Queensland Child Protection Submission of Enquiry 2012

Mookai Rosie Bi-Bayan's Submission

Mookai-Rosie Bi-Bayan

Mookai Rosie Bi-Bayan is an Aboriginal community controlled organisation that specialises in Maternal Health Care for Aboriginal and Torres Strait Islander women and children and from Cape York communities in Far North Queensland.

Since Rosie's earlier inception in 1983, Mookai Rosie Bi-Bayan has worked hard to provide a culturally sensitive service that helps to improve the health status and well-being of Aboriginal and Torres Strait Islander people, particularly that of women and children.

As there are no birthing facilities in remote Cape York and Western Queensland pregnant women must come to Cairns approximately four to six weeks before the birth of their baby. Mookai Rosie Bi-Bayan is in a unique position to have a major and critical influence on the health of Aboriginal and Torres Strait Islander people.

Initially starting as an accommodation service, Mookai Rosie Bi-Bayan (MRBB) has grown and evolved over 30 years in response to the needs of Cape York Aboriginal & Torres Strait Islander women and children.

MRBB's Aboriginal & Torres Strait Islander women and children's health care model is based on a holistic health approach to provide quality culturally sensitive health, social support, and accommodation services. The organisation works in close partnership with Queensland Health Cape York District Health Service, Apunipima, Royal Flying Doctor Service and other service providers to ensure the best possible services are provided to clients in the areas of:

- Antenatal, perinatal/birthing and postnatal services
- General health monitoring and support
- Chronic disease and oncology support
- Child development support and care
- Health education
- Social & emotional wellbeing

The model is grounded in a client centred approach that builds on client strengths and capabilities to improve their health and parenting knowledge as well as promoting self-care and social and emotional wellbeing. Service provision is based on health education and a commitment to empowering women to learn about nutrition, reproductive health, pre and postnatal care, emotional wellbeing, parenting skills, child development and stimulating play.

Indigenous Children and the Queensland Child Protection System

The data available on the Department for Communities' website indicates that in Queensland there is:

- A growing over-representation of Indigenous children in the child protection system. The number of Indigenous children subject to notifications grew from 2,965 in 2005/2006 to 4,832 in 2009/2010 whilst the number of non-Indigenous children subject to notification declined from 22,722 to 14,804 over the same period.
- Within the increasing rates of Indigenous children subject to notification the largest proportion are children in the 0-4 years of age category.
- Increasing numbers of indigenous children in out-of-home care: From 1,577 to 2,686 over 5 years to 2009/2010.

- A declining proportion of children in out-of-home care placed with kinship, indigenous carers or indigenous residential services: down from 64.1% in 2006 to 53.8% in 2010.

When considered by region, the highest percentage of Indigenous children in out-of-homecare are located in Far North Queensland, the catchment area from which Mookai Rosie draws its existing clients.

In response to the increased need of Mookai Rosie clients requiring support and advocacy in communicating with and working with Child Safety Services (CSS), a specialist social and emotional wellbeing (SEWB) case management role was developed in 2011. The SEWB Case Worker provides client support and case plan coordination to mothers and newborns affiliated with CSS. This has led to successful outcomes for some mothers and their children as we have worked in partnerships to support the reunification process with CSS and other service providers.

A Memorandum of Understanding (MOU) between Mookai Rosie Bi-Bayan and Department of Communities – Child Safety Services is in the final stages of development. The MOU records processes that MRBB and CSS have agreed to follow when delivering services to mutual clients. These processes seek to preserve the integrity of each agency while clarifying agency role, responsibility and expectation of each other.

Identified Issues with Queensland Child Protection Services.

1) Changes in legislation specifically relating to 'unborn children':

The Queensland Child Protection and Other Acts Amendment Bill 2010 section 21A states:

- (3) If the child is an Aboriginal or Torres Strait Islander child, the chief executive or an authorised officer must consult with a recognised entity for the child for the purpose of -
  - (a) assessing the likelihood that the child may be in need of protection after he or she is born; and
  - (b) offering help and support to the pregnant woman.
- (4) However, subsection (3) applies only if the pregnant woman agrees to the consultation taking place.

In practise, what MRBB observes with ante and post-natal clients are the following issues:

- Child Safety not notifying mothers about an unborn child alert until the child is born. Sometimes the first a mother knows about it is when Child Safety Officers (CSOs) come to the hospital after birth – sometimes in the first 24 hours after birth. CSS department staff have told MRBB staff this practise occurs because of concerns that the mothers might run away with the baby if they know in advance.

  Example: Refer to Case Study #4

- CSO are conducting visits in the first few days after birth without arranging for consent for a Recognised Entity (RE) to be present or allowing for the client's legal representation to be there. Mothers have just gone through labour are medically recovering from labour, exhausted and hormonal and CSOs turn up without allowing the mother an opportunity to have someone present or legal representation. It is an incredibly distressing and disempowering process for the mothers.
  - MRBB has been informed by an RE that they are not able to be informed until the child is born unless the parents gives permission prior. If a CSO does not invite the RE to that initial meeting then usually they are excluded. This practise in Cairns varies among the district offices with some having a good reputation for inviting REs (i.e. Atherton) and others not (i.e. Cape North & Cape South Cairns).

- Sometimes also if an RE is present, both the RE and CSO fail to inform the mother of their right to legal representation.

It seems the client's right to fair representation and support is being compromised due to a lack of the CSO being pro-active in seeking the consent or being clear with the parents what the process will mean and supporting them to make arrangements for the RE and/or legal representative to participate in the process.

Please refer to case study examples #2 and #3 in Appendix for actual client experiences in relation to these issues.

- Unless clients tell us they are involved with CSS we don't know until after the birth. MRBB clients are referred by Queensland Health (community health clinics or Cairns Base Hospital). The only time CSS refers is after the baby is born. The option of residing at MRBB with their newborn for up to 3 months is sometimes presented as an option to the mother by CSS as an alternative to removing the child. There are set programs the mother must engage with according to the care plan that is developed, that usually entails engaging in counselling and parenting programs whilst at MRBB.

  It needs to be considered that this is while they are coping with the demands of caring for a newborn, are physically recovering from labour, sleep deprived, hormonal and often suffering from medical conditions such as gestational diabetes. They are also naturally keen to go home and introduce the newest family member to their father, siblings and kinship network. The majority of our clients are from remote communities and in Cairns without their partner. Unless it's their 1st child (an escort is provided under the Patient Travel Scheme), their partners are not here to provide input to the CSS process, share parental responsibility and provide emotional support. Given the considerable amount of time they are away from their other children and families, mothers are often stressed and worried their children's care and wellbeing at home in community. It's clearly not the best time for CSS assessment and investigation and resultant implementation of therapeutic intervention and education. The expectations that are placed on them at this time can be very stressful and overwhelming.

  Example: Refer to Case Study #1 in Appendix

- Usually, at least 1 contact is made with the mother prior to birth. This may be early on in the pregnancy, usually with the main objective of alerting the parents to the fact there will be an unborn child alert and further investigation soon after the birth. There are lots of variables and inconsistencies to the service provision by CSS at this point, seemingly dependent on whether or not the parent has children in care and has an allocated CSO or not and what support plans (if any) are put in place to work with the mothers/family on the concerns raised by CSS.

  Example: Refer to Case Study #1 in Appendix

2) Contact visits

- A common complaint from many clients staying at MRBB with children in the care of Child Safety Services is about the frequency of contact visits to see their other children that are in the care of the State residing in or around Cairns. There are mothers coming from remote communities where they have little or no contact with their children in care and when they get here and request contact visits they often aren't arranged. Clients report frequently about the multiple requests they have to make to the CSO to see their children before these get actioned and the frequent

cancellations of planned contact visits on the day or prior to it because of logistical factors such as no care workers available to supervise or transport available.

Frequency of contact visits between children in care and their parents depends on the care plan developed by CSS. As such, families closer to reunification receive more frequent contact visits than those families with children on long term orders. Therefore it comes back to the capacity of the CSO to organise these or not and so it is concerning there it is left to CSS discretion and there is no legislative policy to maintain a minimum number of contact visits for parents to spend time with their children in care.

3) Lack of communication to notifiers of complaints

- Rarely do we hear back from CSS about a notification made.
- A CSS Regional Intake Services (RIS) worker informed an MRBB staff member who requested information about follow up on a notification that this was not a required service by CSS. This occurred in March 2011.

4) CSS conduct at interview and family meetings

- Not informing parents of their rights for representation at meeting by REs, legal representation and support people.
- Often there is no RE present at meetings other than Family Group Meetings. In these cases MRBB's SEWB Case Worker essentially performs this role providing cultural advice, interpreting and explaining departmental processes and advocating to uphold clients' rights in the process.
- CSO informing attendees that the CSOs can decide who is allowed to be present as support people, rather than the parent and sometimes dictating the limits of the support role not consistent with legislation and policy around the role of support persons.
- Poor communication processes for care team meetings – dialogue with the parent is often launched into by the CSO according to their agenda before everyone in the room is even introduced, explained their role and the reason for the meeting is explained.
- Culturally inappropriate communication, including RE presentation by tele-link.

Examples: Refer to Case Studies #1 and #2 provided in Appendix

5) High Staff Turnover

- The CSOs involved with clients constantly changes affecting the relationships built up with the family and also with other service providers.

6) Inconsistent interaction, collaboration and communication among district CSS offices with MRBB and other service providers.

Refer to examples in all of the Case Studies provided in the Appendix.

Identified Strengths

- MRBB recognises that some Child Safety Officers work from a strengths perspective and are good communicators. MRBB has written letters of compliments in the past to the regional director about CSOs that have demonstrated good practises of openness, transparency and communicated well with us to work collaboratively on client's issues, needs and goals.

- MRBB is developing an MOU with Department of Communities - CSS to formalise collaboration between providers and improve communication and shared services between agencies, whilst also formally recognising our service as a safe environment providing a holistic service for health and wellbeing including parenting and counselling programs.

Recommendations for Change

- The current practise of visiting mothers after birth without assisting in ensuring RE or legal representation and support are also present, ceases and is replaced with respectful adherence to legislation and the rights of the individual.
- CSS responds to notification reports and communicates with the notifier (whilst maintaining confidentiality).
- CSS improves collaboration and inclusion of other service providers.
- CSS improves cultural competency and communication with Aboriginal and Torres Strait Islander clients.
- Parent's regular contact visits with their children are maintained and prioritised in the case management duties of a CSO.
- CSS staff poor retention rates are examined and addressed.
- Greater emphasis on family strengths are incorporated into the assessment and intervention processes by CSOs.
- CSOs consistently remind all parents of their right to legal representation in all situations.
- CSOs take steps to ensure the provision of support services to pregnant mothers as early as possible in their pregnancy. For example, unborn alerts could be accompanied by referrals to local agencies who can then work with the mother to improve her capacity to care for her baby before it is born. *Please refer to the section below on Earlier Intervention and Prevention.*
- MRBB's SEWB Case Worker position is utilised as a Recognised Entity position.

Early Intervention and Prevention

- Earlier intervention is required by CSS in cases of planned investigation into unborn children alerts to assess the family situation and develop a case plan to work with the family on any concerns if it is deemed intervention is required. The time during pregnancy could be used effectively to provide support services to the parents, working holistically with family and whole kinship network in the context of the home environment and community.

From our agency's perspective, women are usually flown in 4-6 weeks prior to birth and this time could be utilised building upon the community based interventions they have been involved with to engage in further counselling and parenting programs. For this to be effective however it requires early intervention by CSS and referrals from CSOs to notify there is unborn child alert and arrange some collaborative through care. The earlier we know a client has CSS involvement the better and we could more appropriately target supports if we are building upon early intervention programs based in community prior to their arrival.

Any parent that has been involved with CSS will flag as unborn child alert as well as pregnant women new to CSS being investigated. As such, in some cases parents have not had any involvement with the CSS for many years and the primary issues of concern have been addressed – i.e. been abstinent from drinking long term or have left the violent relationship.

In these cases, early intervention and assessment prior to the birth of the baby would remove the fear, stress and indignity of being investigated from the birth of the child and the mother is free to enjoy this special bonding time with her baby and family.

MRBB's Proposal for an Intervention and Reunification Centre

Clients referred by Child Safety Services often have complex issues and special needs and require a range of supports over a reasonable length of time to address issues, change behaviours and adopt new parenting practises.

To adequately respond to these clients and address the issues, MRBB has developed a proposal for a separate facility which can provide the confidentiality, care, safety and support required to intervene in children being removed from the region and most importantly a place where a reunification program can be implemented.

The proposal seeks to develop and deliver a service that will decrease the number of children removed from their mother's care at birth, and support reunification of those Indigenous children, who are in statutory care, with their families.

This program will be an extension of MRBB's current service which provides pre and post natal care and support to women from Cape York communities. Within the current MRBB service it is inappropriate for women under investigation by Child Safety Services to reside in the same premises as those attending MRBB to receive health and wellbeing care before and after the birth of their baby. The current MRBB is a safe place for community women that cannot be compromised by Child Safety interventions.

Therefore a new premise is proposed to provide intensive support to mothers who have children removed or are at risk of removal by Child Safety Services. The length of time women stay at MRBB premises will depend on assessment at point of intake by MRBB staff, Child Safety Services and the women themselves. Women will be encouraged to actively participate in making decisions affecting their stay and involved in programs to take steps towards improved parenting. In supporting the reunification process MRBB recognises the child protection statutory framework which guides the work of Child Safety Services.

PROPOSED ACTIVITY

Facilitate a residential, capacity-building program to address the over-representation of Indigenous children in care by preventing child removal, including child removal at birth, and increasing rates of child and family reunification through early intervention and prevention activities.

AIM OF ACTIVITIES

Proposed activities will build parental capacity to:

- Prevent child removal, in particular child removal at birth.
- Maximise opportunities for children to remain in the care of their parents, where possible, or with Indigenous families in line with the Aboriginal Child Placement Principle.
- Enable reunification.

DESCRIPTION

The proposed service will deliver intensive programs and support Cape York mothers build their capacity to provide for the protective needs of their children.

Mothers will participate in intensive parenting program activities while also learning day-day skills related to health and nutrition (including cooking), budgeting and childhood development. Activities will focus on increasing self-confidence and esteem, and enhancing life skills to allow mother's to achieve competence and independence.

Many of the women eligible for this program will have been identified as having issues in their community relating to family and domestic violence, alcohol abuse, as well as social and emotional issues. Intensive support and activities will also be facilitated by skilled staff in addressing these concerns through counselling, education, participation in group sessions and referrals to other professional services for shared care.

Parenting intervention and prevention activities will be facilitated by trained Indigenous staff to ensure cultural safety and the implementation of appropriate support and education.

Activities to support the reunification of children with their families will focus on engaging families whilst their children are in statutory care and will work in close partnership with Child Safety Services in ensuring sustainable reunification is achieved.

MRBB is currently seeking funding support for further development and implementation of this project.