To: DCJ Child Protection Policy Team
Via email: childprotectionpolicy@dcj.nsw.gov.au
Date: 5/9/2024

Feedback from Family Inclusion Strategies in the Hunter Inc (FISH). Response to *Discussion Paper, Pre-natal Policy Review*, August 2024.

Thankyou for the opportunity to provide feedback to this discussion paper.

Family Inclusion Strategies in the Hunter (FISH) is a parent and family led community organisation based in the Hunter Valley of NSW. We are led and staffed by parents and family with lived experience of the child protection system. The parents at FISH have experienced child removal, restoration, out-of-home care and other child protection processes. We bring this lived experience expertise to our response to this submission and to all the work we do.

FISH was established in 2014 and formally incorporated in 2016. We are a registered charity and provide a range of peer parent and family support and advocacy services in our community including individual peer support and advocacy, support groups and workshops, workforce development, research and systems advocacy. We promote greater family inclusion in child protection processes and the lives of children in out-of-home care. We are a children's rights organisation, driven by the needs of children and their right to family, community, and culture.

Peer parent and family support and advocacy is crucial when mothers are pregnant and fear child removal. It will help parents to navigate the system, get needed help and ensure children stay at home. It will also help to ensure restoration occurs as the first priority. We have not responded to the discussion paper questions as such. Instead, we have written an overall response based on our proposed solutions.

For more information about FISH, please visit our website at www.finclusionh.org where you will also find this submission. To discuss this submission please contact Tammy Prince-Doyle, FISH President, or Jessica Cocks, FISH Secretary, at contact@finclusionh.org.

The prevalence and impact of prenatal reporting and information sharing.

Well over 2% of newborns in NSW are being reported and screened in by DCJ due to risk. The paper provides no information about how many pre-natal reports are made in total, only those reports that are screened in. These numbers are very high and are disproportionately affecting Aboriginal and Torres Strait Islander families.

Parents and family live in fear of reports to DCJ which are often made without their knowledge or are followed by long periods of uncertainty and fear while families await a response. There is no evidence that reports ensure families are helped. There is considerable evidence that they are solely used for decision making about whether to remove at birth. Pre-natal reporting drives distrust in the health care system and fear of DCJ. It is contributing to harm, including very high stress levels during pregnancy which is known to be harmful to mothers and their unborn children. In other words, prenatal reporting is not helpful.

Information sharing with DCJ during pregnancy needs to be kept to a minimum. See below for our comments on the role of health and other sectors in responding to prenatal concerns and ensuring mothers and babies in utero receive the care they need. If women live in fear of information being shared about them with DCJ or in a way that may lead to child removal at birth, this will continue to drive fear, high levels of stress and distrust in a system that surveills and does not support.

Pregnancy Family Conferencing.

FISH supports the improved availability of Pregnancy Family Conferencing and note that this was recommended in the Family is Culture report. Referral rates to this valuable service are unnecessarily reliant on DCJ and are too low. Access to Pregnancy Family Conferencing needs to be available for all families who fear DCJ involvement at birth and should not be dependent on DCJ referrals, assessments or on DCJ participation at all.

We need to decentre /decouple the role of DCJ in pre-natal service delivery, including safety planning.

The discussion paper asks for feedback about the nature of DCJ's potential role to provide supports and respond to reports at the pre-natal stage and at various possible points prenatally. Our view is quite simple: DCJ is not the right agency to provide prenatal supports or to act as a gateway to prenatal services.

Instead, families need to be offered culturally safe, accountable, and trustworthy services that will mandatorily support (not report) them. There is strong evidence that when women have access to safe and trustworthy prenatal care which helps them plan for safe parenthood, child removals are less likely. This has also been the experience of FISH parents. Sadly, many FISH parents and many of the parents we support have not experienced this.

This is not about improving practice at DCJ. We know there are DCJ caseworkers with the skills to build respectful relationships with families, at least some of the time. FISH parents have experienced this good practice at times, and we encourage the families we support to try and build positive relationships with DCJ caseworkers and managers. Regardless of how much practice improves, DCJ is not the right organisation to respond at the prenatal stage. There is an inherent conflict between relationship-based practices that will help families and the assessment, child removal and surveillance powers that are inherent to and inseparable from DCJ's role.

Instead, services in the community need to be resourced and skilled to respond to mothers in pregnancy and to ensure they get the information and care they need. This includes supporting families to know there might be a risk of removal at birth and exploring with them and their extended family networks how to build and plan for safety around mother and child. Services that need to be easily accessible and available (without the requirement for a DCJ controlled entry point or waiting lists) are:

- Peer parent and family advocacy (see elsewhere in this submission for more information).
- Legal services.
- Drug and alcohol services during pregnancy and following childbirth.
- Maternal health care services, modelled on services such as Nabu at Waminda and other Birthing on Country[1] services. These services have an evidence base in reducing newborn removals. They are mother/woman centred: imperative in a prenatal service.
- Safe and secure housing.

[1] Evidence has found that BOC services contribute to reduced child removals at birth.

- Family violence prevention services, using evidence-based approaches such as the Safe and Together approach – which does not blame mothers for the violence of other people.
- Family Finding and Family Group Conferencing (delivered and supported by non-statutory services with as much ownership and leadership by families themselves).
- Adequate income support.
- Pregnancy Family Conferencing.

If a newborn baby is removed, then early restoration must be the priority.

While we agree that the goal of the prenatal policy should be to keep mothers and babies safely together, the discussion paper does not currently emphasise restoration or provide appropriate policy direction if a child is removed.

The removal of a newborn from their mother is a profoundly sensitive and significant decision that requires a high level of care, with a primary focus on the wellbeing of both the mother and child – their interests cannot be separated. Children should not be removed without prior planning with pregnant mothers. Any removals that occur without informing the mother first should be extremely rare – the harm to mother and child of this action is profound. In the lived experience of FISH parents, mothers often do not know whether their baby will be removed and if they do find out, it is often late in the pregnancy and generally when they are told their child will not be removed. The stress and trauma this causes mothers (and their baby in utero) is well documented and dangerous.

Safety planning to prevent removal should be the first priority, followed by early restoration. This involves the identification of family members and safe and supportive services who can best support the relationship between the mother and her baby. As stated earlier, DCJ is not best placed to provide these services. Early attachment is critical during this period, as it forms the foundation for the child's emotional and psychological development. The opportunity for bonding, particularly through breastfeeding, should be preserved. This necessitates that the mother remains with or has very frequent time with her baby in a safe space, as the benefits of breastfeeding extend beyond nutrition, nurturing both physical and emotional connections and the healthy development of children.

It is widely acknowledged that the standardised practice of allowing only two-hour weekly or fortnightly visits is grossly inadequate for maintaining breastfeeding, for relationship development and is counterproductive to restoration. Such limited contact increases the risk of the mother's milk drying up and can lead to mastitis, a painful and potentially serious infection. Pumping milk merely to maintain supply without the immediate presence of the baby is psychologically distressing. This can severely impact the mother's mental health, particularly when experiencing the let-down reflex in response to the cries of other children, highlighting the deep emotional toll of separation and the damage done to children and mothers.

The lived experience of *Ruby, who was removed as a young baby and restored home after three and a half years, underscores the critical importance of maintaining and strengthening the mother-child bond during periods of separation. Through kinship placement and advocacy, unfortunately not initially supported by DCJ and only achieved through advocacy, time spent together was gradually increased in natural settings, allowing the mother to maintain her role as Ruby's primary carer. Today, Ruby does not see herself as a child who was removed, which has been pivotal to her thriving. This example illustrates why restoration should be pursued as swiftly as possible, and during periods of separation, the relationship between mother and child must be supported in the most seamless way possible, allowing the mother to address safety concerns, and get the help she needs, without further disrupting the attachment process.

*Names and identifying details have been changed.

While the primary focus at this stage of the child's life is typically on the attachment with the mother, it is also important to recognise and support the ongoing role of fathers and other family. The father's family should be included in the child's life; however, the mother and her baby's relationship must remain the priority during this critical period of early development. FISH endorses and supports the work done by Wright et al (2024)[2] and others which challenges the western understanding of attachment theory. We agree with Wright et al that this narrow view of attachment theory has done great harm to children and families.

Based on our lived experience, the removal of babies at birth is occurring unnecessarily in NSW. Removal of all children must be a last resort, only occurring after substantial investment in services and in the resolving of problems such as safe housing, poverty, state protection from family violence and timely access to drug and alcohol treatment. Our lived experience is backed up by research (such as the family is culture research and research into parent experiences) which has found that newborn removals occur too often and unnecessarily, restoration is not pursued and families rarely receive the safe support and help they need. Instead, the focus of the service system tends to be on surveillance.

The best interests of the mother = the best interests of the child.

FISH has always argued that the needs and interests of children cannot be seen in isolation from their families and that a whole of family focus is needed. This is well backed up by research as well as our lived experience. Children need their families in their lives and families are the best places to care for and nurture children. Families play an irreplaceable role throughout children's lives, including when children are living in out-of-home care. Family inclusion is essential. This is even more the case prenatally. While a child is in utero it is very clear that the best way to nurture and care for that child is to nurture and care for the mother.

A key principle of the child protection system is that the welfare of the child is paramount. At the prenatal stage we suggest that this key principle needs to be that the welfare of the mother and her child is paramount. By starting from this premise, we are more likely to design and provide services that will help children to thrive in utero and at birth.

Peer Parent and Family Advocacy: an essential ingredient in pre-natal services and in children's early years.

Advocacy is increasingly being called for in the sector, especially with First Nations families.[3] Advocacy, including peer advocacy, helps families interact positively with workers, challenges power imbalances, aids productive engagement with legal representation and helps families participate. Peer advocacy has an evidence base in prevention and restoration[4] and has been successfully implemented in Australia by FISH and our partners.[5] FISH now continues to independently deliver peer parent and family advocacy in the Hunter Valley, and there are other initiatives around Australia.

What is peer parent and family advocacy?

Peer advocates are parents and family members with lived experience of child protection intervention. They support and advocate for parents and family who are currently experiencing or fear this intervention. Peer advocates drive equitable and child and family

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[2] See article here: open access.

[3] Absec, 2020; Davis, 2019.

[4] For example, Chambers, et al., 2019; Sankaran, 2021; Gerber, et al., 2019

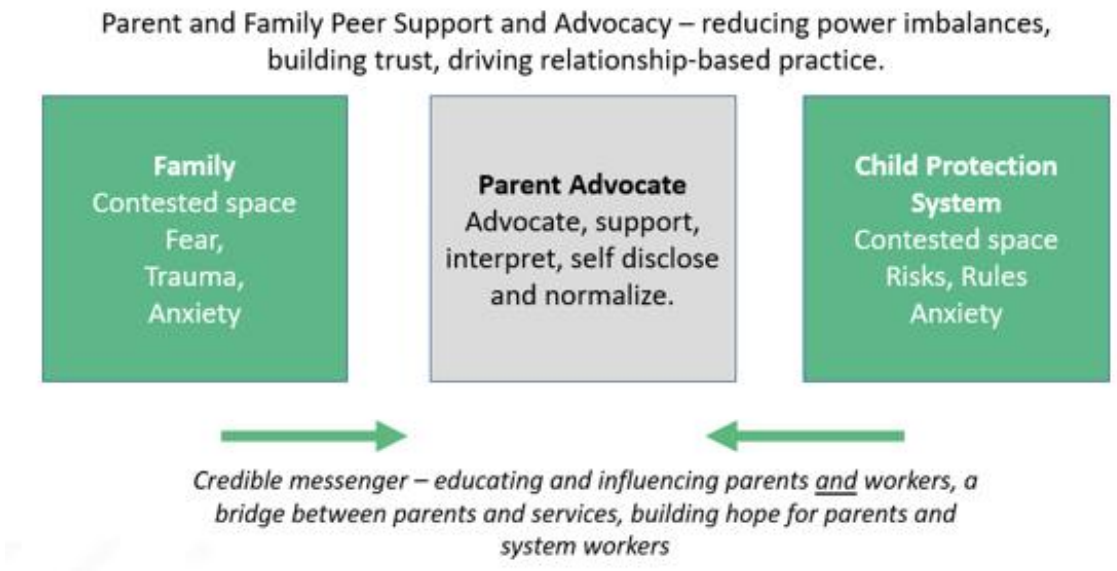
[5]. Our report, *From Little Things Big Things are Coming*…, describes implementation of the Parent Peer Support Project. It also provides a summary of other peer initiatives emerging around Australia. The report is available at our website at https://finclusionh.org/our-documents/

focused practice. Through role modelling and their lived experience, they become credible messengers to and for parents and family. They provide valuable insight to child protection workers in government and non-government settings, who rarely share the life experience of the families they work with.

Peer advocates have a unique understanding of the confusion, anger, grief, disorientation, and distress that parents experience. They can quickly connect with families and provide information, advocacy, and hope at critical times when families fear and distrust statutory services. For many families, their motivation to engage in services is driven by an urgent and understandable need to escape the gaze of statutory authorities. Timely and unconditional support from a peer advocate is crucial to help families process this fear and anxiety in a safe context where they are not being constantly assessed. It can enable families to think more clearly about their circumstances, set goals and move to plan collaboratively. Peer advocacy also challenges risk averse and negative thinking in staff, reducing fear and anxiety in staff and enabling better and more hopeful practice. This connection is depicted in Figure One, showing how peer advocates bring people together to collaborate in the interests of children.

Peer advocacy can be readily integrated into services working at the prenatal stage and with families with new babies. The *advocacy* role of peer advocacy is crucial, and this is required throughout all child protection processes including those being delivered outside of the statutory system as should be the case at the prenatal stage.

Figure One: Peer Parent and Family Advocacy: driving better relationships in prenatal child protection.



Integrating peer advocacy will:

- Provide hope and encouragement to families and staff. Peer advocates are living proof of the strength and capability of families. They challenge negative and one-dimensional discourses about families by their very existence.
- Advocate for case plans that are targeted to the problems families face. They challenge the sole focus on family change and call out the social conditions that also need to be addressed.
- Connect families to one another through group programs and peer networks.

*Names and identifying details have been changed.

- Actively improve relationships between child protection workers and families which is key to family preservation and restoration.
- Challenge the stigma and shame attached to child protection system involvement.
- Shift expenditure to where it is needed: prevention and restoration.

Peer advocacy emerged in the US where it has a strong evidence base. It is developing globally, including in Australia[6]. It is now being explored in a major research project led by the University of Queensland and funded by the Australian Research Council. FISH is a partner in this research. Peer advocacy occurs at individual, group, community, and systems levels. Peer advocacy at all levels is vital in a redesigned child protection system, including prenatally. A summary of how peer advocacy helps and where it is provided is in Table 1. Figure 2 provides a summary of our conceptualisation of how peer advocacy needs to exist in NSW. FISH is currently working at all these levels in NSW and stands ready to expand and support expansion throughout the state.

Table 1 – Examples of how peer advocacy helps and where it can happen.

Where in the system (examples)	Examples of how peer advocacy helps	Examples of the evidence base
Legal services	Improves instructions to lawyers, emotional support, ensures case plans are targeted to family needs, coaching, helps parents navigate the system, improves relationships with workers.	Restoration and prevention[7].
Integrated into health and birthing teams	Emotional support, ensures case plans are targeted to family needs, coaching, helps parents navigate the system, improves relationships with workers.	Restoration, family participation, relationships with workers, prevention.[8]
Group processes	Connection to other parents, access to information and education, coaching, emotional support.	Prevention, restoration, participation[9].
Family group Conferencing and other meeting processes	Emotional support, coaching, helps parents navigate the system, and improves quality of safety and case planning.	Participation and prevention[10].

FISH is currently providing individual and group advocacy in the Hunter Valley in the form of phone support, court support and our restoration workshops. Prenatal groups, developed and delivered by parents and family, with parents and family, hold enormous potential in NSW, and are urgently needed.

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[6] Cocks J, (2020). "Peer Parent and Family Advocacy in Child Protection: a pathway to better outcomes for kids" in Yarnold, J., Hussey, K., Guster, K. & Davey, A. (Eds). *Policy Futures, A Reform Agenda, University of Queensland, and Winston Churchill Memorial Trust*; Tobis, D., Bilson, A. & Katugampala, I. (2020). *International review of parent advocacy in child welfare: Strengthening children's care and protection through parent participation*. Better Care Network and International Parent Advocacy Network.

[7] Gerber, L., Pang, Y., Ross, T., Guggenheim, M., Pecora, P. & Miller, J. (2019). Effects of an interdisciplinary approach to parental representation in child welfare. *Children and Youth Services Review, 102*, 42 – 55. University of Michigan (2013) *Detroit Center for Family Advocacy Pilot Evaluation Report: 7/2009-6/2012*, University of Michigan Law School

[8] Chambers J M, Lint S, Thompson MG, Carlson MW and Graef MI (2019) 'Outcomes of the Iowa parent partner program evaluation: Stability of reunification and re-entry into foster care', *Children and Youth Services Review,* 104.

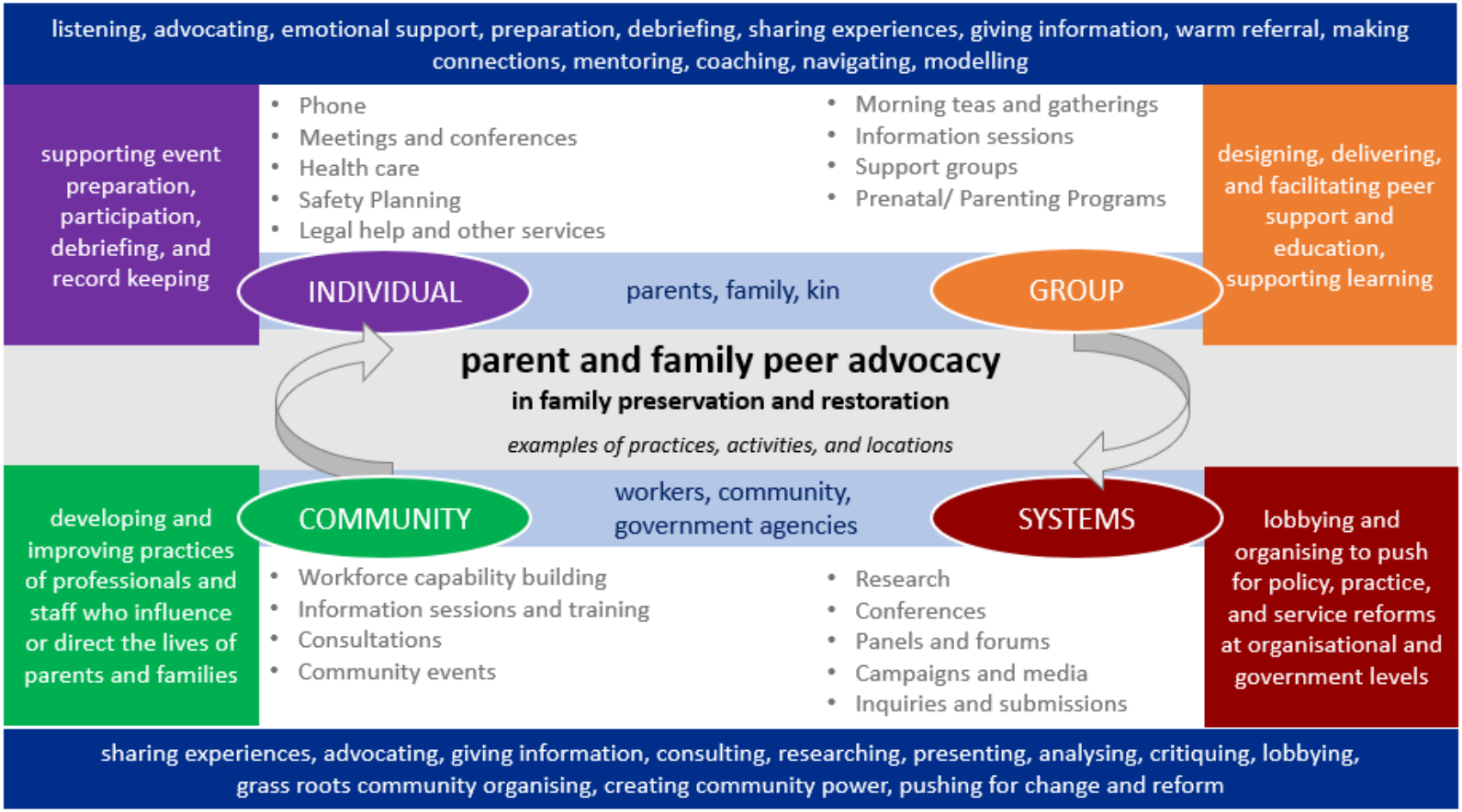
[9] Polinsky ML, Pion-Berlin L, Williams S, Long T and Wolf AM (2010) 'Preventing child abuse and neglect: a national evaluation of parents anonymous groups', *Child Welfare,* 89(6):43–62.

[10] Lalayants M, Wyka K and Saitadze I (2021) 'Outcomes of the parent advocacy initiative in child safety conferences: placement and repeat maltreatment', *Children and Youth Services Review,* 130:106241, doi: 10.1016/j.childyouth.2021.106241

She's a mum, just like myself, she has experienced some of the same life experiences I have. She made me feel very comfortable and very supported, in the sense that she has been there and done that, and experienced the same things that I was going through at that time... So, she's been absolutely fantastic, just letting me know I don't have to go through this stuff alone and that I do have support from other mums who are going through what I'm going through. Parent user of FISH.

Peer advocacy properly implemented is there for families and does not play a role in surveillance, assessment or evidence gathering. Peer advocacy creates a safe space for families to navigate complicated and power laden relationships and overcome fear and distrust.

Figure 2 – our conceptualisation of how peer advocacy can play a role family preservation prenatally and in early restoration.[11]



[11] This diagram was developed in partnership with Lou Johnston on behalf of Family Inclusion Strategies in the Hunter and has been adapted for this submission. It is © Family Inclusion Strategies in the Hunter Inc and can only be reproduced with permission.

Legal services are evidence based and will drive prevention and restoration.

When legal services are combined with peer advocacy as part of a multi-disciplinary team the benefits are huge. Legal services combined with peer advocacy address the underlying causes of child removal and it is time to learn from the evidence and integrate them systematically including prenatally. FISH is well placed to drive the development of multi-disciplinary legal services in NSW in partnership with legal services. We have already partnered with legal services providers and currently partner with the NSW Children's Court in the delivery of court support.

FISH is strongly supportive of early legal advice as part of prevention and prenatal care including the early intervention legal advice service currently in place at NSW Legal Aid. This service needs to be expanded and combined with peer support and advocacy.

Addressing underlying causes.

The discussion paper refers consistently to the need for mothers, parents, and families to make and demonstrate change. While there is frequently a need for families to make changes for children to be safe there are almost always a range of social, ecological, and structural issues that need changing. The prenatal policy needs to name these issues and ensure that the responsibility for resolving them sits with the service system, not solely with families. These issues are well documented and include:

- Inadequate social and legal responses to gendered violence.
- A lack of culturally safe and appropriate services.
- Housing.
- Poverty.
- Inadequate mental health and AOD services including waiting lists.
- Transport.
- Inadequate services, especially in rural and remote areas.

Families have the solutions and need to lead redesign.

In this submission we have proposed new and innovative approaches at the prenatal stage, such as peer parent and family advocacy and multi-disciplinary legal services to keep families together AND to ensure timely and safe restoration. FISH calls on DCJ to partner with us and others with lived experience, to redesign responses to pregnant women when there are prenatal concerns for the unborn child.

Once again, we thankyou for the opportunity to provide feedback and for the extension in time allowed for us.