife summed up a management plan:

> So the written plan would clearly outline what was possibly going to happen, or what was likely going to happen, and what the midwives' roles and responsibilities were around that. And we had fairly good mechanisms for that process to take place in terms of where it happened, when it happened and how we tried to protect the other mothers and babies in the unit from being exposed to it happening to them (Midwife 7).

The management plans were placed in the woman's' medical health records as a guide for all staff to use whenever an assumption of care may occur.

Crunch time: The decision making process

One of the midwives in the study, whose role was to work with vulnerable families, described the experience of working with a family to prevent the outcome of a removal of a newborn as rewarding. This was a rare comment in the data set. This midwife talked about her experiences in the following way; 'It's been a really good outcome. That's been incredibly rewarding, but I guess they are few and far between' (Midwife 9). 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).

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[6] A birth alert is sent to birthing units in NSW to flag the mothers of unborn babies identified as being at risk by Community Services. The birth alert will detail risk factors, expected date of birth and the potential hospital of birth.

However, others gave examples that demonstrated that despite doing everything Community Services requested of them, some women 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®[7] (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).

Another midwife expressed her experience in the following way:

> We feel like we have betrayed them (the women) thinking that we were doing the right thing. It turned completely pear shaped (Midwife 1).

Midwives' frustration with the process was especially evident if the woman had other children previously removed. The midwives often felt these women were not given the opportunity to prove that 'people can change'. At times, Community Services were viewed to have made the decision to remove the next baby early in the pregnancy without taking into consideration the support services involved in the pregnancy and the woman's effort to make significant efforts to demonstrate change in her circumstances and her current ability to parent. Midwives expressed feeling somewhat aggrieved that their expert opinion was not taken into account and no one seemed to be interested in hearing how hard the woman had worked to change her circumstances. This is evident in the following extract from Midwife 8:

> They took that baby away from that girl and her partner, but she had never been allowed to parent. And she has another baby, and guess what (they took the baby away)? They (Community Services) are not listening. Why are they not hearing what we are saying? Because I think sometimes we are better placed to make the decision or to help make the decision.

Midwives said they were often 'confused' as to how decisions around assumption of care actually occurred. As a result of their past experiences they thought they could anticipate the

[7] The Triple P-Positive Parenting Program® is a multi-level, parenting and family support strategy. Triple P aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

decision Community Services would make about the removal of a baby. However, midwives were often 'left wondering' why a similar circumstance resulted in a different decision. The following quote reflects this:

> I think social work and I have had this conversation many a time. If they can just be a bit more balanced, you could live with it. But it's like you flip a coin. This one will go, this one mightn't (Midwife 8).

This midwife went on to reflect:

> I wonder whether we're as inconsistent in looking at things as they are? When you're working in something you don't always see it, do you? I wonder if they know that we perceive them as being incredibly inconsistent (Midwife 8).

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 they talked about being 'relieved' that a decision had been made. As one experienced midwife said: Working with a family where the mother or the father has serious mental illness and where there is just no way that they can ever take care of a baby (Midwife 9). For some midwives, like the one in the previous quote, decisions of this nature, where there was real clarity around the situation, they felt were easier to 'live with'. This midwife went on to say:

> 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' (Midwife 4). The following quote perhaps best sums up the midwives' internal dilemma:

> In my head I know that it's for the best reason for the child, for the safety of the child but there is still a woman who has had a baby removed, a woman with dreams (Midwife 4).

As previously eluded to, sharing their thoughts on decision making also led some midwives to make specific comments about resourcing and functioning of Community Services, which included their thoughts and reflections on child protection case workers. The midwives acknowledged that being involved in decision making and removal of babies from their mothers also must be challenging for these workers. Like themselves, midwives were well aware of how 'hard' the role of child protection workers must be: 'I think they must have a terrible job' (Midwife 4). As another midwife reflected:

> And I think they are drowning in paperwork, process and rules and regulations. I know that. And I do think you are asking from the Community Services' workers perspective, you're asking them to be lawyers, and that's not what they are trained to do (Midwife 8).

Midwives with multiple experiences of assumption of care reflected on how many of the case workers seemed 'so young' to be making potentially life changing decisions. They wondered how the reality of 'age' and 'experience' played out in their decision making process. Similarly, they noted that there seemed to be a large turnover of staff in Community Services. These ponderings were articulated by one midwife in the following way:

> I think you need to be very wise sometimes to know what the right thing to do is. And I say that at my age (middle aged), so how does a 24 year old or 26 year old, make such a wise decision? And no wonder their attrition rate is high (Midwife 8).

Finally, reflections on Community Services' decision making around assumption of care led some midwives to also mull over issues related of 'power'. Those with extensive experience felt that at times there was a 'them and us' mentality. These types of reflections were, in most instances, the result of situations where decisions seemed inconsistent with how hard the woman and midwife had worked to prevent the removal of the baby. Midwives talked about how Community Services had the 'final say' and 'the authority' to use the information they received in whatever way the deemed fit. These midwives 'felt' for the woman as they believed she was seen as the 'least powerful' in the three way relationship and thus the decision making process. Midwives said the voice of the woman was rarely heard, except through the 'reports' submitted by midwives and other services engaged in the woman's care. This midwife sums it up in the following quote:

> And Community Services are the ones with the statutory powers, so in the power equation, 'they're here' (pointing up high). We're probably 'somewhere here' (pointing down lower) and the poor mother is 'down here' (pointing to the ground), just drowning quietly. Really, cause she is at the mercy of a whole lot of services (Midwife 8).

Involvement in the decision making process was difficult for the midwives as they often felt in the middle trying to support the woman, protect the baby and work appropriately with Community Services.

The challenge of non-disclosure: Being forced to keep secrets

One of the most challenging scenarios for midwives was when they were forced to remain 'silent' in the face of caring for a woman when Community Services had decided to remove a baby. In the main, this situation occurred when the baby was considered to be in real danger and the woman or couple were deemed to be a 'flight risk', meaning there was a genuine concern that the baby would be taken from the hospital before Community Services could attend. Often the safety of staff was also a consideration. As one midwife explained:

> In some cases, we would have been advised by Community Services because of safety issues for the child and the staff, either from the woman or her partner or family, not to inform them, and so we're very careful to keep the notes separate and not let them see the notification (Midwife 5).

Another more experienced midwife shared how she also contributed to the decisions around this situation saying:

> I try to balance what is the safest thing to do. If I think the mother will stay with us and stay the course regardless of the outcome, I'll tell her, or the social worker will tell her, depends who's got the best relationship with her. If I think she's a flight risk, I reconsider and I have been asked by Community Services on a couple of occasions not to disclose (Midwife 8).

The gravity of the situation was not lost on midwives. They could appreciate how not disclosing the assumption of care was the safest thing for the baby, and to some degree for the woman and the 'only thing to do'. Loss of engagement within the service was considered a

huge risk particularly when there was some sense the woman might birth unassisted. An experienced midwife stated that in her experience:

> We never ever tell them (about an assumption of care), even if we do know. No, because I guess there's always that risk that they might not come to the hospital to have the baby, and that's a big fear I think (Midwife 9).

Having to follow a principle of 'non-disclosure' however sometimes resulted in the midwives themselves being put at risk and/or being placed in a situation where after the removal occurred they had to face a distressed woman. While midwives understood the justification and could 'rationalise' the decisions, they still expressed suffering some sense of feeling guilty that they had worked with the woman while 'deceiving them'. Midwives often commented that the women had the 'right' to accuse them of a wrong-doing. The following quote from one midwife is reminiscent of others made by her fellow colleagues:

> Those cases where you haven't been able to disclose to the women it's sort of a little bit worse because you feel like the betrayer as well (Midwife 5).

The midwives worked hard to ensure appropriate communication between everyone involved. Communication between services and individuals prior to removal of a baby was a vital part of ensuring everyone has the important information to make appropriate decisions related to the woman and her baby for the safest possible outcome. Effective working relationships with Community Services were a priority for the women and the midwives.

The actual assumption of care

The second main theme, labelled 'The actual assumption of care' describes the process of the removal of a baby. This theme defines the flow of events described by the midwives within the hospitals, once a decision was made for an assumption of care to occur and when Community Services actually came to remove a baby from their mother at birth or the early postnatal period. The procedural requirements formed an important part of how the midwives navigated the experience. As described earlier for some of the midwives in this study, their involvement of actual assumption of care was a one off experience, while for others it was an ongoing and significant part of their daily midwifery role.

When discussing actual assumption of care the midwives explained how systems and roles were developed so that midwives and other professionals in the maternity unit knew what to do. Six main sub themes were identified. These were labelled:

- Knowing the time frame when an assumption of care occurs
- Creating a safe place for the removal
- 'Serving the papers'
- Actually removing the baby from the mother
- Involving security staff and police
- Mother and baby as individuals: A dyad no longer.

Knowing the time frame when an assumption of care occurs

Ideally and when possible, immediately prior to the assumption of care, a meeting would be arranged for the relevant hospital staff and Community Services workers involved to meet and discuss their expectations and responsibilities. As this quote outlines:

> We (the hospital) normally have a case conference before they (Community Services) actually see the parents, so that will involve the midwifery manager of the area where it's going to take place, social worker, the Community Services officers and we also involve security. So we have a multi-disciplinary meeting about how it's going to work; who is actually going to remove the baby from the area and bring it to the nursery, and since we've been doing that it goes a lot smoother (Midwife 6).

Knowing the time frames helped the midwives prepare the women for the actual 'serving of the papers'[8] and removal of the baby. Some midwives stated they 'knew that they (Community Services) are coming' and were actually given 'a few hours' notice' of arrival to the hospital for an assumption of care. However this did not always happen.

Most of the midwives described circumstances where Community Services arrived at the hospital with little warning. One example was:

> The baby was born at around lunchtime and I got a call on my mobile (from Community Services) about an hour after the birth saying 'we're coming, we are on

[8] An Assumption of Care Order may be issued where Community Services suspects, on reasonable grounds, that the child or young person is at risk of serious harm and is satisfied that it is not in the best interests of the child or young person to be removed from the Health premises by their parent(s)/carer(s).

> our way, in ten minutes we'll be there with two workers and security guard and we are going to assume care immediately' (Midwife 2).

This was often frustrating and distressing to the midwives. The less experienced midwives were often shocked about how immediately the removal of the baby occurred. The rapid nature of the event is clearly evident in the following quote from one midwife, 'in the birthing unit where a baby was plucked from its mother's arms, in the birthing unit like it wasn't even dry yet' (Midwife 5).

Even if management plans were in place, assumption of care episodes that occurred 'out of hours', even when known, for example, late on a Friday afternoon created difficulty and were considered to be 'unhelpful'. The midwives stated that Friday afternoons, when the hospital was winding down for the weekend seemed to be a common time for Community Services to remove a baby. They said:

> It hasn't always been handled very well on other occasions, they (Community Services) come on Friday afternoon at 5 o'clock and that's historically they do that we don't know why and that's very difficult for the staff involved (Midwife 10).

This timing was described as the worst time for the removal to occur as the majority of the midwives and other allied professionals who knew the woman and could offer support from a known carer had gone home.

Creating a safe place for the removal

Creating a safe place for the removal of the baby was described by the midwives as a priority. The midwives described how the place of removal was based on the woman's and/or partner's history, their 'flight risk' (fleeing the hospital with the baby) and their level of engagement during the antenatal period. Commonly midwives stated the removal happened in the birthing unit, postnatal ward or the nursery. As one experienced midwife stated; 'If there is a flight risk, the assumption of care will be done in the birthing unit' (Midwife 6). Another said, 'The women whose babies were assumed in the birthing unit, were generally those women who hadn't engaged in any antenatal care' (Midwife 7).

Alternatively, if the woman was known to the midwives and had been attending antenatal care throughout her pregnancy, the midwives felt more confident these women would not leave prior to Community Services arriving to serve papers. These women were often transferred to

the postnatal ward. For example, one midwife who provided continuity of care to a woman stated, 'Where we'd (the midwives) had continuity through their pregnancy, those babies were invariably assumed in the postnatal ward' (Midwife 7).

One midwife stated that in the unit where she worked, they had made a decision to routinely admit the baby to the neonatal nursery. This was believed to be the safest place for all concerned. She said:

> Where we just know that Community Services will be removing the baby, in those cases, after the birth, we just automatically take the baby to the nursery. Like let the baby stay with the parents for a few hours, but then put the baby in the nursery because we've just found over the years, it's just a lot less stressful for the family if the baby is removed from the nursery, than for them to come into the room and take the baby out of the mother's arms and walk out the door with it (Midwife 9).

Likewise another midwife talked about their changing processes:

> We're trying to contain it now to a more controlled environment because we're having people with violence and things happening in public places. Like on the ward with other mothers around, and other babies at risk, so we try and do them (assumption of care) all in the nursery now if we can (Midwife 6).

In some hospitals, the place of assumption of care was carefully planned for safety of everyone. The women would be taken to a quiet private room, if possible away from the other women in the ward. One midwife described:

> I cleared all the staff, we deliberately placed her in a room away from some of the others ... We were trying to contain it from the other mothers and babies (Midwife 5).

Ensuring the assumption of care would take place in a safe and private environment was seen as important for the woman, the baby, the other women in the ward and the midwives.

'Serving the papers'

When describing the process of removing a newborn from their mother, midwives talked about the 'serving of the papers'. The 'serving of the papers' is the legal aspect of the assumption of care. Midwives stated how the attending Community Services workers were required to explain why the baby needed to be removed from their mother's care. Part of the

processes also included notifying the mother of the legal process to follow. The following extract from an interview explains the requirements of this process well:

> The Community Service workers come. They serve the papers and explain that the baby needs to go into care. They usually explain the reason, whether we agree or not, but they usually have a fairly clear case from their perspective as to why the baby needs to go into care. They explain the situation, explain that it will go to court in a couple of days and that they (the family) will need to be there and that they will also need to seek legal aid if they wish and then more often than not the social worker may hand the baby to the Community Services worker (Midwife 8).

In some circumstances, the process part of serving the papers was well planned to ensure safety and privacy for everyone. For example:

> Community Services are met in the (hospital) foyer by the social worker or myself and brought up to the nursery or where the assumption of care will take place, and we tend to find a room that's safe for all. So that, we're near the door and can quickly get out and the family is on the other side of the room with no flying objects available (Midwife 6).

However, for those with limited experience of an assumption of care episode being present for 'the serving of the papers' created uncertainty and could be confronting and overwhelming especially when police and added security were involved. One midwife reported her experience in the following way; 'There was this huge security guard and two other people come in, they were nice, but they (Community Service workers) read it out like it was a police sort of thing, a crime actually' (Midwife 2). Another described how she observed the Community Service workers to say they, 'Just said they were serving her with papers, and they would explain to her what the papers meant and that we would take the baby' (Midwife 3).

For the more experienced midwives, their understanding of the legal implications of serving papers allowed them to follow up with the women to explain what this process meant and encourage 'the importance to get legal aid'. One midwife said:

> I've seen them (the woman) afterwards, 'I've said, so have you got the documents? Look at the documents, they will tell you the reason, they will also tell you when you have a court case, so it's when? In a week?' So knowing all that stuff, knowing the

> process makes a big difference and that only happens with going through it (Midwife 10).

During the interviews it became evident that some of the midwives who held management roles had been active in trying to improve the process for all involved. Concerns around safety, timing and the place of the removal were particularly mentioned as areas that required addressing. One example given was the development of guidelines in consultation with the social worker to ensure the processes were very clear. The guidelines were to ensure the appropriate members of staff in the hospital were aware an assumption of care would occur and could be present if required, for example:

> There were clear guidelines that Community Services needed to by fax, send the paperwork to the Clinical Director of the service. So it needed to happen generally in business hours and generally it did, so the Clinical Director was aware and we could see the process in place. Which would mean that mum was interviewed by the Community Services but not in the maternity ward, but generally in an adjacent area and with other members of this team (Midwife 7).

Some hospitals followed this up with an offer of education to the Community Service workers, to improve the systems and process around coming to the hospital to serve papers and assume care of a baby. As one midwife described:

> I think it is because we've actually been to the two Community Service offices, in the two areas that we deal with and given our points of view on how the assumption of care works. They had no understanding of it from the hospital's perspective, so by going there and giving them an 'in-service' as such, they understand after they serve the papers and they walk away, the shrapnel that we have to deal with (Midwife 6).

The serving of the papers immediately precedes the actual removal of the baby.

Actually removing the baby from the mother

The expectation of and experiences of the midwives varied about the process of actually removing the baby from their mothers. Having to physically remove a baby from a mother's arms was not what most midwives expected to have to undertake. For most, having to 'prise' (Midwife 5) a baby from his or her mother's arms was hugely challenging. As one midwife said:

> The baby was in the crib and I was the one who actually had to roll the cot away from the mother and take her baby. I remember saying to her. 'Do you want to give the baby a cuddle or a kiss, or whatever' and she didn't and she was crying by that stage and I was trying very hard not to cry (Midwife 3).

Some midwives deferred the role of removal of the baby to the social workers if they were available at the actual time. Midwives felt that as the social worker was engaged with the woman and her family throughout the pregnancy and their service was often available out of normal hours then they should be the ones to take the baby. Some midwives perceived that the women often 'expected' the social worker to be more involved in the assumption of care than the midwife,' more often than not the social worker may hand the baby to the Community Services worker' (Midwife 8). One midwife explained that she preferred the social worker to assume this role as it prevented role conflict, saying:

> I tended to perhaps let social work take that, because there is quite a bit of role conflict. It goes on as a midwife caring for a woman knowing what's going to happen, so it was important that, it was very clear that the leader or the leadership in the assumption process was a social worker and not a midwife (Midwife 7).

Regardless of their opinion on 'who' should actually take the baby from the mother most midwives felt they had a role to play on supporting the woman through the experience. Those midwives offering continuity of care and who had established a relationship with women described wanting to be present as part of their ongoing care and commitment to the woman. For example one said, ' So I'd been engaged with these families since the word 'go' so I felt that I should be the one present'. (Midwife 5). Another stated, 'so I might be involved in the care of the woman through the pregnancy. I may know the assumption of care is coming, or I may not ... If I'm here and I am available I will be there' (Midwife 8).

Even those not providing continuity of care stated it was important to be there, 'in the room' to 'just nurture' the woman. Those with experience felt it was important to 'be yourself' with the woman and 'If you need to have a cry because she is crying, don't bottle it up, just be yourself (Midwife 9). Another stated:

> So if you can get to her beforehand I always ask 'is it ok, do you want me to be there?' and they usually say yes, because no one wants to be on their own and then you ask

> questions that you think would be helpful for her because they're in a very emotional state (Midwife 10).

The involvement with the actual removal of the baby from the mother was emotionally challenging experience for the midwives whether they knew the woman beforehand or not.

Involving security staff and police

Despite finding it somewhat difficult and increasing everyone's sense of 'trauma' around the assumption of care episode, the role of security staff and the police was sometimes acknowledged as sometimes necessary, for example:

> Some people require police to be involved, because it's not just the mother that we have to consider, it's the partner. It's often the partner who becomes a violent person. So, our assumption of care guidelines state that if a partner is known to carry weapons, known to have been in gaol for assault, we have police presence for our own safety (Midwife 6).

In most instances, the midwives described how security staff and/or police were just 'discreetly placed' outside the room, in case they were required. The midwives felt that the presence of security staff and police was warranted when there was a real threat of violence from the partner or family. Midwives gave examples of partners 'arguing', being 'very aggressive' and 'violent'. This midwife described:

> If it looks like it is going to be really difficult, security will be notified as well. And we have had the police here as well. We did have one family who, in the antenatal period, threatened violence and guns and all sorts of things, so that baby was removed from (operating) theatre under a caesarean section and the baby went a secret way. There was security and police here that day (Midwife 8).

The security staff and police were also used to support the midwives when threats had been made toward them as a result of their involvement with Community Services, mandatory reporting or removal of a baby. It was recognised that additional security support was sometimes required, for example:

> I actually was here until 7pm because I was a bit concerned about how I was getting to my car, and then the police turned up and said that I was going to my car and they

> actually drove me to my car. And coming back to work the next morning it was like, now I've got to walk in, like I was very nervous (Midwife 6).

The presence of security staff and police were recognised as a necessary part of the assumption of care process. The midwives worked hard to ensure their involvement was at an appropriate level for the safety of everyone, but sometimes this decision was taken out of their hands. During the interviews, midwives also gave examples of situations where they felt the presence of security staff and/or police was not warranted. The midwives described how their presence on the ward created additional shame for the woman and distress for the staff. As one midwife said:

> And the fact that there are security guards there when it happens is really stigmatising too (Midwife 4).

Another midwife was quite scathing when describing witnessing police presence on the ward at an assumption of care.

> These big, burly cops and security guards, what are they expecting for God's sake? Absolutely hideous!! This is a maternity unit, and you've got big burly cops (Midwife 7).

The involvement and impact of security staff and police had on the other staff and woman in the ward, was one more factor the midwives were required to negotiate during an assumption of care.

Mother and baby as individuals: A dyad no longer

Once a baby was removed from the woman's care the focus of care was on each as an individual, rather than as a connected dyad. In most instances, the midwives described how the baby was removed to the hospital's nursery. Postnatal wards were considered to be busy and thus difficult environments to monitor. Midwives explained how Community Services determined whether the mother could have access to the baby whilst in hospital. They also stated that decisions around access were often dependant on the reason for removal and security risks. As one midwife described, 'They (the parents) could come in any time, they weren't a threat, it wasn't an issue for security for that baby, for them to come in, and they did, they spent all day for the next three weeks, until he was discharged into foster care' (Midwife 5).

Some women and/or their partners were considered to be a 'flight risk' with the baby which meant they were not allowed access to the baby on hospital premises. Midwives explained how these couples had to wait until the baby was discharged to commence supervised access visits organised by Community Services. While the baby was in the hospital, the nursery was often seen as a secure environment for the baby and the staff until discharge. A midwife involved in such a case stated:

> Because of previous neglect and abuse, the baby was taken to our nursery and the parents were actually denied access to that baby. They had decided that the security risk was so high with that partner that the visits would resume when the baby was discharged to foster care and it would happen on Community Services premises (Midwife 5).

The time the baby spent in the nursery was dependant on the baby's medical condition and the availability of foster care or next of kin placement. In normal circumstances where a woman's baby is admitted to the nursery for medical reasons, the midwives role is to ensure and facilitate the development of a healthy mother-infant connection. In an assumption of care scenario their focus changed. Midwives described how looking after these women often reminded them of providing care to women whose baby had died. Similarly to these women the midwives stated that it was very common for these women to discharge themselves almost immediately. Midwives believed that this was likely to be related to their sense of emptiness and the fact that they no longer 'belonged' in a maternity ward because they didn't have their baby. One said:

> Yeah, once the assumption has happened, they usually want to go home straight away. Not unlike a mother that has lost a baby through trauma or whatever. And so they discharge very quickly (Midwife 8).

The immediate discharge of a woman after such a 'traumatic event' concerned the midwives. They worried that the women were going home in 'acute distress' with no appropriate follow up or community resources. As one midwife said, 'You send them out to the wild blue yonder in a state of acute distress' (Midwife 7). The midwives felt that many women missed out on basic care either because they discharge themselves or because they, the midwives, were often 'not allowed' to visit the women because of the heightened risk to themselves. In the following extract these themes are evident as a midwife talks about a specific experience she encountered.

> So they are missing out on midwifery care, basic care, and contraception care as well. We were a bit worried about her. It was her 8th baby. She left 4 hours postpartum. We made sure she understood the bleeding risks and infection risks (Midwife 2).

As alluded to in the above quote, the lack of contraceptive advice was regularly mentioned by the midwives as cause for concern. Midwives, with multiple experiences of assumption of care, feared that women would return pregnant again only to suffer the same fate of the removal of the next baby,' they just come straight back after removal (with another pregnancy)' (Midwife 9). Some midwives talked about becoming increasingly proactive in trying to provide information to the women and organise contraception for them.

> So, where possible, I will fly to the moon and back to get contraception on board for some of these families if I could. And you have to be really proactive and talk about it antenatally, you've got to book the appointment antenatally and then ring them postnatally. If they've had the baby assumed, that's trickier (Midwife 8).

Another challenging feature for some midwives was a woman's decision to breastfeed. Supporting, encouraging and facilitating breastfeeding is very much a part of a midwives' role. While some midwives perceived women were highly motivated to breastfeed because of the belief that it was best for the baby, others they felt chose to breastfeed in an attempt to keep the baby. As one midwife stated:

> Most of them want to breastfeed, which is good for baby. I sometimes have to toss up in my head why they are actually breastfeeding. Some of them I'm a 100% sure they think because they're breastfeeding they have to keep their baby and you can't take the baby off them (Midwife 6).

Another experienced midwife spoke about trying to promote breastfeeding for this group of women:

> We always encourage them to breastfeed, even if we know the baby is going to be removed and have had some women, who after the baby has been removed say, well that's it, I'm not breastfeeding any more. Other women who are really motivated will do that, and it's certainly a conversation that we do have with them (Midwife 9).

However, the encouragement the midwives gave was not always supported by Community Services. There were several examples given where midwives perceived Community Services

had actively discouraged breastfeeding once the baby was removed into foster care. One midwife gave the following example:

> I've had Community Services case workers ring me up and say 'can you stop that woman from breastfeeding?' and I've said 'no I can't. I have no legal right to do that' and I've outlined the benefits of breastfeeding to them. But that is a big issue (Midwife 4).

Another stated:

> I had one family who wanted to express and drop their milk to the Community Services office for that to be then given to the baby and Community Services said 'that was logistically not going to happen' (Midwife 6).

The midwives expressed that most of the time they were unable to provide postnatal midwifery care, support and follow up for the women who had their baby removed and left immediately. The best outcome for the midwives was to at least give the woman some basic advice on discharge about self-care and potential complications.

Finally, many of the midwives in the study stated that they often thought of the women they had been involved with and wondered what happened to them and their babies. This raised questions like, was the baby restored to the mother or did the mother keep any contact? The longing for closure is well articulated in the following quote:

> There is one thing I'd like to see happen, some feedback and closure for us. Because we just see the baby up and leave, go to a foster family. What happens to the poor child? (Midwife 6).

Such feedback was rarely provided from Community Services. Midwives felt that if they had some knowledge of the outcomes for these families it would generate a sense for closure for them.

Conclusion

Working with Community Services was an essential element for the midwives to negotiate and understand in order to help improve the outcomes for the women. This often began with the mandatory reporting process which commenced the involvement of Community Services in the midwife-woman relationship. Through knowing what Community Services expected of the

woman, the hospital and other referral services, the midwives were able to encourage the women to engage in the system to help prevent removal of their baby. Ensuring appropriate communication occurred with everyone involved with the woman was seen as a key element of the process. Management plans were developed as one means of communication for the midwives to assist in the knowledge and processes they and other staff may be required to be involved in when an assumption of care occurred. The midwives found the decision making process to remove a baby by Community Services from their mother challenging and often viewed the outcomes either with agreement or questioning the conclusion resulting in an assumption of care. It was always acknowledged that it was a complex process based on varied circumstances of which they hoped they could assist to inform Community Services to ensure the appropriate decision was made. The midwives were confronted in their practice when asked to not disclose a decision to remove a baby but recognised that the safety of the baby was paramount. The role of the Community Services workers was seen as difficult. The midwives sort to understand their position in order to safeguard the mother and the baby to try to guarantee the best possible outcome.

By knowing the process and roles of those involved in the actual assumption of care, the midwives felt they were better able to control the situation and support the woman. The actual assumption of care may involve many people including the woman, her family and support people, the midwives, social workers, security, police and Community Services workers. Knowing when the papers would be served and creating a safe place for this to occur could enable the midwife to be with the woman and to protect the other women in the ward from witnessing a traumatic scene. The safety of the baby who is removed from the mother becomes paramount and knowing the roles and the process appeared to ensure the assumption of care occurs in the most appropriate way.

The impact of being involved in the processes of an assumption of care is discussed in the next chapter discussing ‘Being in the Heart space’. This chapter concludes with one final overarching theme ‘Helping make a difference to the head and heart space’ providing some suggestions by the midwives to assist in the process and impact of an assumption of care.

Chapter Five - Findings Part 2

Being in the heart space

Introduction

In the first findings chapter I described how midwives worked in their 'head' to help them manage the tasks and activites involved in caring for a woman at risk of and/or having her newborn removed from her care. In this second findings chapter I move on to present the emotional journey midwives found themselves undertaking as a result of assumption of care. Working from the heart, or 'Being in the Heart space' captured the midwives' impressions of the intense grief women must be feeling in this situation as well as how they dealt with their own emotional challenges, all whilst trying to maintain a supportive nurturing position beside the woman. The two main themes; Seeing *it though the woman's eyes: how the midwives perceived women feel;* and, *Sharing the emotional roller coaster: How the midwives feel* and their subthemes describe how the midwives worked through their own emotions and dealt with their responses to the woman and other midwives and health professionals. The midwives considered assumption of care to be 'highly charged emotional work' which was difficult to prepare for or cope with until you were in the situation and knew how it felt to 'actually be there'. While for the purposes of this thesis I have separated the work involved in both being in the heart space and the headspace, in reality, they are overlapping concepts with midwives wavering between the two. One midwife summed it up like this:

> So it's dealing with the emotional responses to everything ... there is many layers, there's the theoretical stuff, explaining maternal behaviours and then there is dealing with their own (the midwives) emotional responses (Midwife 7).

The chapter concludes with a description of the third and final overarching theme, 'Helping make a difference to the head and the heart space'. Here I present the midwives' thoughts on how best to help negotiate the process and the impact of being involved with an assumption of care episode.

Seeing it though the woman's eyes: How the midwives perceived women feel

During the interviews the midwives continually referred to the physical and emotional impact they believed the assumption of care process had on the women. They described wide-ranging reactions that were dependent on numerous factors. The midwives observed the impact on the women as they tried to come to terms with the news that their baby was to be removed from their care. The midwives were extremely accepting of the women's and their families' responses and reactions. The midwives openly talked about how they tried to support and be with women before, during and after an assumption of care. There were three sub themes that contributed to this theme:

- Acknowledging fear of disclosure
- Recognising women's emotional turmoil
- Understanding maternal grief and loss.

Acknowledging fear of disclosure

Midwives recognised that some women entered the maternity system 'anxious', 'scared' and 'fearful' that their baby may be removed depending on the level of information disclosed. This was especially true when women had prior experience with Community Services. In other cases, it was a result of stories shared from other women that created the fear. If the woman had previously experienced removal of children, this was particularly evident. For example:

> The women talk about their fear of Community Services, occasionally women might say to you 'are they going to take my baby away?' seeking a cast-iron guarantee, and many times the behaviours would indicate that they knew what was going to happen (Midwife 7).

> I think all women come to us when they've had babies (removed) before, they come with a higher anxiety level and suspicious and I think that's well founded, but they still have that hope that they will bring this baby home (Midwife 4).

Midwives felt that some women chose not to disclose any information in the hope no one would find out any significant information and hence they would avoid Community Services involvement. Midwives also shared stories of women moving to a different hospital as a

strategy to avoid contact with Community Services. One midwife described this as 'flying under the radar'. She went on to add:

> And sometimes they come back to the same hospital and don't disclose and their old notes (medical records) don't disclose a lot of information. But sometimes you don't have the old notes with you when they book in either. They (the women) are good at sometimes not disclosing. You can understand with their histories why they don't (Midwife 8).

Midwives also articulated how 'non-disclosure' can affect extended family members such as grandparents. The woman may not have disclosed her circumstances to her parents and family. This created a difficulty because it is not their expectation to not have access to their grandchild. The grandparents may think they are a suitable alternative to care for the baby, however 'this may not be an acceptable situation for the baby by Community Services either'. One midwife described this situation:

> Where the mum is aware antenatally that this is a possibility (of assumption of care), she may not have discussed that with her extended family, she may not have told the grandparents, that this is going to happen, and we often get a lot of upset grandparents (Midwife 6).

This non-disclosure to family members often heightened the emotional turmoil expressed by the woman when an actual assumption of care occurred.

Recognising women's emotional turmoil

Woman often responded the way the midwives expected them to 'crying', 'distress', 'defeated', 'shock' and 'devastation' were commonly used to described women's reactions to the news that Community Services were removing their baby. More disturbing to the midwives were the vocal responses from the women at the actual time of removal. The vocal responses were often extreme. This was one of the reasons many units used a quiet private room away from other new mothers when the woman was informed of the removal. One midwife gave the example of a woman she said was 'literally clawing at the door and screaming blood curdling screams' (Midwife 7). The sound that these women made 'stuck' in the midwives' memories.

In tandem, midwives commonly described how many women also expressed 'fury', 'anger' and often 'aggression'. In these circumstances, midwives shared how the woman's and/or partner's rage could be directed at anyone that was around at the time of the removal including Community Services workers, the social workers, security staff or themselves. These strong reactions are described in the following quote:

> She tore out of the room with security chasing her and she was just like a wild animal. Hell hath no fury like somebody trying to take a mother's cub, all that anthropological stuff makes perfect sense (Midwife 7).

In some cases, the anger displayed by women to midwives grew into something more sinister. These aggressive and angry reactions could develop into a greater concern for the midwives when physical threats of harm to the midwives were made due to their involvement in the process of removal of the baby. There were several examples in the data set where midwives described how families had physically threatened them. For example:

> Families have made verbal threats against us, I've been told to watch my back when I walk out because my throat will be cut and so forth (Midwife 6).

Despite the overt anger, midwives recognised these were normal and justified responses. The midwife in the above quote went on to say:

> But if you took notice of everything they say to you I wouldn't come to work. And I think it is just the emotion, they're upset you're taking their baby away (Midwife 6).

Another said:

> You would get yelled at, or you would just get ignored, you could get sworn at. If it was getting really hostile we knew very quickly that it wasn't appropriate to be in the room so we'd just leave. It was about letting them know that we're here, that we're sorry (Midwife 7).

The midwives with experience knew that once the initial emotional responses had calmed down the women would begin to display sadness and grief at the loss of their baby.

Understanding maternal grief and loss

In some assumption of care scenarios, once the baby had been removed, the midwives described how grief would overcome the woman. One midwife defined this as a 'deep grief' at the loss of her baby. Similarly, midwives described how they perceived women to 'lose hope'. They stated how loss of hope became part of that grief process post removal of the baby, with the women giving up any thought of ever being able to have their baby returned to them or even attend access visits. One midwife from a recent experience provided this example: 'The mum has given up hope and doesn't feel it is even worth pursuing. She feels that she will never have her children back' (Midwife 1). Another said, 'Her initial reaction when they took the baby away was 'OK, that's it; I'm going to give up. I'm not going to go and see the babies at all anymore' (Midwife 9).

In some circumstances, midwives described how women grieved and gave up hope prior to birth, accepting that the removal of the baby would happen and there was nothing they could do to prevent this from happening. Often midwives perceived that these women were 'distancing' or 'detaching' themselves from the newborn, in order to cope with hurt and defeat of their baby being removed. For the midwives who had never previously been involved in assumption of care, this was an unexpected response. For example, one midwife shared her perceptions:

> She seemed more accepting, sort of matter-of-fact about it and a distancing of herself ... She had obviously already steeled herself. She must have known it was going to happen, so she'd already formed a detachment (Midwife 3).

Another strategy midwives felt women used to cope with their loss was to have a 'replacement baby'. Those midwives with extensive experience in this area stated that they had been witness, on many occasions, to women representing pregnant not long after being discharged home without their baby. These midwives talked about how the women would often believe 'next time would be different and that she would be able to keep her baby'. With no change in circumstances, the midwives knew the likelihood of the next baby being removed was high. In one extreme case the midwife said:

> We have women coming back who have had five (babies) removed before, still thinking they are going to keep this baby (Midwife 10).

The midwives sensed the women who had had their baby removed, felt like any women who had just given birth and acknowledge that despite circumstances the woman had still just been through a pregnancy and given birth to a baby. These quotes by the midwives show:

> She's just a human being that's had this happen, she feels the same as any other mother birthing except she is not going to keep her baby (Midwife 2).

> There is still a woman who has had a baby removed, a woman with dreams (Midwife 4).

One midwife tried to sum up women's reactions from her multiple experiences of assumption of care experiences as follows:

> I wouldn't say that it is like a uniform way that the women react, because each story is so different, so varied, incredibly varied. You could write a book about the stories that you hear and it's been such an eye opener (Midwife 9).

Experiencing the assumption of care process with the woman and recognising their turmoil and grief impacted on the midwives own emotions and responses.

Sharing the emotional roller coaster: How the midwives feel

The second main theme making up the 'Being in the Heart space' theme is sharing the emotional rollercoaster which discusses the impact on the midwives. This theme explains how the midwives felt and the emotional aspects of being involved in an assumption of care and their responsibilities around the process. Being involved in an assumption of care challenged the midwives' ability to maintain their woman centred approach and change to a more child focus due to decisions about the removal of the baby. The midwives would try to describe their own emotions and reactions to explain how a removal of a baby from their mother feels for them. They compared this to caring for a woman who experienced a stillbirth in an attempt to explain their emotional response or 'heart space' reaction to experiencing a removal of a baby and caring for the woman. Three main sub themes were identified. These were:

- Being challenged by a shift in focus: Being woman centred versus child focused
- Midwives living the distress
- It's like a stillbirth.

Being challenged by a shift in focus: Being woman centred versus child focused

The continual tension between being woman centred as opposed to child focussed was also emotionally challenging for the midwives. Midwives are philosophically aligned to women. Partnering with childbearing women is a central concept that underpins midwifery practice. Through information sharing, support, advocacy, encouragement and reassurance midwives hope to help pregnant women develop confidence and competence for birth, as well as the transition to motherhood. In doing this they are in fact working with the woman to promote the health and wellbeing of her unborn baby. Midwives actually enact their care through the relationship they share with women. Prioritising the concept of child protection or being solely baby focused before the actual birth has taken place is a conundrum for midwives, because keeping the baby well means ensuring the woman is well cared for and able to access all the resources needed to support a healthy pregnancy and birth. So, for midwives there was little choice but to remain woman focused. The midwives felt that building trusting relationships with women through open and honest communication was important. Doing this influenced their ability to engage with women at risk and in turn protect the growing fetus (baby) whether a removal occurred or not.

> I'd like to think that you can really try very hard to work with the women, because that is probably the best outcome. And even if it doesn't mean that the baby goes home with the mother, you've got to try and have a reasonable relationship with the family. They feel as though you have been able to support them the best you can (Midwife 8).

> …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).

However it was not always easy. As one midwife stated:

> 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. I did midwifery to be with women who are all doing the right thing and have the best possible intentions for their babies (Midwife 7).

And when faced with needing to report, it was difficult. Making a choice to prioritise the baby over the mother did not sit well and further tested their assumptions about their role. For example:

> Because it was quite a different role for midwifery, because midwifery was always about supporting women, being with women, women focus, women centred… but for this population you often became, you were the voice of the baby, because the baby had no voice and you needed to be there advocating for the baby (Midwife 7).

> So then you are looking at who will look after the baby, who am I going to keep safe here. The baby, the mother and I think it comes down to I've got to keep the baby safe at some point as well (Midwife 8).

The midwives in the study made it clear that they wanted to advocate for the women. They clearly saw their role as being 'with' the woman; '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). To manage some of the potential conflict and maintain their position 'beside' the women, midwives at times, 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, and 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).

The midwives used their skills to build effective relationships and maintain their role as advocates in an effort to provide woman centred care. Even when the focus needed to be on the baby due to the child protection issues, the midwives continued in their role of supporting the woman to ensure the best outcome was achieved for both the mother and baby.

Midwives living the distress

Midwives used an array of words and phrases to sum up their reaction to being involved with an assumption of care episode. Those most common to the data set for all the midwives were; 'hard' and 'sad', others used included 'difficult', 'horrible', 'awful' and 'traumatic'. One of the

more experienced midwives, who works consistently with these vulnerable woman and families said: ‘Sometimes I just feel completely overwhelmed by it and just think I can’t do this anymore, it’s just like, way too hard (Midwife 9).

Midwives felt ‘very sad’ for the women and experienced feeling ‘distraught’, ‘distressed’ and ‘heartbroken’ afterward their involvement. As one midwife said:

> Really shocked, and also, yes sad, because as a midwife I feel we’re there to bring babies into the world with the mother, not to take them away, so it was just the antithesis of what you thought your role should be (Midwife 3).

Midwives who had only one experience to draw on commonly described being ‘surprised’ by the immediacy of the removal especially when they did not expect it to happen. As this midwife explained:

> I didn’t know it was that quick I didn’t know it was literally from the birth immediately I always knew that children were taken away as a media show but never thought about babies from a birth (Midwife 2).

As the midwives recounted their stories they realised they could often remember many of the women who they had been involved with during an assumption of care event. The midwives commonly described how the experience/s ‘stuck in their mind’ and was not one that could easily be forgotten. Even those with extensive experiences said they had vivid memories of the women they cared for. For example:

> I was also quite surprised when I looked at their name, how the story instantly came back. There wasn’t one name in there that I couldn’t recall what the situation was. They were all stories that just came to my mind straight away and it was quite distressing to read all those names again (Midwife 9).

Some midwives tried to think what it might feel like to be in the position of the woman who had their baby removed. Understanding and empathising with the woman about the impact of a removal of their baby affected the midwives emotionally. These midwives described:

> As a midwife we feel the women's pain I guess and empathetic to her, what she is going through (Midwife 2).

> Where the mother herself has had years of neglect and abuse herself in her own childhood, see she's got all that to contend with, so that's the reason that she is unable to care for her own babies and she's already had many children removed I find those ones the most painful, cause it's not her fault. You know, it's just trans-generational (Midwife 9).

Other midwives reflected on the fact that they were ones actually involved in removing a baby from their mother. For example:

> Doesn't take away from the fact that you're involved in removing a child from its mother, especially when you feel like it could have been done a whole lot better (Midwife 5).

> That's somebody's child that you're actually taking from them to put in the nursery where they may or may not be able to visit that baby ever (Midwife 6).

One midwife described how she felt she needed to control her emotional response at the actual removal to maintain a professional impression even though her feelings were quite different. She said:

> I get this intense feeling of, just this gut-wrenching kind of wanting to burst into tears and to hug her and tell her everything was going to be all right, but really, knowing that you needed to maintain a professional appearance and not get emotional (Midwife 3).

In contrast, some of the midwives did discuss negative and judgemental responses to the women from some of their colleagues. This was most common toward the women who had had numerous babies removed. The midwives said:

> It was more the staff knew her …it was a bit like oh she's done it again, serves her right. Let's get her out. We have to take the baby, she needs to go and don't come back sort of thing (Midwife 2).

> The sense that I got was that, well, it was the mother's fault anyway, she's to blame, so she doesn't deserve any sympathy so don't worry about it (Midwife 3).

In some cases, it was seen that the 'tougher' more experienced midwives were given the role of the actual assumption of care. They were seen as able to cope by the less experienced

midwives who had fewer years of experience dealing with their emotions. And for those midwives who had been involved in numerous removals of babies from their mothers, they admitted to becoming harder themselves. For example:

> People having assume care to be given to other, the tougher senior midwives, which isn't always right (Midwife 2).

> I think I'm probably getting a lot harder as a result of it. Maybe a self-protection, because I don't feel as upset about it anymore (Midwife 9).

No matter the level of experience of the midwife or number of assumption of care of a baby the midwife had been involved in, all concluded it was a hard and sad aspect of their work.

It's like a stillbirth

To help articulate how they felt about working with women whose babies were removed, the midwives commonly made comparisons to providing care to a woman whose baby had died. Not dissimilar to how they perceived women felt, the midwives expressed emotions of grief, loss and pain. One midwife described it as:

> It was that complete raw emotional pain that you're been subjected to, and I guess in midwifery, … you see it sometimes with the death of a baby but this is a different pain, when babies are assumed (Midwife 7).

One midwife stated that these feelings were intensified and much worse in circumstances where the assumption of care was known but not disclosed. This midwife talked about feeling like she had 'betrayed' the woman. For example:

> The impact on you is the same as the grief and loss that you share with any stillbirth, and those cases where you haven't been able to disclose to the women it's sort of a little bit worse because you feel like the betrayer as well (Midwife 5).

Acknowledging this similarity for the midwives meant some began to initiate forms of mementos for the women similar to what is given to stillbirth mothers. The midwives tried to create some form of memories for the woman like 'photos', 'hand and foot prints', 'hair locks', and giving 'baby quilts' that are usually given to mothers of stillborn or premature babies. The midwives hoped this may help the woman with her loss. The midwives explained:

> So they took a lot of photos of the baby, photos on her tummy. They did all these things that she had not had before (previous removal of baby) which I think really helped her even though the baby was going; it helped her she still felt a little bit better about it (Midwife 2).

> I think the mementos are important and if you look at a woman who loses a baby; as opposed to a death (of a baby), or someone who places a child up for adoption, they get all the support in the world, they get mementos, they get endless support, but a woman who has a baby removed is deeply grieving and is just left (Midwife 4).

Some of the midwives felt passionate enough about making mementos for the woman that they organised the official hospital photographer to take photos if the woman could not take her own. The women did not always take the photos home but they were available in her hospital medical records, if she wanted the photos later. Examples midwives gave were:

> And one of them was being scheduled to a Mental Health facility, so we actually paid for the private photographer to come in and do the big set, the formal set of photos that other parents get (Midwife 5).

> We'd get the hospital medical photographer to come in and take photos ... Interestingly, the vast majority of the women couldn't take those photos home with them so we'd keep them for them for when they wanted them. It was just too painful for them (Midwife 7).

The midwives explained how some of their colleagues caring for the woman did not agree nor understand the significance of creating mementos for the woman who had their baby removed. These midwives questioned if the baby had not died why give similar mementos. The following quotes describe this:

> We spoke about it and planned it and what we were going to do, like footprints and a hand print, so you can keep a diary of the baby's stay here, but it depended on what midwifery staff was around. Not all of them agreed that the parents should have anything to do with the baby (Midwife 6).

> Talking to the nursery staff about doing hand prints and footprints, and telling them 'the baby's not dead, but she's not taking this baby home' (Midwife 7).

Despite some objections from some of their colleagues, the midwives interviewed felt that creating mementos was a positive process.

While there were similarities to caring for a woman with a stillbirth, in relation to her leaving hospital without a baby there were also distinct differences. Certainly the midwives perceived there was less acknowledgement of the loss for the woman and lack of support pathways after discharge. The following two extracts reflect these concepts well with the midwives trying to explain their position:

> When a baby dies there is some form of closure. When a baby is adopted there is hope, and you can actually still have some kind of contact these days, and have a choice in the matter, and you have support. However, when a baby is removed it's a bit like when people go missing and you just don't really know. And there is kind of that glimmer of hope that the longer it goes on the more likely it is that they're not coming home (Midwife 4).

> And what are our support pathways around mothers that go home without their babies. Very different from the mothers who suffer, and that experience a stillborn baby. There's a huge amount of support if they (a mother of a stillbirth) want to access it, but not for mothers who have had their children go into care (Midwife 8).

The midwives used the analogy of a woman who had experienced a stillborn baby in an attempt to find some sort of understanding and closure for the women and themselves.

Helping make a difference to the head and heart space

The third and final overarching theme was labelled 'Helping make a difference to the head and heart space'. This theme clusters together the various suggestions made by midwives about how to improve processes and better support the women and midwives. The three sub themes explored in this section of the chapter are:

- Providing continuity of care
- Ways of supporting midwives
- How do you prepare for taking a baby from their mother?

Providing continuity of care.

The midwives were able to offer various forms of continuity of care/carer to the women as part of their roles. For some, this was exclusively antenatal care whilst others provided antenatal, labour, birth and postnatal care. Although challenging given the nature of the work with at risk women, these midwives believed that providing continuity of care made a significant difference to the woman and the outcomes. Midwives argued strongly that continuity helped both the woman and the midwife because the model facilitated the development of a relationship that was built with full knowledge of the circumstances and possible outcomes for the woman. Within this context midwives felt they could help the woman feel 'secure' and 'supported' and decrease women's levels of anxiety. For example:

> I think there has to be some form of collaborative care and continuity care model, continuity with a known midwife in that way, the women is supported, the midwife is happy (Midwife 2).

> The women with severe mental health illnesses are more secure in the midwifery model of care and the level of trust, and therefore their anxiety is much lower. And they would really benefit from that continuity, especially during labour. It's just so scary (Midwife 5).

As identified in the theme 'Being in the Head space', women often required the care of a multidisciplinary team throughout the pregnancy who generally worked collaboratively. The midwife was often the one health professional who could link these services for the woman and help her engage and remain in contact with these referral agencies. As the midwives explained:

> Some of the girls with the drug and alcohol problems… do really benefit from previous experience of the combined approach of a midwife and the drug and alcohol team that they have, one midwife and one drug and alcohol worker that are all talking the one language to her all the way through (Midwife 5).

> If they're very complex they'll come into (specialist midwife) antenatal clinic, because I can spend a little bit more time with them, in theory, and I've got some more time to put some other pathways in place and link them into social work who will then often liaise with Community Services… or I'll liaise with Community Services. That's the best scenario (Midwife 8).

Midwives expressed great concern that women accessing standard fragmented medicalised maternity care which lacks continuity and collaboration would go through the hospital system without having either appropriate referrals nor gaining adequate support. This could lead to some women having their baby removed at birth without adequate time for assessment, escalating the emotional distress felt by everyone. Having said that, there was acknowledgment that some women may find this advantageous as not seeing the same person may allow them to slip unnoticed through their pregnancy and birth without Community Services being notified. One of the midwives shared the story of a woman whom she stated that her care had been 'terribly fragmented, unbelievably fragmented actually'. The midwife was of the firm view that continuity of midwifery care would have made a difference. She went on to say:

> I think through the continuity of care and proper caseload and everyone around could have avoided that (removal of a baby) but sometimes those decisions are made at the last minute (Midwife 2).

Other midwives suggested that a caseload midwifery group practice[9] was a good option for these women. The midwives stressed the caseload model would need to have fewer women than a standard caseload midwifery group practice. Their concern was for the midwives who had to cope with an entire caseload of vulnerable women with potential assumption of care. The midwives suggested having a 'mixed' caseload could help reduce burnout. These midwives said:

> I really believe that vulnerable women that I cared for would really benefit from a continuity of care caseload model where a lot of these risks that are perceived can be reduced (Midwife 4).

> Well, I don't think you can have them all, you have to have a balance, your caseload has to be a balance, you can't have them all (vulnerable women), or you will burn out (Midwife 10).

The importance of continuity of care and collaboration between multiple carers and agencies was highlighted as an important factor to improve the outcome for these women and their

[9] Each midwife in a caseload midwifery group practice usually has four women booked, per month, providing all antenatal, labour and birth care and postnatal home visits. Midwives usually work with a second midwife providing cover for each other's women.

babies. The midwives recognised improved models of care also were of benefit to their participation in an assumption of care.

Ways of supporting midwives

The midwives recognised that some form of support was required following their involvement in an assumption of care. The experience of assumption of care was not considered a 'normal' part of their daily work, even for those that worked more regularly with vulnerable women. The emotional journey that the midwives rode, as described in the theme 'heart space', had a tendency to stay with them. The midwives discussed various mechanisms of formal and informal support.

Informal networks were developed with each other, as well as with the social workers. The midwives would use the social workers for support either individually or to conduct 'debrief sessions'. The social workers were seen as a good source of support because they were often directly involved in the care of the woman, so were aware of just what the midwife had experienced. Conducting debriefing sessions was one form of support and follow up for the midwives. For example:

> Often I can de-brief with social workers and sometimes with the midwives here, it just depends whose around (Midwife 8).

> We were very conscious of the impact on the ward staff and there would always be some form of a debrief for the staff (Midwife 7).

The midwives would also use each other and would try to ensure that those involved were supported by more experienced midwives. This meant at least someone would follow up the midwives involved in a removal. These midwives explained:

> We all talk together, which is really good and we can talk individually to each other, you know, somebody, if the whole team is not there and we need to talk, we will talk, that is very important (Midwife 1).

> Sometimes I feel that I am the main support for everybody. Everybody comes to me for support around everything and there's not that many places that I can go to get that. That's probably not an issue (Midwife 9).

Formal support opportunities like debrief sessions or clinical supervision (reflection) were used by the midwives when available. Some of the hospitals provided formal clinical supervision[10] on a regular basis for the midwives. This meant that support was continually available in the form of discussing cases that had Community Services involvement and if an assumption of care occurred the midwives knew there was an opportunity to discuss their involvement. They said:

> We have clinical supervision, and I do feel this is important in a role like this for any midwife, and so often raise it in clinical supervision (Midwife 4).

> We have a very visionary manager, who understood that working with very marginalised women was very painful work and that, in order to be able to do it, there needed to be supervision (Midwife 7).

The midwives expressed that clinical supervision was essential. The midwives felt this was an appropriate form of support to prevent 'burnout' as involvement in an assumption of care impacted on them personally and professionally. These midwives described the role of clinical supervision as:

> Our supervisor was a perinatal psychotherapist, so she was incredibly skilled in explaining the meaning of the behaviours. So we used to call it our 'psychological shower' (Midwife 7).

> I think you do have to have that clinical supervision of vicarious trauma stuff in the background supporting those midwives because, you know, some of the stuff is pretty horrible (Midwife 10).

An Employee Assistance Program [11] (EAP) was available at all the hospitals and was utilised by some midwives. The midwives were encouraged to access their local health service EAP. Some of the midwives used this service or recommended it to their colleagues. However, some of the midwives did not have a positive view of EAP. For example:

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[10] Clinical Supervision is a formal process provided for a midwife in a facilitated individual or group session, to reflect on individual practice related to caring for women especially in complex clinical situations. Clinical supervision is voluntary in NSW hospitals and may not be provided in all institutions.

[11] NSW Health employee assistance program (EAP) provides early intervention strategies for staff (and their families) in order to assist them to identify and resolve professional, personal, health or work-related issues.

> I've sometimes gone to EAP when it's really got on top of me. When I start thinking 'I can't go on' and 'can't bear any more of this', that's when I go to EAP (Midwife 4).

> Oh yeah, EAP generally are useless, as we all know, across the board, they sit there and don't do anything, so most midwives will tell you they are useless. I went once and it was useless. If you don't have a good experience then you won't go back (Midwife 10).

The midwives did express concern about an apparent lack of support for their midwifery colleagues in some organisations. Being left to 'just cope' with the personal and professional distress caused by involvement in an assumption of care was considered poor management and affected them all. For example:

> I do not think midwives are supported enough in those roles. I think they just presume that you are fine and it's done and you go home from the shift but it's not at all like that (Midwife 2).

> … even without assumption of care, you know the caring profession is burn out, we are not very good at taking care of ourselves and certainly the institutions have never been good, never (Midwife 10).

Support for midwives was seen as an important part of their ability to care for the women and themselves. The midwives also expressed that being better prepared formally through education processes and informally by experience and learning from other midwives about an actual assumption of care was seen as another way of supporting each other.

How do you prepare for taking a baby from their mother?

During the interviews, midwives were asked to discuss their thoughts and opinions on how best to prepare for the experience of working with a woman/family that was facing an assumption of care. Rarely had any of the midwives received any formal preparation. As one midwife said 'there is nothing in my midwifery training that ever prepared me for this. Nothing!' (Midwife 4). The education around child protection that some midwives received as part of their 'mandatory' professional development, however, was considered beneficial. This midwife explained:

> Child Protection and working with people coping with mental health, drug and alcohol, co morbidity, child protection, that was useful. And the good things were about

> meeting with other workers and sharing stories and supporting each other (Midwife 4).

Having said this, it was generally believed that this type of education did not arm midwives with the knowledge and skills needed when actually providing the care to these families. As one midwife said: 'There is no child protection training that I've gone to that talks about the other side of assumption of care. None. None at all! (Midwife 5).

As a result, the midwives described a process of 'learning as you go'. Common phrases to the data set where; 'learnt it on the job', 'through trial and error' and 'through experience you learn how good or bad it can be'. Some midwives describing seeking out their own learning and trying to figure out what they needed to do. As one midwife shared:

> So I said to the Community Services workers, 'What's the process? What are you actually going to do? Tell me what's going to happen so that I'm prepared. I want to be a little prepared and have a strategy in place for my role in this, because I wasn't quite sure of my role?' (Midwife 3).

Some of the midwives who had more experience described how they consistently tried to use their own knowledge and expertise to skill up other staff. This was also seen as a way of supporting midwives through the experience. One of the managers explained:

> And I think they have to experience it and not everybody can deal with the emotions that go with it, I don't think, but I'm trying to get my staff exposed to it so they know when I'm not here what they've got to do (Midwife 6).

Another experienced midwife shared her thoughts on preparation:

> I do a lot of education with the midwives when we have an assumption of care when we know what's really happening. I talk to them about what have been perceived to be the risks and also the strengths of the woman. I think if you do know the reason behind it, it is a little easier to deal with emotionally (Midwife 4).

A third midwife expressed the difficulty in preparing someone for just such a process but highlighted how important she felt if she was to 'walk' beside her fellow midwife throughout the process:

> I don't know how you prepare anyone, it's like how do you prepare someone for a still birth? You can learn all the theory behind it but until you do it, and doing it with someone, that's the important thing I guess (Midwife 5).

When asked what might help better prepare midwives some suggested that both the process (head space) and the impact (heart space) should be the focus of targeted education. Learning more about 'engagement strategies 'and 'how to support women with child-protection stuff' were suggested approaches. Having said this the midwives still stressed the importance of having 'good basic midwifery skills' and felt it was important not to lose focus on providing care that was respectful of women even in these complex situations where women were facing the removal of their baby. For example:

> I guess every midwife needs to be a bit more in-service about the feelings of these women, woman centred care and normality despite what is going to happen. That might help them cope with it too. They do realise she's a woman and it is normal … she's given birth, they all have the same feelings as other women (Midwife 2).

However another midwife summed up the difficulty of preparing emotionally for the distressing involvement in an assumption of care:

> Like you can only prepare someone, you know you can give them a theory thing, like anything but the emotional experience of something as traumatic as assumption of care, you can't really say you know this is how we prepare you, because each experience is going to be different (Midwife 10).

The midwives offered suggestions to help improve the models of care provision, support for the midwives and develop ways to prepare midwives for an assumption of care. The complexities of the circumstances surrounding an assumption of care meant that any developments in these areas might assist the women and the midwives in future assumption of care experiences.

Conclusion

The impact on the midwives of being involved in an assumption of care evoked an array of emotional reactions. However, the more knowledge, experience and skills the midwives possessed in this situation appeared to help the emotional impact. The challenge for midwives facing an assumption of care, was prioritising the safety and wellbeing of the baby, as well as

the unborn, over the woman. Postnatally, midwives compared their role to being involved with a woman who had experienced a stillborn child as the grief, sense of loss and pain experienced by women felt similar for them. Providing continuity and collaborative care was seen as the best way to engage the women and improve outcomes. The midwives utilised various informal and formal methods of support to assist them emotionally manage an assumption of care episode. In addition, although education related to dealing with the emotional fallout and impact, seemed lacking, it was also acknowledged that an improvement in providing theoretical aspects would at least assist the midwife from a process point of view. Overall, the midwives expressed that experiences of being involved with women during an assumption of care was not something they could ever easily forget.

Chapter Six begins with a summary of the findings and will use the relevant literature to discuss the results to include the implications for midwives. The chapter will conclude with the limitations of the study and recommendations of how the findings of the study need to transform into changes in education, training, clinical practice and support for midwives.

Chapter Six - Discussion and Conclusions

Introduction

This study used a qualitative descriptive design to explore and describe the experience of ten Australian midwives who had experienced at least one assumption of care episode during the past three years. Midwives were recruited from the state of NSW and participated in a one off face to face interview. Thematic analysis was used to make sense of the data and illuminated three overarching themes, each consisting of a number of main themes and sub themes that describe the midwives experiences. The coping strategies the midwives used formed the basis of the two overarching themes labelled 'Being in the headspace' and 'Being in the heart space'. A final overarching theme, 'Helping make a difference to the head and the heart space' grouped together the midwives suggestions on what they considered would better help them manage their responsibilities when newborns were subjects of assumption of care, as well as the emotional response this situation created.

The main themes and subthemes were grouped together to describe how midwives were constantly challenged by the need to work from both their head and their heart, as they tried to provide the best possible care to women who were at risk of having their babies removed or who indeed did experience this in the postnatal period. During pregnancy, engaging with Community Services was often confronting as midwives struggled to come to grips with what they perceived was their obligation to prioritise the unborn fetus over the woman. Having to answer to someone other than the woman posed a conundrum and challenged the midwives ideals of partnership and the philosophy of woman centred care. A lack of knowledge and understanding of the processes added not only to their confusion but ultimately their emotional distress. For those midwives with more experience instigating effective communication and management pathways, as well as providing leadership to those less experienced was seen as important and a way to help other midwives and staff manage not only the actual processes but their emotions.

Being involved with the actual removal of a newborn from their mother was extremely emotionally distressing for midwives. Being involved in the 'formal legal processes' accompanying the removal of a baby by Community Service workers and others, for example social workers and at times, security and police was a totally foreign concept and so removed from what midwives did on a daily basis, that they found it hard to process and integrate. To some extent, those who provided continuity of care to women, faired a little better as they

had time to prepare themselves along with the woman. However, this was not the case when midwives perceived the decisions about removal to be unfair and unjust. Again learning the process and order of events appeared to help the midwives cope, keeping them in what was referred to as their rational logical 'head' space rather than the emotional space of their 'heart'.

Once the baby had been removed, the midwives likened the experience to caring for a woman who had experienced a stillbirth. The analogy of 'being like a stillbirth' seemed to be the closest experience the midwives could draw upon to characterise how it felt for them to be involved in the removal of a baby from their mother and their perception of maternal grief. Reflecting on these feelings resulted in midwives stating that their midwifery education had not prepared them to be involved in the processes and/or the emotional impact of an assumption of care of a baby. This is an area that all the midwives felt needs to be addressed.

As discussed in previous chapters, the research presented in this thesis built on the work of Gaynor Wood (2008a) who explored UK midwives experience of removing babies at birth for child protection reasons. Perhaps not surprisingly there were some notable similarities between the two projects which will form the basis of some of the upcoming discussion. The need or requirement to switch from a woman centered approach, where mother and infant are conceptualized as a dyad, to a more child focused approach where a third party, such as Community Services, has ultimate power over such major life decisions, challenged midwives way of working. Overall, however, it was clear that being involved in and caring for women who have their newborns removed was difficult and distressing for midwives (Wood 2008a).

In this chapter the findings are discussed in light of the available research. The major points of discussion focus around four main challenges. The first is in relation to 'who' is the focus of care. This leads into a discussion on the need to work with a powerful third person; Community Services. Lastly, midwives handling of the removal of the baby and their subsequent feeling of grief reminiscent of working with women who have experienced a stillbirth are outlined. Implications for practice, education and research are then addressed. Finally, I address the strengths and limitations of the study

Being 'with woman' versus the child focus: Midwife muddle

The findings of this study clearly demonstrated that midwives experienced a sense of conflict when involved with caring for vulnerable women whose infants were the subject of

assumption of care. This was the result of needing to shift from being woman centred to child focused. The work of Thompson (2003) examining ethical conflicts for midwives and women, discusses how midwives primary relationship with the woman can at times be challenging and present ethical conflicts. Midwives work in partnership with women guiding them through their pregnancy, supporting and assisting them through labor and birth and nurturing both them and their babies through the early postnatal period. The intent is to support the woman's relationship with her unborn and then her baby within the broader context of the family. Unborn babies assessed to be at significant risk of harm cause a fundamental dilemma for the midwife. She must act in the best interests of the unborn. However, until the baby is actually born, this actually means working with the pregnant woman to keep herself and her unborn baby well and healthy throughout pregnancy. Developing relationships with women that keep them engaged within the service is important and integral to providing quality care, especially as the women have the choice to leave their maternity care at any time. However, as identified in this study, the midwife is likely to feel somewhat compromised generating feelings of guilt and internal conflict as priority is given to the unborn.

The comprehensive work undertaken by Thompson (2002, 2003, 2004, 2005) on the ethical issues in midwifery practice provides insight into the ethical challenges and conflicts faced by midwives in practice. Thompson used narrative enquiry as a method to interview eight childbearing women and eight midwives asking both groups to comment on the ethical nature of their encounter with professional practices and practitioners. The significance of this work is how Thompson describes the ethical issues faced in mother-midwife relationship, elaborating on the processes and the emotional impact for women and midwives. This work is useful for midwives to understand issues surrounding power imbalances, shifts in the 'with woman' thinking and choices around informed decision making about non-disclosure of assumption of care move.

The midwife brings a unique role in child protection of the unborn infant. Whilst multidisciplinary and interagency services may be involved during the woman's pregnancy, like mental health with an adult focus and child protection services with a child focus, the midwife bridges the gap until the baby is born. In reality, care of the baby cannot be paramount, as the child focus approach demands, as this cannot occur separately from the woman until the birth of the newborn. Midwives work inherently to protect an unborn and focus on supporting the woman and her supports. (Australian College of Midwives 2001; Australian Nursing & Midwifery Council 2006). When the unborn was identified at risk of significant harm, the

midwives struggled in knowing just how best to focus their care, as at the birth the newborn becomes a priority for Community Services and was often separated immediately and assumed into care. Even when midwives acknowledged and recognized the need for child protection and felt an assumption of care was warranted they continued to express ongoing concerns for the woman and their own role in the process. As a result the level of emotional work the midwives were required to engage in and negotiate was clearly evident.

Extensive work by Hunter (2001, 2004, 2005, 2009) has sought to explore and describe the challenging aspect of emotional work in midwifery. One paper by Hunter (2004) describes the emotional work for a midwife when challenged to move from a 'with woman ideology' to a 'with institution ideology'. In her study, the institution ideology was described as an affiliation with the maternity services where the midwives practiced and were required to give precedence to the needs of that organisation over the women. There are some synergies between Hunter's work and the findings of my study. Similar the midwives in Hunters work, the midwives in this study engaged in complex emotional work as they were required to firstly partner with a third external organisation; Community Services, and secondly work with an ideology or framework that at times seemed to only priorities infants needs rather than taking a holistic approach. The 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 of 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) cautions the use of telling 'atrocity stories' and forming a 'common enemy' in the context of interagency work as this thinking can increase any dysfunction that may exist amongst the organisation and ultimately split services trying to work together for the common good of the child. At times this was challenging as Community Services were a powerful force in the relationship.

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 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 or potential inequalities of professional power imbalances has 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, so overt power

within the relationship challenges the way they were used to working and the principles underpinning a partnership model of care.

Power inequities or feeling of powerlessness by both parents and workers have been highlighted in both the midwifery and child protection literature (Davies 2011; Leap 2010; Pairman & McAra-Couper 2006; Rouf, Larkin & Lowe 2011; Wickham 2009). Midwives could see how worried or concerned women were especially if they had experienced a prior encounter with Community Services or a removal of a previous baby. Knowing the statutory power that Community Services possessed to make decisions to remove a baby caused the midwives, especially antenatally, to actively encourage women to make sure they did everything Community Services asked of them in an effort to keep their baby. The midwives used their position where possible to advocate for the woman and also the unborn perceived to be at risk. At times, they felt a sense of powerless to adequately support the woman and protect the newborn resulting in an assumption of care.

There were certainly examples in the data where midwives became despondent, angry and distressed when they perceived that despite the woman 'jumping though hoops' the decision was still made to remove the baby. Those with previous experiences acknowledged the importance of knowing the processes and procedures Community Services were likely to require. Equipping oneself with knowledge was considered a way to help women. Participating in planning meetings and ensuring management plans were in place was therefore important to midwives and ultimately to women, a finding similar to that of Wood (2008a). By pushing for more streamlined communication the midwives hoped they could advocate for the woman and highlight the strengths identified in the family unit. Like others have suggested, (Buckley, Carr & Whelan 2011; Bunting, Lazenbatt & Wallace 2010; Dale 2004; Devaney 2008; Wood 2008a) the midwives in this study really wanted to make a positive difference. They wanted to reduce the potential for harm whilst ensuring a good outcome for the baby.

One of the greatest challenges for midwives was when Community Services requested that they not disclose to the woman and/or family that an assumption of care would take place after birth. Again, the midwives struggled with the emotional and ethical conflicts of being asked not to disclose a known assumption of care and to prioritise the wellbeing and safety of the baby over the mother. This type of situation challenges the essential elements of the midwife-mother relationship; trust, honesty, open communication and working in partnership with the woman (Anderson & Pelvin 2006; Homer et al. 2009; Kirkham 2010; Thompson 2005). The midwives in the study demonstrated different responses to this requirement. Most agreed

not to disclose for the safety of the baby, other women and staff and/or themselves. Some midwives however said they did not always comply. These midwives used their professional judgement to make an assessment of the situation and their relationship with the woman. In some cases this meant disclosure to the woman did occur. In these situations the midwives were drawing on their National Competency Standards of a Midwife (Australian Nursing & Midwifery Council 2006), the Code of Professional Conduct for Midwives in Australia (Australian Nursing & Midwifery Council 2008b) and Code of Ethics for Midwives in Australia (Australian Nursing & Midwifery Council 2008a) all of which serve as a guide for midwives in their professional practice regarding this complex issue. These documents highlight many of the issues and challenges of midwifery responsibilities in child protection, including maintaining human rights, working in accordance with relevant laws and legislation, treating information as confidential, and ethical decision making.

Handling the actual removal of the baby

Midwives' involvement in the actual removal of a baby is a complex aspect of their role. The midwives in this study gave detailed accounts of their experiences when actually involved at the time of removal. For some midwives this was a one off experience while for others it was a much more frequent and continued part of a midwives role. It is important to understand the challenges midwives face. Again, when discussing their experiences, the midwives responses resemble strongly the work of Wood (2008a). For example, both sets of midwives questioned whether they should be the professionals actually physically removing the baby from their mother. While midwives were keen to ensure the safety of the baby, they also felt the need to appropriately support the woman. Some midwives suggested social workers are the appropriate professional to fill this role. However, a discussion paper about assumption of care by Wickham, an Australian social worker (2009), noted that social workers feel the same challenge of doing child protection work and being an advocates for the woman. Involvement of the woman in the decision making process, perhaps is therefore the best solution of whom she would want to actually remove her baby.

What was clear in the findings of this study was that having effective communication and procedural processes made a significant difference to how the midwives approached and processed the removal of a baby. Knowledge and understanding was certainly considered 'power' and essential to relieving or preventing physiological distress in all those who were part of this experience. For those midwives with considerable experience in this area it was clear that they knew the importance and benefit of planning, informing and documenting,

during the antenatal period, what was to occur at the birth. Planning meetings and written birth management plans were essential. The work of Buckley, Carr and Whelan (2011) supports this findings. In their work, investigating service users' views of their involvement with child protection services planning meetings, they found that families benefited from having the opportunity to discuss the outcomes of the meeting with a social worker after the event (Buckley, Carr & Whelan 2011). Not dissimilarly, the midwives in this study articulated how helpful it was to be part of these meeting and be able to gain an understanding of decision making processes, as well as roles and expectations for everyone. Indeed Freel (2010), who wrote about the unlawful removal of a baby from his mother in the UK at birth, strongly recommended that the woman's named midwife should be involved in a pre-birth meeting and, where possible, the mother should also be involved or informed of the outcome. In this particular case, a birth plan was used to guide staff about need for removal of the baby at birth but was subsequently criticised as not having any statutory basis for the midwives to take this action (Freel 2010).

The emotional rollercoaster of the physical removal of a baby

Working with a woman with child protection concerns during a pregnancy was difficult but being witness and/or actively participating in the actual event of removal of her baby provoked serious emotional responses in the midwives. The roles and relationships of a midwife during the processes of an assumption of care impact how they cope emotionally. The midwives in the study described a vast array of emotions, mostly negative, related to their involvement in the process. Even if the midwife acknowledged that the removal of a baby from their mother was necessary, it was understandably hard and sad. Knowing how to deal with emotions at the time and afterwards was a challenge.

The midwives discussed how the experiences of being involved in an assumption of care 'stuck in their minds'. The midwives recounted stories of their involvement in the removal of a baby from their mother with vivid clarity and identified it was not something they could forget, no matter how many occasions they had been involved in or if it was just a one off experience. Distress and trauma were common concepts related by the midwives. Likewise, both Chapman (2003) and Wood (2008a) have spoken of how midwives hold onto the difficult and painful memories of the events such as, removal of a newborn for many years afterwards. In work around midwives' experiences of stillbirth, Kenworthy (2004) wrote how midwives may conceal their pain, emotions and distressing memories for many years after such an experience. Kenworthy described this as a form of 'professional sadness' or even 'professional

grief' and highlighted that no adverse event such as a stillbirth is ever the same and midwives will respond differently to each event. Similar to a stillbirth experience midwives may only ever be involved in a small number of removal of newborns, yet it appears to have a similar profound professional and personal impact.

As mentioned previously, learning to deal with the emotional work in midwifery has been extensively explored by Hunter (2001, 2004, 2005, 2009) and provides helpful insights into this aspect for midwives. Hunter describes how normal midwifery work creates emotional labour purely as a result of how midwives work with women. The midwives involved in assumption of care acknowledged the emotional work which, as described by Hunter (2009), involved managing their emotions by either suppressing or inducing those demanded or expected. Some of the midwives suppressed their urge to cry while others openly cried. Midwives described women reacting in a number of different ways and how it was important for them to comfort and support the woman. Sometimes this also meant allowing themselves to be the target of anger and verbal abuse. The less experienced midwives appeared to struggle, quite considerably, with dealing with both the woman's emotions as well as their own. The more experienced midwives discussed ways of managing their emotional labour even admitting to 'hardening' up when responding and interacting with women. According to Hunter (2009) the phrase 'hardening up' is a protective strategy to manage emotions. It's important to recognise however, that the long term use of this strategy may cause midwives to become isolated, decrease their ability to access appropriate support as well as provide it, and send mixed messages to inexperienced midwives. Hunter (2001) acknowledged that emotional labour is potentially a minefield in midwifery and implications for practice in assumption of care clearly support this concept today.

There have also been a number of studies in the field of social work and child protection that have explored these professionals' levels of emotional labour (Gray 2002; Leeson 2012; Reder & Duncan 2003). Not unlike midwifery, these studies have found that professionals struggled with the emotional impact of child protection work in their professional roles. Knowing how to deal with the expected emotional responses of families was acknowledged as part of the role of being involved with vulnerable parents and children in the child protection system (Gray 2002; Leeson 2012; Reder & Duncan 2003). The more experienced workers became, the more they developed skills to appropriately deal with emotional responses, either by increasing their ability to engage hostile or resistant families or knowing when to withdraw to a place of emotional safety (Leeson 2012). The more experienced midwives also displayed similar

protective skills gained through their involvement with assumption of care. However, Keys (2009) in her extensive literature review of the skills required to work in child protection, demonstrated that managing the emotional impact was not regularly recognised to be crucial part of the process. The findings of the current study support Key's work as the midwives articulated that the issues pertaining to emotional labour were not addressed in any of the child protection training they had attended.

When the baby is gone … It's like a stillbirth

Once a baby was removed the midwives commonly equated their experiences, including the feelings of grief and sadness that were evoked, to that of caring for a woman who had experienced a stillbirth. This finding resonates strongly with those of Wood (2008a) who similarly identified that the UK midwives regularly used this same analogy to describe their experiences of assumption of care and the feeling of grief and stress that were elicited. In the current study however, midwives took this further by actually initiating memento's for the woman, for example, photos, foot and hand prints, hair locks and giving baby quilts similar to those usually given to a woman who had experienced a stillbirth.

As there is limited work exploring the midwives role in, and the emotional impact of assumption of care, research investigating midwives' experiences of stillbirth may provide some added insight into how midwives can deal with their emotions during the removal of a baby. For example, Kenworthy (2004) examined the lived experiences of midwives coping with loss and grief related their involvement with stillbirths. In this, in-depth original piece of work, midwives used words such as traumatic and horrendous to define how it felt during their experience. Similarly, in an assumption of care the midwives used words such as 'difficult', 'horrible', 'awful' and 'traumatic' to explain their involvement. Likewise a number of the major themes including working with women during a stressful unexpected event, the vividness of the memories created and the extent of the emotional labour and professional grief (Kenworthy & Kirkham 2011) match closely the experiences of midwives of assumption of care outlined in this thesis.

Some of the strategies discussed in Kenworthy and Kirkham (2011) book appear to be transferrable as well. For example, these authors make the point that understanding and knowing the legal requirements and processes for a still birth helped midwives cope with this traumatic event. This is what being in the head space represented to midwives. Kenworthy and Kirkham (2011) went on to highlight the lack of literature exploring the difficulty of

documentation during emotional clinical situations. Midwives caring for women experiencing a still birth often suffered additional stress as a result of the pressure to make sure they met all the statutory requirements. Similarly the findings of my study demonstrate that lack of understanding and knowledge around processes only adds to distress and confusion and ultimately the amount of emotional labour midwives engage in. The processes around women having papers 'served', was also stressful for midwives. The midwives were aware the woman's records could be subpoenaed for court proceedings related to a removal of a baby and their communication with Community services was often documented. The policy directive by NSW Health related to assumption of care outlines in detail the documentation requirements for the mothers record (NSW Health 2011). However, similar to a stillbirth, the extensive amount of paperwork involved may challenge midwives to ensure correct record keeping occurs whilst at the same time supporting a mother in emotional turmoil and recognising their own emotions during an assumption of care (Kenworthy & Kirkham 2011).

Implications for clinical practice: Helping make a difference

Assumption of care is an area of practice where midwives require support and education related to the processes and the emotional impact of their involvement in the actual removal of a baby from their mother. Emotional support mechanisms both informal and formal need to be available for midwives. Furthermore, the importance of the midwives' roles in working with women and Community Services during the pregnancy to enhance collaboration and develop management plans needs acknowledgement as part of the practice. How to educate midwives in relation to this complex and difficult area is challenging but given the personal and professional impact of the experiences described by the midwives in this study, assumption of care requires urgent attention and inclusion in undergraduate, postgraduate and mandatory training for midwives. The midwives in the study did provide some suggestions to help make a difference for midwives and woman.

Emotional support mechanisms

Providing midwives with personal and professional support is important if midwives are to successfully manage an assumption of care, which results in the best possible outcomes for both mother and newborn. Midwives may be involved with a woman and her unborn baby at risk along the childbirth continuum from early pregnancy, during labour and birth or the early postnatal period when the baby is actually removed, whether the assumption may be planned

or unplanned. Therefore, support mechanisms need to be provided in various forms related to the differing needs and experiences of the midwives.

A variety of informal and formal methods of support were used by the midwives including debriefing, individually or in a group with peers or the social worker, clinical reflection, clinical supervision or the Employee Assistance Program [12](EAP). For those whose role involved working with vulnerable women antenatally and numerous involvements in assumption of care, provision of formal and ongoing clinical supervision was seen as essential. Several studies exploring nurses involvement with child protection cases recommend the need and the benefits of consistent formal clinical supervision to reflect on feelings and responses when working with children and families in this challenging area of practice (Hall 2007; Lister & Crisp 2005; Paavilainen et al. 2002; Rowse 2009). Work in Australia by Mollart, Newing and Foureur (2009) on midwives' emotional wellbeing when involved with psychosocial screening noted that while clinical supervision is not common practice within midwifery and nursing in Australia, those in the study expressed worthwhile benefits from participating in clinical supervision related to the complex disclosures and vulnerabilities of the women. The experienced midwives and the midwifery managers in my study often provided a form of clinical supervision to other midwives involved in assumption of care. All agreed support and follow up is necessary for involvement in an assumption of care.

The work of Kenworth and Kirkham (2011) of midwives coping with grief and loss also offers some insights into the types of supports that may be helpful for midwives in an assumption of care. Midwives may experience some shock or bewilderment at involvement in an unexpected event and need help in the head and heart space. Support strategies with stillbirth included working with someone with previous experience, making sense of the emotions like grief and fears, clinical supervision, telling stories and writing journals as a form of reflective practice (Kenworthy & Kirkham 2011). Similarly, the midwives in this study recognised that support for other midwives especially after the event, from someone with previous experience, allowed staff to work through the process and the emotional impact of an assumption of care.

[12] NSW Health employee assistance program (EAP) provides early intervention strategies for staff (and their families) in order to assist them to identify and resolve professional, personal, health or work-related issues.

Management plans and policy directives

A practical organisational support was the development of management plans and hospital guidelines for midwives. Management plans need to be made in collaboration and partnership to ensure best practice and suitable outcomes. Midwives working together with other health professionals, social workers and government agencies is seen as essential to ensuring that appropriate communication and management planning occurs (Wood 2008a). Wood argues open disclosure and discussion is necessary between agencies and professionals to ensure all available information is shared and an appropriate management plan for care can be constructed. In the current study, the midwives working antenatally with women were aware of the benefit of writing management plans not only for the woman but for the other staff so they were aware of their responsibilities. This was considered especially important if the assumption of care occurred out of business hours when there was limited support. Midwives need to be aware of their role in working in these collaborative plans. According to Wood (2008a), case conferences and appropriate communication can also ensure professional skills and responsibilities do not overlap and everyone works together for the best outcome for mother and baby.

In conjunction with management plans, creating guidelines in hospitals was seen as another useful strategy. As previously described, since the interviews in this study were conducted, NSW Health developed a policy directive outlining the hospitals and health workers responsibility when an assumption of care occurs. The policy directive was to ensure legal requirements are followed in all health premises (NSW Health 2011). The policy directive details many of the issues raised by the midwives in the study including creating a safe place for removal, the process of 'serving the papers', care of the baby after the removal, advice to parents about their rights, and roles and responsibilities of health staff and Community Services workers including addressing security risks (NSW Health 2011). The directive is a very process orientated document with a broad focus that includes not only infants but children and young people up to age 17 years old. NSW local health districts are required to comply with the principles in this policy directive and ensure local protocols consistently reflect its intent. Doing this would appear to address some of the process issues the midwives described as challenging. NSW Health has also recently incorporated all their child protection policy and procedures into one single document to provide tools and guidance for every health worker to meet their responsibilities. This now includes the assumption of care policy directive (NSW Health 2013).

Education on how to prepare for assumption of care

The midwives found the processes involved in an assumption of care as well as the emotional impact it created difficult, especially as involvement in a removal of a baby was a role they never expected to do as a midwife. The midwives felt 'nothing had prepared them' and they 'learnt on the job'. A study by Rowse (2009) of nurses experiences for child protection in the UK found they too similarly lacked procedural and emotional knowledge of involvement in child protection cases. This deficit in preparation of a midwife for practice needs to be addressed at multiple levels. Under graduate and post graduate midwifery education needs to provide not only the procedural aspects, but address the emotional impact of involvement in child protection issues and specifically assumption of care of a newborn. Mandatory hospital training should also include similar topics of education on an ongoing basis (Long et al. 2006; Paavilainen & Flinck 2012). Access to, and knowledge of policy directives, procedures and local guidelines should be assist health workers to meet their role.

The literature relating to improving skills and training in child protection consistently recommends interagency programs (Bunting, Lazenbatt & Wallace 2010; Paavilainen et al. 2002; Reder & Duncan 2003). These recommendations come with the aim of improving communication and collaboration between agencies, and promoting an understanding of the differing roles and responsibilities of professionals involved with child protection issues (Baverstock et al. 2008). All of these issues were identified by the midwives in this study to assist in their part in an assumption of care. Education and training needs to include an acknowledgement of the anxieties that midwives face in their dual role and responsibilities to the mother and unborn child which places them with a unique dilemma (Keys 2005). Interagency training may be within the health sector across specialties including drug and alcohol services, mental health workers and social workers to ensure an understanding of the multidisciplinary teams roles and responsibilities of caring for a pregnant woman.

The work by Glennie (2007) discusses some of the challenges of interagency training. Her work examines not only the complexities of meeting the needs of different professional groups, but the effectiveness of various approaches of interagency training about child protection. Some of the midwives in the study did describe attempts of combined education sessions with Community Services, from the perspective of the hospital to try to increase the understanding between the organisations. The aim was to try to improve how the hospital and Community Services could work more effectively together in the actual process of an assumption of care and to acknowledge the emotional impact, especially on the woman following the 'serving of

the papers' by Community Services and subsequent removal of a baby. The impact of attitudes, values, core professional and personal beliefs, status and power of organisations need to be acknowledged in any interagency training to ensure the headspace process and heart space impact is addressed adequately (Glennie 2007; Keys 2005).

In Australia, Child Protection and Nursing and Midwifery Education Curriculum Standards were only recently developed (Briggs et al. 2010). These curriculum standards for pre-registration and post graduate nursing and midwifery programs aim to 'equip graduates with the knowledge and skills to enhance child wellbeing and prevent, identify and respond to child abuse and neglect' (Briggs et al. 2010, p. 3). The curriculum standards fulfill an essential requirement to include child protection for all nursing and midwifery programs and provide recognition of the involvement for midwives or nurses in the statutory requirements and responsibilities of child protection. Similarly, in Finland, a national guideline for identifying and intervening in child maltreatment within the family have been developed for clinical nurses (Paavilainen & Flinck 2012). This came about as a result of work that clearly demonstrated that doctors and paediatric nurses had a lack of adequate basic education training in child abuse identification (Paavilainen et al. 2002). The Finnish national guideline aims to assist nurses in the knowledge of risks factors, signs of maltreatment, early intervention and identification of referral pathways including legislative requirement and documentation. Particular discussion topics are identified so the nurses can develop skills around questioning the problem areas, risks factors and when family issues are identified. The guideline is for use in undergraduate teaching and whilst the guideline is written for nurses, the authors acknowledge it may be relevant for other professionals (Paavilainen & Flinck 2012).

Nurturing and Protecting Children: A Public Health Approach (Leap, Flowler & Homer 2010) is a teaching and learning resource that was developed and funded by the Australian Centre for Child Protection to support the Nursing and Midwifery Education curriculum standards. There are ten modules including accompanying DVDs to assist educators within specific subjects and curriculum development in midwifery and nursing programs (Leap, Flowler & Homer 2010). The package provides reflective activities, trigger questions and DVDs using research and clinical experiences of practitioners and is an example of a quality resource for educators and organisations. The approach aims to address some of the complexities of understanding the processes and emotional impact of child protection. The first module has a small section relating to 'when a baby or child is placed in care' allowing students to reflect on their involvement and feelings of being involved in a removal of an infant or child from their

parents. This public health approach provides essential knowledge and skill development around prevention, early intervention and response in child protection across all subjects to build capacity in child and adult services to ensure sensitivity of child-parent relationship and to understand protective factors with the aim to prevent child abuse and neglect (Scott 2009).

It is clear from the findings of this study that all education and training related to child protection must not only address the legal procedures required, but also the emotional impact of being involved in these complex and emotionally charged situations. In both the Finnish, (Paavilainen & Flinck 2012) and Australian (Briggs et al. 2010) standards there is recognition and promotion of the inclusion of appropriate provision of support for the students and the educators to manage any distress. The complex emotional responses of the midwives in the study who felt unprepared and unsupported in the clinical setting highlight that education must include knowledge of pathways for support and outline that clinicians can expect to experience a level of emotional turmoil when confronted with child protection issues and assumption of care of a newborn. Both in the education and clinical setting, fears and emotional responses need to be acknowledged as the 'normal' response of being involved in child protection (Rowse 2009).

The study has identified several implications to improve practice for midwives, and working with Community Services to improve outcomes for vulnerable women, newborns and their families. This is a small qualitative study, therefore any outcomes of the study must be considered in light of the following limitations.

Limitations and challenges of this study

The results of this study describe the process and impact on midwives of working with an assumption of care of a newborn at birth, in NSW. Due to the specific nature of the study there are several limitations to consider. The study interviewed ten midwives in NSW who had various roles and levels of experience in assumption of care, recruited via purposive and snowball sampling. The study focussed on Sydney metropolitan area however, two midwives discussed their experiences in rural communities. These midwives highlighted some issues and experiences faced by midwives in rural and remote communities in Australia that vary from a metropolitan city and would require further investigation. For example, in small country towns, the midwives are part of the local community and it can become common knowledge when they are involved in an assumption of care especially in a management role. Six of the midwives held senior clinical midwifery consultant roles often with a focus on caring for

vulnerable women and two held management positions. Consideration could be given to further explore how these leadership roles support and provide ongoing education for midwives at the local health district level. The perspectives of less experienced midwives, and the how the model of care or area within a maternity unit where these midwives work needs exploration in relation to these findings.

The midwives explained how the baby is often sent to the nursery within the hospital before or after the assumption of care. The nursery was seen as a secure area to protect and keep the baby until discharged into relative, kinship or foster care. If the family was unable to visit due to the court orders from Community Services, the midwives became carers of a newborn without parental access. This is an area for additional study as the limited discussion of the experiences of the midwives in the nursery indicated there were different challenges for staff working in this area. The neonatal nurseries in NSW hospitals may also be staffed by nurses who do not have midwifery qualifications and these nurses' experiences should also be investigated.

Legislation in each state and territory also varies, meaning the processes and legal requirements for midwives and other health professions differ. International laws also have different levels of determining risk of significant harm for newborns and children, prevention and support systems, ideologies and cultural concerns related to child protection, that will be different from the process and communication systems outlined in the results (Kojan & Lonne 2012). Larger studies across different states and territories could produce helpful information for practices within a broader Australian context. It would be helpful for data systems to be developed to accurately collect information in relation to number of newborns removed at birth and the longer term outcomes for these children. At local, state and national level this data should be transparent and available to influence practice and policy.

Due to the limited size and timeframe of this study, it was beyond the scope of this study to discuss the removal of children from Australian Indigenous families, Aboriginal and Torres Strait Islanders, 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). Some of the midwives discussed their role in the removal of Aboriginal babies and working with families. These stories and issues have been sensitively woven into the results to maintain confidentiality. Further work in this area would be significant as legislation in each state and territory has specific laws related to the removal and placement of Indigenous children.

Alternative options to assumption of care were not investigated or evaluated within the thesis. Some limited models of care including residential facility offering supervised support for women and newborn are available in NSW. These include young mums and drug rehabilitation placement which Community Services sometimes negotiate short or long term placements as options with women instead of removal of their newborns at birth. Further study could explore alternative models of care offered within Australia or internationally and measure outcomes of these children in comparison to those removed to OOHC.

Some of the midwives had experiences of working with women in prison who gave birth in their care and briefly referred to this situation. The issue of assumption of care of newborns differs for this group of women depending on the facility they are incarcerated in, the crime they had committed and the length of their sentence. For ethical reasons these stories have not been included to maintain confidentiality and prevent identification of the hospital or area health service that may be involved. As women from prison do give birth in public hospitals in NSW, at times requiring an assumption of care, this is an area for further study about how midwives engage and care for this group of women with special needs and their newborns.

The perspective and the responses of the women, and at times their partners, family and support people in this study are only reported through the midwives experiences and viewpoint. Some studies have reported parents' experiences of being involved in child protection (Buckley, Carr & Whelan 2011; Dale 2004; Davies 2011) but further study could involve the woman's perspective of removals of newborns and Community Services involvement in pregnancy.

The experiences of hospital social workers and Community Service workers were discussed by the midwives from their standpoint. Both the social worker and the Community Service workers have a major role in the removal of a newborn and examining their views could add further to understanding this issue (Wickham 2009).

My own professional experience as a midwife with assumption of care could be considered a limitation of the study as my knowledge and personal experiences cannot be excluded from the interpretation of the data. The advantage of this knowledge and experience however meant I had an understanding of the involvement in assumptions of care as a midwife during the telling of their stories in the interviews, allowing for a sensitivity to ensure the findings represented their collective experiences. This issue has been addressed in the method chapter.

The challenge of studying midwives' experiences of assumption of care of a newborn at birth or the early postnatal period is that unless a midwife had been directly involved in an assumption of care, very few midwives and even less of other professions like nurses and other academics, knew what is meant by the term 'an assumption of care' or what that means in practice. This fact was highlighted throughout my candidature of this Masters (Honours) research project. Continually, through my candidature I would be asked to explain what an assumption of care of a newborn was, if it really did occur, was it very frequent and the reasons why it would be necessary. This again highlighted a lack of understanding of this topic.

My research has resonances with others however, who have been involved in experiences of assumption of care. I have had the privilege to present the progress and findings of my work to several maternity and midwifery conferences during my candidature. The feedback from these presentations from midwives was the themes developed from the data and the discussion of issues about assumption of care of a newborn for midwives was extremely positive and correlated to their experiences (Appendix 1). Knowing the findings from my research have been and will hopefully be of benefit to midwives in their practice has strengthened my commitment to ensure this research topic is explored and reported effectively and professionally.

Conclusion

This study used a qualitative explorative approach to explore 10 midwives experiences of assumption of care of newborns at birth or in the early postnatal period in maternity units in NSW, Australia. The findings indicate that caring for a woman whose unborn is at risk of removal and being involvement in the removal of a baby from their mother after birth is an extremely challenging area of practice for midwives. The experience is one that midwives commonly described as distressing and not easily forgotten. To make sense of the complexity of this experience, the processes involved and the emotional impact were described separately and represented under the overarching themes of the head and heart space. However, each element continually interacts as the midwife attempts to be with the woman and ensure the ultimate safety of the unborn and then newborn.

Whilst the study set out to explore the midwives actual involvement in an assumption of care at birth, their involvement often began in early pregnancy with identifying and reporting risk factors for the unborn. Learning to work with the woman and Community Services was often a perplexing part of the midwives' role as they tried to maintain a woman centred philosophy to

care and yet were required to prioritise the needs of the unborn/newborn separately to their mother. The more the midwives learned the processes of working with Community Services, the greater their ability to advocate and support the woman during pregnancy, and work towards assisting them prevent an assumption of care from taking place.

By describing the actual assumption of care processes, the midwives explored the practices that they had been involved in and were able to explain the practical and challenging aspects for the woman and the midwives. These included a range of steps such as knowing the time frames, creating safe places, knowledge of the legal requirements of serving the papers, to involvement in the actual removal of a newborn and the additional requirements of the need for security and sometimes police to provide protection for everyone involved. For midwives who have not been involved previously, knowledge of these processes through incorporation in formal and informal education and policies may be helpful to prepare them for this part of their involvement.

However, making sense of the woman's responses and reactions and the emotional work that comes with being with a woman during an assumption of care is the most difficult aspect for midwives to navigate. Overwhelmingly, the midwives felt it was hard and sad for them to be involved, even in those circumstances where the removal of the newborn was considered in the best interest of the newborn. This study has clearly identified that the extent of the emotional labour midwives needed to engage in must be recognised and incorporated into education. In addition, the availability of formal support mechanisms are a priority. Maternity units must provide avenues through which midwives can reflect on their experiences and be supported to unpack the emotional impact of their assumption of care experiences.

These findings fill a gap in the literature about how midwives experience an assumption of care of a newborn. Midwives play a unique role in terms of child protection. They have responsibility for working with women across pregnancy. By the very nature of their work, they also have responsibility for supporting the woman to grow a healthy baby and prepare for birth and the transition to motherhood. In essence to protect an unborn baby at risk means working in a positive way with the women ensuring she remains engaged with services and able to access appropriate resources. The challenges these dual and sometimes conflicting responsibilities have for midwives has been highlighted in this study, as too has the emotional impact of working with women after birth. The findings also have implications for other health professionals involved in assumption of care, such as the social workers and the Community Services child protection workers. It is extremely important that all key stakeholders and

agencies work together in an effective way to ensure those most vulnerable in our community, newborns infants, are given the highest priority and opportunity to grow and develop with all the appropriate supports available.

Appendices

Appendix 1 - List of conference presentations

Everitt, L. (December, 2009) Addressing the challenges of assumption of care of newborns for midwives. Research Student Symposium (RSS) UTS (Oral 20 minute presentation).

Everitt, L & Homer, C. (October, 2009) Addressing the challenges of non-voluntary relinquishment of newborns for midwives. Australian College of Midwives 16th National Conference Midwives & Women: A brilliant Blend. Adelaide. South Australia. (Oral 20 minute presentation-concurrent sessions).

Everitt, L (2009-2010) Australian College of Midwives Nominated Representative Advisory Committee:-Professionals Protecting Children: Child Protection and Nursing and Midwifery Curriculum Standards development.

Everitt, L. (September, 2010). Too many ports in the storm: Providing protection for vulnerable women Australian College Midwives–NSW Branch Inc. Annual State Conference, 'Midwifery: Providing a safe harbour' Kiama, NSW. (Oral 20 minute presentation-entire conference).

Everitt, L & Rojas, J. (October, 2011) Management of breastfeeding issues in women with social issues St George / Sutherland Hospitals& Health Services (SGSHHS) Breastfeeding Seminar Kogarah, NSW Invited Speaker (Oral 45 minute presentation entire conference).

Everitt, L,. Homer, C. & Fenwick, J. (May, 2012). Midwives Experience of Working with Community Services during Assumption of Care of Newborns Breathing New Life into Maternity Care: Working together: balancing risk in maternity care. Melbourne, Victoria. (Oral 20 minute presentation-concurrent sessions).

Everitt, L. (September, 2012). Assumption of Care. St George / Sutherland Hospitals & Health Services (SGSHHS) Annual Midwifery Seminar Working Together, Kogarah, NSW. Invited Speaker (Oral 45 minute presentation-entire conference).

Everitt, L,. Lock, K,. Fenwick, J & Homer, C. (September, 2012). Breastfeeding and assumption of care of newborns. The Inaugural Lactation Consultants of Australia and New Zealand (LCANZ) Conference Sydney (Oral 20 minute presentation-concurrent sessions).

Everitt, L. (September, 2012). Learning to play the hard course: Midwives role in assumption of care of newborns. Australian College Midwives – NSW Branch Inc. Annual State Conference, Playing the Course: A Round in Midwifery. Wyong, NSW. (Oral 20 minute presentation-entire conference).

Everitt, L. (November, 2012). Research with a clinical focus: Assumption of care of newborns St George Hospital Social worker professional development sessions. Kogarah, NSW. Invited speaker (1 hour presentation and discussion).

Everitt, L. (December, 2012). The head and heart space of midwives experience of assumption of care of newborns at birth. Research Student Symposium (RSS), UTS, Final presentation. (Oral 30 minute presentation).

Everitt, L,. Homer, C. & Fenwick, J. (October, 2013) Assumption of Care of a Newborn: How can you be prepared? Australian College of Midwives, 18th National Conference: Life, Art and Science in Midwifery. Hobart-Abstract acceptance (Oral 20 minute presentation-concurrent sessions).

Everitt, L. (2013) Research Matters: Assumption of care of newborns in maternity units. Published article Midwifery Matters Newsletter of the Australian College of Midwives-NSW Branch Incorporated Vol.31 No.2 June, p.10-11.

Everitt, L. (2013) Collaboration Matters: Working with 'chaotic' complex women: A case study. Published article Midwifery Matters Newsletter of the Australian College of Midwives-NSW Branch Incorporated Vol.31 No.2 June,p.14-15.

Appendix 2 – Information sheet

Midwives experience of working with assumption of care of newborns
INFORMATION SHEET

Dear …….

My name is Louise Everitt and I am a research student at the University of Technology, Sydney.

I am researching the experience of midwives when assumption care of a newborn occurs at birth or in the early postnatal period due to risk of significant child protection issues. If you have been involved as a midwife in caring for families during this experience and I am interested in your views. The research would involve one face to face interview and should take no more than one hour of your time. All information will be confidential and your name and place of work will not be identified in any report or publication.

Sometimes talking about these experiences is upsetting for midwives. Assistance to explore and direct to resources for counselling support will be offered if required. These could include own GP, clinical psychologists or community mental health services. If the issue is related to workplace issues you may choose to contact your hospitals Employment Assistance Program (EAP).

If you are interested in participating, I would be glad if you would contact me by phone on or email at

Participation is voluntary and you are under no obligation to participate in this research and may withdraw at any time from the research project.
Yours sincerely,

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NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number 2010-223A. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 3 - Consent form

Midwives experience of working with assumption of care of newborns
CONSENT FORM

I _____ *(participant's name)* agree to participate in the research project Midwives experience of working with assumption of care of newborns after birth (UTS HREC REF NO. 2010-223A) being conducted by Louise Everitt, Centre Midwifery, Child and Family Health (CMCFH) UTS Broadway, Mobile [redacted] of the University of Technology, Sydney for her degree Master of Midwifery (Honours). .

I understand that the purpose of this study explores the experience of midwives when assumption of care of a newborn occurs at birth or in the early postnatal period due to risk of significant child protection issues.

I understand that my participation in this research will involve one face to face interview for approximately one hour. The interview will be conducted in a private room at a convenient location. I understand that sometimes talking about experiences of assumption of care of newborns in the interview process can be distressing to me. I have received information about support or counselling services should this be required.

I am aware that I can contact Louise Everitt or her supervisor(s) Professor Caroline Homer or Assoc Professor Jennifer Fenwick if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Louise Everitt has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant)

_____ ____/____/____
Signature (researcher or delegate)

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number 2010-223A. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

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