THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by - Emma Searle – 2013 Churchill Fellow

To study culturally competent ways of engaging pregnant Indigenous women with identified child protection issues within an urban hospital environment

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Signed:  
Dated: 17th July 2014
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Introduction

Working in Aboriginal health in Australia as a non-Aboriginal health practitioner involves confronting many difficult realities on a daily basis. These include the presence of significant social and emotional health inequalities within Aboriginal communities, the overrepresentation of Aboriginal families with child protection involvement, a national history that includes significant levels of trauma through the forced removal of children and occupation of Aboriginal lands, a shortage of Aboriginal health and welfare practitioners and the current dominance of non-Aboriginal frameworks for assessing wellbeing and responding to identified risk.

With the knowledge that Indigenous people all over the world face similar disadvantage as a result of colonisation I have possessed a long standing curiosity as to how non-Indigenous health practitioners in other Commonwealth nations effectively engage pregnant Indigenous women when those women are known to have child protection concerns and may be reluctant to have contact with maternal health services. The Winston Churchill Memorial Trust provided me with the opportunity to satisfy this curiosity and ‘ask the questions’ in order to find examples of innovative practice that could be applied in Australia.

Discussing the prevalence of child protection issues within the lives of urban Indigenous women requires an extremely high degree of sensitivity and interpersonal rapport. Meeting with practitioners and community members face to face is therefore ideal and for this reason the opportunity provided by my Churchill Fellowship to travel abroad and have direct conversations with both Indigenous and non-Indigenous practitioners in their work environment was absolutely invaluable.

The opportunity to engage in reflective discussion with professionals working in a similar field and hear about how things worked for them ‘on the frontline’ provided the chance to directly identify differences and similarities with Australian practice and service provision. Whilst it was alarming to learn about many similarities regarding disadvantage faced by Indigenous communities and shared systemic difficulties it was also encouraging to hear directly how services had addressed challenges similar to those faced in Australia and despite identifying many significant areas for improvement I was encouraged by the new insight into current practice in Australia that my fellowship provided.

Consequently, it must be noted that I did not undertake this Churchill Fellowship on behalf of or instead of an Aboriginal person but rather as a non-Aboriginal practitioner seeking to find ways myself and other non-Aboriginal health staff can better engage Aboriginal women in their maternity care and how we can respond to identified risk of harm issues in a way
that is culturally competent and sensitive to historical trauma. For this reason it is also important to acknowledge that I cannot speak on behalf of Indigenous people and that the observations detailed in my report are based on information and discussions interpreted through the lens of a white Australian female social worker.

My Churchill journey would have not at all possible without the support and guidance of many people.

Firstly, I would like to thank the Winston Churchill Trust and all those Australians who made a donation many years ago in honour of Winston Churchill for making my dream of speaking to peers internationally a reality. I hope this was the living memorial Winston had in mind!

I would like to acknowledge all the dedicated professionals I spoke to along the way. I am aware it’s not easy to squeeze in visitors amongst large client loads and work commitments (and even harder when you only find out they are coming that morning!) so am forever grateful for warm welcome and the time you took to share your thoughts as well as the further relevant reading many of you provided. Special thanks to Linda Haultain for her professional and personal guidance before and during my time in New Zealand that served as a springboard to further reflection on culturally competent social work practice. Hannah Frost also deserves a mention for her comprehensive assistance with co-ordinating visits in Auckland!

I would like to acknowledge the Indigenous practitioners, elders and community members I met during my travels. It was an immense honour and a privilege to spend time with them and I was extremely humbled and convicted that they took the time to share their invaluable wisdom, concerns and vision with me. In particular the welcome I received from Maori elders in Auckland enriched reflections on my project enormously and is something I will never forget.

I extend my thanks to the Royal Hospital for Women for allowing me to undertake such a large venture and the Malabar Midwives and RHW Social Work teams for their support and patience. In particular I need to thank Sheila Sim without whose persistent suggestion of applying for a Churchill Fellowship this project would ever have left the ground.

Huge thanks to family, friends and fellow fellows for making it all possible by means of your ongoing support, celebration and understanding through the joys and challenges of completing a Churchill Fellowship.

Lastly, I would like to acknowledge the Aboriginal women and families who share their lives and stories with us every week. My hope is that by the time your babies are nursing their grandchildren the recommendations of this report will seem unnecessary and the nation’s health and wellbeing statistics changed for the better.
Executive Summary

Statistically it is evident that within urban environments in Australia Aboriginal families are overrepresented with regards to families with child protection involvement and non-Aboriginal professionals are overrepresented with regards to the clinicians who make the decisions about the health, care and protection needs of Aboriginal families. This is a challenging reality which when combined with historical factors such as the forced removal of children by government agencies, can have a significant impact on the way Aboriginal women and families engage with maternal and infant health services. I therefore embarked on my Churchill Fellowship to discover how non-Indigenous practitioners in countries with a similar history of European occupation address these complex imbalances particularly in the context of working with Aboriginal women that may be reluctant to engage with health and welfare services due to the presence of child protection issues.

Highlights of my Churchill Fellowship included the opportunity to speak directly to compassionate, informed practitioners working ‘on the ground’ with vulnerable Indigenous women & families, seeing how programs operate when they have little or no government support, the opportunity to have honest conversations with Indigenous practitioners about the past and their vision for the future and observing services which holistically respond to urban pregnant Indigenous women’s needs, whether it was through addressing transgenerational trauma via strengthening ties with traditional culture or providing practical assistance in response to a woman’s most urgent priorities.

I learnt that to effectively engage pregnant Indigenous women with child protection issues urban health services must be able to holistically take into account a woman’s cultural, psychological and practical needs and do so in a way that recognises both her existing strengths and possible history of past trauma. My fellowship also provided new insights into what enables Indigenous and non-Indigenous staff to have difficult conversations with Indigenous women about identified risk of harm issues and what enhances working collaboratively with other agencies to respond risk of harm. I identified many differences and similarities with the current Australian healthcare context regarding the challenges of providing culturally competent care within a risk averse clinical environment where staff are predominantly non-Indigenous and a key highlight was witnessing bi-cultural practice in action in New Zealand.

I plan to disseminate the invaluable knowledge gained from my Fellowship at a state and federal level through Aboriginal Maternal & Infant Health networks and relevant Perinatal Mental Health conferences, and at a local level through Royal Hospital for Women staff education forums, inter agency forums and hospital Social Work professional development sessions. I also plan to expand on specific aspects of my Fellowship for publication in relevant journals.
Outline of visits undertaken 31st March - 2nd May 2014

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<tr>
<td>31st March - 1st April</td>
<td>Wellington, New Zealand</td>
<td><strong>Te Papa</strong> - National Museum of New Zealand</td>
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<td><strong>Wellington Hospital</strong></td>
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<td></td>
<td></td>
<td>• Joy De Villiers – Social Work Team leader</td>
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<td>• Women’s Health Social Work Team</td>
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<td>• Francenne Smith – Professional Leader Social Work</td>
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<td>• Rebecca Solomon – Maori Social Worker</td>
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<td>• Whanau Care Services (Maori &amp; Pacific Health Team)</td>
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<td>• Cathy Sowden - Child, Youth and Family Hospital Liaison</td>
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<td>• Bonnie Fordham - Child Protection Co-ordinator</td>
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<td>2nd April – 7th April</td>
<td>Auckland, New Zealand</td>
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<td>• Sue Fitzgerald – Midwife Manager</td>
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<td>• Te Aka Ora – Vulnerable Pregnant Women’s Meeting</td>
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<td><strong>Waitakere Hospital</strong></td>
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<td>• Maori and Pacific Women’s Health Liaison Workers</td>
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<td><strong>Auckland City Hospital</strong></td>
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<td>• Linda Haultain – Allied Health Director for Women &amp; Children, Social Work Professional Leader</td>
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<td>- Hannah Frost</td>
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<td>- Nicole Gapes</td>
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<td>• Jude Cottrell – Midwifery Educator</td>
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<td>• Craig Newby - Child, Youth and Family Hospital Liaison</td>
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<td>• Laurel Webb - Child Protection Co-ordinator</td>
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<td>• He Kamaka Waiora (Maori Health Team)</td>
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<td>• Pippa Dawson – Maori Social Worker</td>
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| Auckland, New Zealand | Greenlane Clinical Centre  
• Pori Tomahai Gisby – Maori Community Health Worker  
• Jane O’Neill – ADAPT Midwife  
Community Alcohol and Drug Service (CADS)  
• Marijke Cederman – Clinical Team Leader, Pregnancy & Parental Service  
Te Hononga Trust  
• Emma Collis and Taonga Teen Parent Support Service  
Middlemore Hospital  
• Social Work Team  
• Tish Taihia - Charge Nurse, Maternity Ward |
| 9th-11th April | Los Angeles, California, USA | Native American Families Partnership  
• Barbara Arvi - Director  
• Lise & John – Group co-ordinators  
• Phases & Stages Group Participants  
United American Indian Involvement - Seven Generations (Phone interview)  
• Eric Sanchez  
Families in Good Health (Phone interview)  
• Lillian Lew – Director |
| 14th-15th April | Phoenix, Arizona, USA       | Heard Museum  
Healthy Families Arizona  
• Amy Jaffe – Senior Program Manager  
• Sandy Milward – Senior Program Manager  
First Things First  
• Cathy Brown – Regional Director Gila River Regional Partnership Council  
Healthy Steps - Summit Healthcare Regional Medical Center (Phone interview)  
• DeAnn Davies – Director Early Childhood Outreach Division |
| 18th April    | San Francisco, California, USA | Homeless Prenatal Program  
• Johanna Jetton – Wellness program co-ordinator  
• Martha Ryan – Founder and executive director |
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<th>Date</th>
<th>Location</th>
<th>Locations and Contacts</th>
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| 23rd April – 25th April | Vancouver, British Columbia, Canada | **Museum of Anthropology** - University of British Columbia  
**FIR Square BC Women’s Hospital & Health Center**  
- Serena Kuller – Social Worker  
- Johanna Sherwood - Nurse  
**SHEWAY Project**  
- Kari Stout – Social Worker  
- First Nations Family Support Worker  
**Vancouver Aboriginal Child and Family Support Service (VACFSS)**  
- Anju Sohal – Senior Child Protection Clinician  
- Holly Anderson - Senior Child Protection Clinician  
**Maxxine Wright Centre – Surrey (Phone interview)**  
- Denise Penaloza – Program Manager  
**HerWayHome – Victoria (Phone interview)**  
- Amanda Seymour – Co-ordinator |
| 28th April – 2nd May    | Toronto, Ontario, Canada        | **St Michael’s Hospital**  
- Heather Burns Shillington – Social Worker  
- Marissa Cicero – Professional Practice and Education Leader, Social Worker  
- Jay McGillivray – Midwife, HIV and Pregnancy Outpatient clinic  
**Toronto Birth Centre**  
- Seventh Generation Midwives  
**Pregnancy Outreach Program – Children’s Aid**  
- Michelle Gahwiler – Pregnancy and Aftercare worker  
**Breaking The Cycle**  
- Mary Motz - Clinical Psychologist  
- Margaret Leslie – Director, Mothercraft Early Intervention Department  
- Nerina Chiodo – Pregnancy Outreach Worker  
- Domestic Violence Support Group participants  
- Toronto Pregnancy and Substance Use Working Group |
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<td>5th May</td>
<td>New York City, New York, USA</td>
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<td>Toronto, Ontario, Canada</td>
<td>Native Women’s Resource Centre</td>
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<td>• Penny Deeth – Volunteer and Events Co-ordinator</td>
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<td>• Aboriginal Healthy Babies, Healthy Children Team</td>
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<td>Anishabwe Health (Phone interview)</td>
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<td>• Iris Taylor – Health Practitioner</td>
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Living a difficult past

‘We are the bearers of many blessings from our ancestors and therefore we must also bear their burden as well’

Kevin Rudd, Apology Speech to the Stolen Generations, House of Representatives 2008

Enduring legacies

As a white health practitioner one of the challenges of working with Indigenous women and families in Australia is being, by very nature of ethnicity, a representative of a settler society that inflicted significant trauma on Australia’s first nations through the process of colonization and occupation. It is widely acknowledged that many of the psychosocial issues experienced by Indigenous communities today have their roots in European occupation and the longstanding effects of colonisation. Bindi Bennett (2013) identifies that Australia’s history is one whereby Aboriginal economic stability was damaged by the taking of land, resources and wealth, political institutions were replaced by European administration and social systems were replaced by the imposition of European laws. Religious practices and all forms of expressive culture including language were prohibited and the system of passing on culture was limited by moving people into differing areas and onto missions. In addition to these socio-political actions unequal food rationing and lack of basic nutrients, overcrowding, mass killings and inadequate shelter all took their toll on the Indigenous population1.

Due to the identified ongoing impact of European occupation on Aboriginal families it has been said that mental health practitioners in Australia and other colonizing countries need to be able to practice ‘In the Presence of History’2. The initial conception of my Churchill Fellowship came about from a long standing curiosity regarding how non-Indigenous primary health practitioners in countries with a similar history of European occupation engage Indigenous clients and communities facing significant socio-economic and health inequalities. These considerations were informed by an awareness that the data indicates alarming similarities with regards to psychosocial issues and disadvantage experienced by Indigenous communities in Australia, New Zealand, the USA and Canada, all nations that

1 Bennett.B (2013) ‘The importance of Aboriginal and Torres Strait Islander history for social work students and graduates’ Chapter 1, Our Voices: Aboriginal and Torres Strait Islander Social Work  p10-11
could be considered settler colonial states (Appendix A provides a brief snapshot of some of these similarities).

Considering the past actions of colonial governments in response to Indigenous peoples is relevant as they are a foundation for relationships between Indigenous communities and governments to this day and in many instances have contributed to current adverse health and wellbeing issues experienced by Indigenous people around the globe. Specifically, both in Australia and throughout the Commonwealth it is the actions of settler governments that have made a significant contribution to the distrust many Indigenous individuals and communities demonstrate when it comes to engaging with current government services including maternal and infant healthcare.

For this reason and to assist in establishing similarities and differences with Australia’s past and current social & political context, where possible at the beginning of my visit to each city during my fellowship I attempted to visit museums or places of cultural and historical significance. This was an extremely helpful practice in seeing how the ancient and recent histories of the Indigenous nations of each place were told including dark and difficult events that occurred as nations were colonised. Many of these places recalled the impact of European invasion and consequently were very useful for establishing a context for current post-colonial practice with Indigenous individuals and families within those cities. Moreover, how stories are told in public places can be a reflection of public policy or at the very least some of the views that have informed public policy.

The past actions of governments were frequently referenced by non-Indigenous and Indigenous practitioners and community members spoken to throughout my Fellowship. They described histories characterised by cultural genocide, dispossession of land, slavery, forced removal of children and denial of practicing traditional culture. Worth highlighting and of particular relevance to my Fellowship is the similar history of forced removal of Indigenous children from their families that Canada and the USA share with Australia.

In Australia it is estimated that between one in three and one in ten Aboriginal children were forcibly removed from their families and communities in the period from approximately 1910 until 1970\(^3\). The result being that nearly every Aboriginal family has experienced the effects of forcible removal and what is known as the ‘Stolen Generations’. In addition those children who weren’t removed from their families were often still under the care of the state.

Similarly, in Canada between the 1870s and the 1970’s over 150,000 First Nations children were taken from their families and communities by the Royal Canadian Mounted Police (RCMP) and forced to move to residential schools\(^4\) to be assimilated into ‘white’ culture where they were not permitted to speak their native language or practice their culture. It is

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\(^4\) [Truth and Reconciliation Commission of Canada](http://www.trc.ca)
estimated that between 90-100% of children at these institutions suffered severe physical, emotional and sexual abuse at the hands of staff there. As in the case of Australia’s Stolen Generations of great significance within this history is the traumatic removal of young Indigenous children from their parents only for them to then be parented by non-Indigenous institutions. Practitioners in Canada also spoke of the ‘Sixties Scoop’ a term coined by Patrick Johnston in his 1983 report ‘Native Children and the Child Welfare System’ that refers to the practice, beginning in the 1960s and continuing until the late 1980s, of apprehending unusually high numbers of Aboriginal children and fostering or adopting them out, usually into non aboriginal families.

Consequently, no other government policy has had such a devastating impact on Indigenous families in Australia, Canada and some parts of the USA as that of the forced removal of children from their families, communities and ultimately their culture. Considering the intergenerational effects of such trauma is relevant to the aims of my Churchill Fellowship as it concerns parenting, who makes decisions about the care and protection of Aboriginal children, the mental health and wellbeing of Aboriginal mothers, and the ongoing impact of disrupted perinatal and infant attachment.

New Zealand’s colonial history also reveals a nation whose Indigenous population struggled with the spread of unfamiliar diseases and rapid loss of land as the European population expanded. What distinguishes New Zealand’s history from other nations visited during my Fellowship and from Australia is the creation of a nationwide treaty to be upheld by the whole nation. In 1840 many British settlers in New Zealand were acting unlawfully, whilst other European powers were showing an interest in occupying the land and there were concerns about the long term survival of the Māori population as the settler colony grew. Whilst not a constitution the Treaty of Waitangi was conceived to establish the nation and governance of New Zealand and represents an agreement entered into by representatives of the British Crown and Chiefs of Māori iwi (tribes) and hapū (sub-tribes) based on a set of principles or exchange of promises. For this reason the Treaty acknowledges both the British settlers and the Indigenous people of the land, the Māori, and offers partnership, protection and participation to the two signatories.

**Bi-Cultural Practice**

Whilst there remains contention about its effectiveness the Treaty of Waitangi is of particular relevance to my fellowship as it concerns decision making powers and official recognition of alternative ways of understanding from a Eurocentric way of life. The Treaty formally declares that the Māori world view is legitimate, authoritative and valued in relation to other cultures.

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5 Dr Bryce Report 1907, Medical Inspector, Department of Indian Affairs (www.reconciliationcanada.ca/welcome/history)
Within minutes of my first interview in New Zealand I was introduced to what is referred to as ‘bi-cultural practice’. The foundations of bi-cultural practice can be located solidly in the Treaty of Waitangi. The treaty serves as a guiding principle for current day to day professional practice in New Zealand and has particularly influenced the development of professional competencies in the fields of education, child welfare and healthcare. Bi-cultural practice differs from multicultural Practice in that it is specific to a landscape of building relationship between a First Nations people and a settler people. The Treaty of Waitangi represents government responsibility to respect and uphold Māori customs and as such through practicing bi-culturally government departments including Child, Youth and Family Service (CYFS - the agency responsible for statutory child protection) must ensure a particular quota of Māori staff and must enact cultural requirements in all their assessments.

The fundamental principles of bi-cultural partnership specific to social work as outlined by Aotearoa New Zealand Social Workers (ANZSW) are:

- A sense of shared history and unique responsibilities between said partners
- A sense of development towards autonomy for the purpose of establishing real interdependency
- A sense of advancing Indigenous and non-Indigenous best practice in social and community work in Aotearoa/New Zealand
- A sense of open partnership that reinforces collaborative sharing of knowledge, wisdom and experience within this professional body of practitioners, thinkers, theorists, researchers, managers etc who identify as their root profession ‘Social and community work’

Consequently health staff in New Zealand reported that currently every health and welfare professional is educated extensively about Māori values and customs at university and must then establish their bi-cultural competencies each year as a matter of essential practice.

The implications of practicing from a bi-cultural framework cannot be underestimated and extend far beyond the scope of health, education and child welfare practice. In the 1990s the New Zealand Government accepted that the Crown had an enduring obligation to take active steps to support the growth and development of the Māori language. As a result Māori language is clearly visible on all signage and public documents. My observation as a visitor was that the visibility of Māori language and culture sends a strong message that ‘this culture is valued and respected by us’ in a way that moves beyond tokenism.

Similarly, my observation was that the presence or integration of Māori customs and beliefs within the workplace acknowledges and pays respect to Indigenous culture and ascribes value to an alternative way of life in ways that are not tokenistic.

In Auckland I observed cultural needs being accounted for within Child at Risk decision making processes. Similarly upon my arrival to Auckland City Hospital it was incredibly

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8ANZSW website - http://anzasw.org.nz/about/topics/show/58-bi-cultural-partnership
humbling and convicting to receive a Māori welcome from a Māori elder that also included the Pakeha (non-Māori) staff participating in Karakia (prayers & blessings) and singing.

What stood out for me during conversations with health and child protection practitioners from both Māori and Pakeha backgrounds in New Zealand was a sense of ‘We’re all in this together’, a sense of acknowledging the past whilst moving forward to create a nation into the future. This includes non-Indigenous staff practicing an awareness of their own culture and what some refer to as the ‘privilege of whiteness’ that incorporates the biases being part of the cultural majority may bring. Subsequently, the integration of bi-cultural practice into clinical practice has significant implications for engaging ‘high risk’ or vulnerable Indigenous families.

Firstly, representation of culture through language, artwork and customs equals visibility. Studies indicate that connection to culture and a sense of cultural identity is a protective factor for both Aboriginal children and adults. It is therefore interesting in this context to consider honouring Indigenous culture within Eurocentric health systems as a task that plays a role in addressing health inequalities.

Secondly, visibly acknowledging Indigenous culture may assist in creating a space where vulnerable Indigenous women feel more comfortable. In Australia people of European ancestry make up the majority of the population. This is significant because it means that European Australians make up the majority of public representation, and consequently they are most often the people who make decisions about the lives of Aboriginal Australians from broad political matters to individual case management. To practice bi-culturally means to recognise the difficult dynamics of overrepresentation and work in a way that respects both the culture of the Indigenous minority and the non-Indigenous majority.

Finally, it is also interesting to consider change beginning from the implementation of government policies and the subsequent impact on engaging vulnerable families. My observations of bi-cultural practice in action and reflecting upon its conception in the Treaty of Waitangi therefore provided an awareness of the importance of recognition of Indigenous culture and way of life at an official level. In an Australian context constitutional recognition for Australia’s first peoples would be one such step towards strengthening Indigenous culture through respect and recognition.

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Hopeful Practice Example:

Incorporating Māori values into everyday Social Work Practice in New Zealand

- Prior to the transfer of a baby into foster care at Auckland City Hospital the Women’s Health Social Worker supporting the family arranged for Karakia (Māori prayers & blessings) to take place with the parents and family.

- Prior to lunch at Wellington Hospital the team stopped and blessed the food. The fact that there was no Māori staff present at the time indicated to me as a visitor that there is a bi-cultural mindfulness that is integrated into all aspects of everyday practice. Consequently, if non-Indigenous staff are approaching meals from a bi-cultural perspective there is a strong possibility that they will approach engaging vulnerable Indigenous women from the same perspective.
Living in the city

A key aspect of my Churchill Fellowship was the exploration of what the specific needs of Indigenous women living in urban environments are. Often in Australia the Indigenous experience can be homogenised resulting in Aboriginal Australians living in urban areas being categorised with those living in rural or remote areas. This can contribute to false assumptions made by health and welfare staff about what the support needs are of urban Aboriginal women particularly with regards to family and community support available. My travels revealed that this is also a familiar scenario in the USA and Canada and even New Zealand and thus led me to ask the question ‘What are the specific needs of Indigenous women in urban environments?’

Cultural Dislocation & Isolation

At each site visited during my Fellowship staff spoke of the reality that urban Indigenous women were often separated from the communities they grew up in or even the wider Indigenous community and that one of the most significant consequences of this was that they were frequently dislocated from their traditional culture. Staff at United American Indian Involvement in Los Angeles made clear that within the USA cultural customs and beliefs differ greatly from one tribe to the next therefore it is not useful to generalise, but that despite this the experience of being isolated, forgotten and alienated is one that is universal for Indigenous people within a large city where they are not represented in the majority of the population or compromise one culture among many.

Furthermore, United American Indian Involvement explained that for this reason living in an urban environment was a different experience for Indian women compared to living on a reservation where there is a tribal government and the additional support networks of extended family may be more available thereby providing a protective factor. Likewise on a reservation the majority of the population is American Indian whereas in a city such as Los Angeles American Indians were exposed to a multitude of other cultures, a fact which presents both strengths and challenges.

Staff at Anishabwe health in Toronto spoke of many women no longer identifying with traditional ‘cultural markers’ through decolonization. Once again this is particularly relevant for Aboriginal women living in Australian cities and in my experience particularly Sydney. Due to deliberate policies of assimilation and integration in NSW’s past very few Aboriginal women are able to speak or even know more than a few words from their tribal language. As previously mentioned this is particularly pertinent to my Churchill Fellowship as studies
show that knowledge of traditional language and cultural customs can be a significant strength or protective factor for both children and adults.

Discussions with Indigenous practitioners in New Zealand and Canada revealed that, similar to Australia, the factors that have led to Indigenous women being disconnected from their culture are many and varied including:

1. Historically when Indigenous children were forcibly removed from their homes they were not permitted to practice their culture or speak their native language and consequently lost touch with many traditional customs. Similarly in New Zealand, USA and Canada it was often forbidden to speak Indigenous languages at school or in the workplace and people were prevented from passing on cultural identity through giving their children Indigenous names.

2. When women have cut ties with a particular community they may be living away from elders and those who ‘practice’ culture thereby maintaining traditional wisdom.

Furthermore, staff at the Sheway Project highlighted that Indigenous women living in urban areas have often chosen to leave their communities and move to the city for a reason and that this must be recognised when engaging Indigenous women with high risk needs and planning the ongoing care of their babies. Recognising this factor also means acknowledging that the woman may be choosing to escape a situation of abuse or past trauma and that sending a baby back to that community if it is taken into care or requesting that a women return there may carry the risk of re-traumatising the woman and therefore place her at further risk of harm.

Exploring the impact of separation from community and culture involves being open to the spiritual aspects of health and wellbeing. In an Australian context many Aboriginal people often describe a ‘sickness’ that comes from being disconnected from who you are and where you came from. Besserab and Crawford reference the views of Halloran (2008) who suggests that

‘Under colonisation, Aboriginal people’s cultural worldviews were denigrated and in some areas completely destroyed, resulting in ‘a collective helplessness and eventual ‘maladaptive coping behaviours’ that we are witnessing today’.

I found this holistic consideration of the impact of separation from culture applicable to the experiential knowledge shared by many Indigenous staff at health services visited. Both the Whanau Care Team in Wellington and staff at the Sheway Project in Vancouver suggested that whilst many women are disconnected from their home community through the choice to leave they may still be seeking to reconnect with their Indigenous culture through a subconscious longing.

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In tackling the loss of identity that can come with disconnection from community and culture, one Māori Social Worker at Wellington Hospital described how she encourages Māori women to “find out who you are and where you came from” as a foundation for them addressing their psychosocial issues and becoming a parent themselves. Similarly, the use of traditional music and activities as detailed at United American Indian Involvement is a useful example of integrating a spiritual component as part of Indigenous people’s care and reconnecting them with their own history in a way that assists with addressing future challenges. Moreover, Indigenous health staff spoke of pregnancy as a great time to engage and talk about women’s cultural and spiritual health as becoming a parent may bring up questions for a woman about her own family history, cultural identity and the story she wants to share with her child.

An additional product of colonization and aforementioned policies of assimilation can be that women feel they are “not Aboriginal enough” and subsequently are too ashamed to identify as Aboriginal. Politics can continue to be an obstacle to this particularly in some parts of North America where women are required to prove their status to obtain particular health services. For this reason, one worker at the Native Women’s Resource Centre in Toronto explained that when women access the centre, she assumes that they have no knowledge of their culture to begin with and that this avoids the women feeling a sense of shame at ‘not knowing’ about their Indigenous identity or having close links to an Indigenous community.

Frequently, practitioners interviewed emphasised that there was no ‘formula’ or specific method of engaging Indigenous women and that instead it was important to assess each woman on a ‘case by case basis’. This is relevant when considering the assumptions or ways the Aboriginal experience can be generalised. Staff at Anishabwe health in Toronto explained that it is essential to identify individual barriers first and foremost when working with Aboriginal families as each family has unique and diverse needs and is complex within itself. In this way, whilst it is important to acknowledge that separation from culture and identity can contribute to cycles of transgenerational trauma experienced by Aboriginal women and to take this into account when conducting initial assessments, it is also important not to ‘lose’ the woman in her culture and make assumptions about what she needs based on her cultural identity.

**Hopeful Practice Examples:**

**Fostering cultural reconnection with urban American Indians in Los Angeles**

- **American Indian Families Partnership**
  Los Angeles has the highest population of Urban American Indians in the USA yet given its size and multicultural composition many people (including locals) are not aware of this. In addition to crisis intervention and family support services, the American Indian Families Partnership runs a Phases and Stages group for pregnant women during their pregnancy and the early postnatal period. At the group, women from tribes all across the USA make cradleboards. Cradleboards have been used for hundreds of years by Native American women to carry their...
A Holistic Approach

Throughout my Fellowship I met Indigenous practitioners who spoke of the importance of employing a holistic perspective when assessing and caring for pregnant Indigenous women in urban environments. In Australia and internationally a holistic approach to health can be found in many Indigenous concepts of social and emotional wellbeing such as the framework included in Appendix B. This model shares similarities with Australian Aboriginal concepts of Social and Emotional Wellbeing that recognize the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect an individual’s mental health and wellbeing.\(^2\)

In many instances a holistic perspective may include assessing a woman in the context of her whole family and extended family. The Whanau care unit at Wellington Hospital sensitively advised that it is not always effective to assume that Māori women in urban areas have strong, stable family to support them. This is another example of how the Indigenous experience can be generalised. Whilst many Indigenous women may have close

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connections with extended family other Indigenous women living in urban areas may actually have very little contact with their family through their own choice or their family’s choice and this can understandably impact on a woman’s vulnerability and level of engagement with services.

Conversely, the Whanau Care Unit also acknowledged that part of assessing a woman in the context of her family and extended family may be to identify any additional caring responsibilities the woman may have. Due to the substantial amount of health inequalities and social disadvantage experienced by Indigenous communities women may be the support people for other family members or may even be caring for other family member’s children.

A truly holistic approach I encountered numerous times during my Fellowship travels was services which catered for women’s practical and cultural needs whilst simultaneously meeting their healthcare or pregnancy needs. A reality for many Indigenous women living in urban areas is significant structural poverty. Factors contributing to this can include a lack of adequate housing, proximity to hard drugs & alcohol and other chaotic lifestyle factors. This is noteworthy because literature indicates that family violence, parental substance misuse and parental mental illness are closely associated with issues of poverty, homelessness, unemployment and isolation which can then increase difficulties for children who may already be at significant risk of harm13. Subsequently, staff at HerWayHome in Victoria, Canada identified that poverty, lack of housing and violence often contribute heavily to the reasons why babies are apprehended into care.

Travelling to the west coast of the USA also provided me with the opportunity to witness an environment where significant structural poverty exists with regards to homelessness and no system of universal health care. These factors place a significant barrier on vulnerable women’s ability to access antenatal care and for this reason the way agencies address these barriers with limited government support holds many valuable lessons for Australia. At American Indian Families Partnership in Los Angeles one of the practical and sustainable ways they have found to address the issue of poverty is to provide financial literacy education. Similarly, whilst it does not service a high percentage of Indigenous clients many lessons can be learnt about engaging ‘high risk’ women in antenatal healthcare from the Homeless Prenatal Program in San Francisco, California. The program is based on an international development framework and in conjunction with antenatal care & birth education provides practical and social support services including housing assistance, trauma counselling, child care and tax assistance.

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**Trauma informed care**

In recent years trauma informed care has gained prevalence as a model of care for women whose social histories may include significant emotional, physical or sexual abuse as children and/or adults. Trauma informed care encompasses

‘care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services’\(^\text{14}\).

The trauma informed care approach to providing healthcare is based on the core principles of safety, trustworthiness, choice, collaboration and empowerment\(^\text{15}\) and is not deficit or risk based nor does it undermine a strengths based approach. Alternatively, it is about identifying that a woman may have experienced trauma in her life and the subsequent impact this can have on her care needs.

At nearly every visit during my Churchill Fellowship practitioners referenced applying a trauma informed perspective to the ways in which they engage vulnerable Indigenous women. One midwife in Toronto highlighted that as statistics show that 1 in 3 women in Toronto have been assaulted it is useful to approach every woman sensitive to the fact that she may have experienced trauma. Similarly, staff at Breaking the Cycle in Toronto also outlined how as a by-product of trauma a significant amount of women with substance misuse issues also have mental health issues and it is therefore useful to assess each woman in the context of having struggled with adverse mental health as a by-product of trauma.

Furthermore, staff often spoke of Aboriginal women having ‘extra’ or additional layers of trauma due to historical and socio political factors. Nursing staff at HerWayHome in Victoria, Canada where 50% of clients are Aboriginal identified that Aboriginal women often face challenging circumstances such as transgenerational trauma, high rates of child removal and racism that both contribute to a traumatic history and can perpetuate the impact of current trauma. It must therefore be recognised that within a post-colonial context employing a trauma informed care approach with Indigenous women involves consideration of the additional levels of past and present trauma experienced by Indigenous communities as a result of loss of land, culture, and the removal of children both in the past and present.

From a biological perspective recent advances in the field of behavioural epigenetic suggest that traumatic experiences in a person’s past, or in their recent ancestors’ past, can leave molecular scars adhering to their DNA and impacting psychological and behavioural traits. These advances have been based on research with descendants of individuals who have experienced situations of extreme trauma such as the holocaust or domestic violence and suggest that trauma experienced by past generations can be transferred in utero to future

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\(^{14}\) National Association of State Mental Health Directors (NASMHD), (2004)

\(^{15}\) Roger D. Fallot & Maxine Harris, ‘Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol’ (Washington, DC: Community Connections, 2009), p.3.
During my time in Toronto I discussed this research with midwives from Seventh Generations Midwives at the Toronto Birth Centre and the relevant application to pregnancy care and engaging women. The midwives explained how they attempt to integrate this knowledge of the impact of transgenerational trauma into their daily practice and the care of Indigenous women and their families during birth. Staff acknowledged that due to transgenerational trauma a woman may be anxious about birth yet not fully conscious to the reasons why. Similarly, the potential trauma histories and subsequent needs of extended family are taken into account at the birth centre through the provision of a quiet, culturally safe, comfortable space for them to spend time during the birth.

In a similar way staff at Maxxine Wright in Vancouver suggested that when reflecting upon the impact of trauma it is important to take a ‘big picture’ view that includes recognising the impact of trauma on all aspects of life. One example provided by both the Whanau Care Unit and by a First Nations family support worker at the Sheway Project was that many Indigenous women may be concerned about family members who struggle with their own issues such as substance misuse or violence. Similarly, the presence of trauma and it’s far reaching impacts on whole communities may influence the availability of family available to place a child with in instances where orders have been put in place and a child has come into care. This has practical implications for the way in which transgenerational trauma can impact the capacity of Indigenous families to respond to child at risk issues and support one another through child protection processes.

Many hospital staff interviewed also identified that an additional layer of trauma for urban Indigenous women can be the experience of systemic or institutional racism. Relevant to this is recent research in the USA which identified that the cumulative effect of chronic stress and anxiety caused by subtle racism over a lifetime can place strain on the body’s organs and systems and may have an impact on birth outcomes.17 These findings are relevant to consider in locations where mainstream health staff have not had adequate cultural competence training and are not aware of the impact of historical trauma. Staff in hospitals visited in New Zealand and Canada spoke of how racist or simply ignorant attitudes of non-Indigenous health staff can often compound trauma for vulnerable Indigenous women and therefore impact on the way they engage with essential healthcare services.

In addition, from a trauma informed perspective several maternal health practitioners in Toronto also spoke of not overloading women with information and choices about their care in the context of speaking to someone who was already overwhelmed due to social circumstances. They highlighted that cognitively vulnerable pregnant Indigenous women are already overloaded and may therefore be looking for a practitioner who they can trust

‘knows what they are talking about’. Presenting the woman with too many options may therefore make her doubt the capacity of a service to meet her needs or even ‘hold her’ during a period of crisis where she may not feel strong enough to confront multiple vulnerabilities alone.

**Time & relationships**

A resounding message that emerged during my Fellowship was the fundamental importance of fostering relationships both with Indigenous women, their families, Indigenous and non-Indigenous professionals. The Kamaka Waiora Team at Auckland City Hospital described the significance of ‘Kanohiki Te Kanohi’ or taking the time to meet people and connect ‘face to face’. It may sound like obvious practice in engaging people in their healthcare however it is useful to stop and review if methods of engaging Indigenous clients, particularly at intake or ‘first contact’ level, are based on a relational approach. Often before establishing a relationship with the client practitioners can go straight to addressing healthcare needs or even what they require the woman to do and this can impede establishing a relationship of trust and transparency. In addition, prioritising taking the time to connect provides a foundation from which to explore risks with women and their families. What became apparent in speaking to health and welfare practitioners is that taking the time to build a relationship often means creating a space where you can genuinely let women know that people have worries about them. In this way staff frequently demonstrated that they took time to establish a relationship where the woman had room to make mistakes and therefore less likely to feel judged.

Staff readily acknowledged that this is not easy. Taonga Support Services, a part of Whanau Ora Roopu, in Auckland is a service for teen parents comprised of a Whanau community health worker, registered nurse, teen parent co-ordinator, social workers. The team explained that often Māori families can demonstrate resistance to engaging with Pakeha (European) staff and that they have addressed this through persistently taking the time to establish rapport and clarifying how the service can meet young parents practical needs such as transport and housing. Similarly, staff at United American Indian Involvement described not necessarily neglecting clients when they demonstrate reluctance to engage and instead ‘persisting’ gently with support until clients gain an understanding of the potential advocacy being offered.

Many health staff identified that engaging vulnerable Indigenous clients within a mainstream health context can be challenging as Indigenous and non-Indigenous cultures often have very different concepts of time and the time it takes to build relationship. The Whanau care team at Wellington Hospital spoke of how their communities often had a different approach to time which could appear to be opposed to European time structures and western concepts of time that healthcare is constructed around. They team identified that this different understanding needs to be taken into account at a policy level when
services are being thought out and planned for. This can often be a challenge as it is non-Indigenous staff creating health targets and outcomes and they therefore may have a different understanding of time and the formation of relationships.

As cited previously assessing women on a case by case basis is related to not assuming that a woman needs particular things because she is Aboriginal. Several practitioners in New Zealand were helpful in highlighting that reflecting on cultural competency also means considering what other cultures a woman is a part of e.g. sexual identity, other ethnicities, work life, age bracket. This is particularly relevant for pregnant Indigenous women living in urban areas who may be a part of a ‘street culture’ due to homelessness, violence, substance misuse or other chaotic lifestyle factors. Regarding relationships and transparency, in environments where violence and conflict prevail and a chaotic ‘way of being’ exists this can impact how and when people engage with services. Being part of a street culture can also have an impact on what they have heard from peers on the street about other services including maternity care and child protection. In the same way the Taonga service highlighted that when working with young Indigenous mums it is important to consider the importance and priority of relationships to teenagers. This may mean reflecting on their relationship patterns and thus identifying the impact abusive relationships can have on a young mother’s priorities and whole state of social and emotional wellbeing.

A woman’s choice

As is the case in Australia professionals in each nation visited spoke of the fact that some Aboriginal women may choose to go through a non-Aboriginal service or engage with non-Indigenous staff instead of Indigenous staff available. The reasons for this choice are delicate and diverse however can often be linked to concerns about internal politics within the Indigenous community and confidentiality. For many urban Indigenous women this choice may also be related to the reasons a woman originally chose to leave her community. For this reason it is also essential that mainstream or universal services have the capacity to respond in culturally competent ways. One worker at the Native Women’s Resource Centre in Toronto highlighted how many Indigenous women may not be aware of their basic rights e.g. living in substandard housing with no knowledge of their right to safe, hygienic accommodation. It is therefore important to consider a woman’s awareness of her rights and services available when identifying barriers to healthcare and the fact that some women may not realise they have a choice of healthcare provider. Ensuring woman are aware of their right to choose applies to both availability of Aboriginal specific services, eligibility requirements for these services or the option of choosing to go through a different health or welfare provider to the specific Aboriginal service. For non-Indigenous practitioners to respect an Indigenous women’s right to make decisions about her healthcare is to avoid practising in a paternalistic way that makes decisions for the woman as countless health practitioners have done in the past.
Care in a climate of risk

A key component of my Churchill Fellowship was to explore how to engage pregnant Aboriginal women in their pregnancy care when those women have identified child at risk issues. The central motivation for this enquiry was the reality that the ongoing impacts of European occupation can have a significant impact on the way Aboriginal women and their families engage with relevant primary health services. Understandably, the painful actions of past governments in Australia have contributed to the current distrust of government services demonstrated by many Aboriginal Australians. At the same time, consideration of the statistics snapshot in Appendix A suggest that Aboriginal women are likely to have more contact with health and welfare services than the general population due to higher rates of family violence, substance misuse and mental health issues.

Additionally, the professional context for the health and welfare practitioners that Aboriginal families come into contact with within health services must also be taken into account. Increasingly, health practitioners have specific outcomes to achieve and processes to undertake in order to obtain and maintain funding. Moreover, policies and protocols are often constructed around preventing risk of harm to staff and patients. Hospital environments in particular are becoming increasingly risk averse which can lead to a focus on deficit based assessments and interventions. The combination of all these factors led me to ask the question ‘How do we provide culturally competent care in a risk averse environment?’

The fetus at risk

At this point in time in Australia different states and legislatures have varying definitions of when a baby is classified as a ‘child’ at risk of harm. In 2008 Bromfield and Holzer conducted a review of the delivery of child protection services in Australia which noted that

in recent years a common feature in most, if not all, jurisdictions, was the introduction of measures providing for statutory involvement where there were protective concerns for unborn children18

In addition, The Australian Institute of Health and Welfare in 2009 identified that newborns or infants were the fastest growing category of children entering Out of Home Care (OOHC)19

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Currently in NSW health professionals are no longer mandatorily required to report risk of harm to an unborn child however are encouraged to consider the benefits for the mother and unborn child of making a report to both enable FaCS to either respond and identify relevant supports or to prepare appropriate statutory/protective intervention following the birth of the child. Both in Australia and globally the decision to notify child protection agencies of risk of harm concerns is frequently informed by the ‘Paramountcy Principle’ whereby the welfare of the child is paramount. Consequently, there are significant challenges associated with an unborn baby not being considered a ‘child’ in statutory child protection terms until after birth. In several cities visited such as Vancouver and Toronto child protection services do not have the capacity to conduct a thorough assessment of risk of harm issues identified or provide case management beyond a ‘supportive’ role until after the baby is born when there is officially a ‘child’ present. Historically, these circumstances were similar to many cases at The Royal Hospital for Women whereby FaCS assessment and intervention was more likely to occur as a ‘crisis response’ following the birth of a child rather than antenatally when a risk of harm report was received.

In situations where statutory child protection is unable to get involved until postnatally creating a ‘safety net’ of support around a woman becomes essential to avoid increased stress for the mother and professionals postnatally and to avoid a crisis response. The Pregnancy and After Care Program at the Children’s Aid Society of Toronto was developed to reach out to pregnant women with psychosocial concerns early in their pregnancy to engage them in services that will promote the delivery of healthy newborns and will ensure that sound plans for their child’s care are in place at the time of birth. Through a perinatal caseworker the program has the capacity to offer outreach and to work closely with other services that work with high risk mothers. The perinatal caseworker also explained that due to the opportunity to meet women early in their pregnancy and develop a rapport over time they are able to inform mothers in situations where a baby was likely to come into care and work with them around who they would like to care for the baby if the assessment is that the baby would be at risk of harm in their care. Staff interviewed at Breaking the Cycle explained that since they had commenced working in partnership with the Pregnancy and After Care Program there had been a 20% reduction in the amount of children coming into care highlighting the effectiveness of being able to offer a response prenatally to risk of harm issues.

Facing the facts

Responses of child protection agencies internationally are significantly influenced by the outcomes of local child mortality reviews. Recent Child Death Reviews in NSW and Victoria have identified that many accidental child deaths occur in the presence of parental substance misuse, family violence and mental health. Similarly, Child Protection staff at
hospitals visited in New Zealand frequently referenced the NZ child mortality review and the data within regarding rates of SUDI (sudden unexplained death of an infant), non-accidental injury and the disturbing overrepresentation of Māori families in these statistics.

Consequently, recent reviews of Child Mortality statistics in Australia reveal that risk factors cannot be considered in isolation from one another. A growing amount of research indicates that the combined presence of family violence, parental substance misuse and parental mental illness can have a far greater impact on children’s lives than each of those risk factors separately. It is therefore interesting to reflect upon what this means for Aboriginal families who statistically have higher representation regarding families with identified family violence, parental substance misuse and parental mental illness risk factors. As evidenced in Appendix A Indigenous families all over the world face significant challenges through higher incidences of adverse psychosocial issues than the settler colonies they co-exist with. This reveals a challenging reality which is that serious risks exist with regards to the health and wellbeing of Aboriginal children particularly vulnerable infants less than 2 years of age.

As with all other aspects of care it is important to reflect on risk of harm issues from a holistic perspective and to consider the impact of the whole in assessment and intervention. Thus, when considering the concerning statistics identified it is important to explore how they intersect with one another and what they represent within ‘the big picture’. For example children’s exposure to domestic violence may mean increased exposure to police involvement, separation from their mother whilst she’s hospitalised and uncertainty about their family’s future. The data also indicates that due to an increased presence of significant risk of harm factors Aboriginal families are more likely to come into contact with child protection services. This may mean that Aboriginal families have a sense of being ‘monitored’ or watched by child protection agencies which then translates to how they engage with other government agencies such as health. This may mean that Aboriginal families have a sense of being ‘monitored’ or watched by child protection agencies which then translates to how they engage with other government agencies such as health. Māori health staff identified that it is also often difficult for women who have family already known to child protection as they may come to the attention of child protection inadvertently and experience judgement based on their family’s history.

Women’s Health Social Workers at Wellington Hospital identified the challenge that exists for frontline hospital staff at being required to assess and identify risk of harm issues whilst also being a key support person for a family. In addition, within a hospital or universal health context the challenge can also be waiting for a response from child protection agencies following the identification and notification of risk of harm issues. These dynamics can be significant when there are pre-existing distrust issues between Indigenous women and non-Indigenous staff.

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Creating a safety net

A key future direction identified by child protection reviews globally is that responding to identified risk of harm issues and providing care to women and unborn babies requires a systemic multi-agency approach. Multi-Agency case planning can be employed directly and indirectly with women identified as ‘high risk’ or with identified child protection concerns.

Many staff within New Zealand hospitals visited spoke of the concept of providing a ‘safety net’ for Indigenous women and families by ‘wrapping’ services around them. I had the opportunity to witness this first hand within a hospital context through observing discussion at a Vulnerable Pregnant Women’s Meeting. In accordance with the guidelines outlined in the White Paper for Vulnerable Children and the Memorandum of Understanding that exists between Child, Youth and Family (CYF), Health and Police in New Zealand Vulnerable Pregnant Women’s Meetings were created to foster collaboration between key service providers, identify and build supportive networks around vulnerable pregnant women in the antenatal period and provide support to practitioners who care for these women. Vulnerable Pregnant Women’s Meetings occurred at each of the city hospitals I visited in New Zealand and I was fortunate enough to attend the North Shore/Waitakere Hospital meeting. Attendees at the meeting included hospital and community midwifery staff, Social Workers, Māori Health workers, Drug & Alcohol, Child Youth & Family (child protection) liaison. This particular Vulnerable Pregnant Women’s meeting is called Te Aka Ora. A name provided by the Māori community instead of ‘vulnerable’. The co-ordinator of the meeting explained that Te Aka Ora was the result of months of collaborative discussion. This was evident through observing the meeting and the way in which staff responded to contributions from other staff. Staff are encouraged to bring relevant information and concerns to the meeting and therefore other staff are careful not to critique the timing of someone sharing information or their role in caring for the woman. The presence of a worker from Child, Youth and Families also means that health staff can be made aware of any known child protection involvement a family may have. As such my observation was that there is immense value in having meetings where there is a diverse range of professional opinions and expertise represented in the discussions.

In many ways creating a safety net around families is about doing as much as possible prior to notifying statutory child protection agencies then, if and when child protection agencies do become involved, being able to indicate what has been put in place so far. At the Pregnancy and Parental Service (PPS) within the Community Alcohol & Drug Service (CADS) in Auckland there is discussion within the team prior to notifying the Child, Youth and Family statutory child protection service and the decision to notify happens collaboratively.

Conversely, if agencies are well known to provide comprehensive health services or a safety net of support around a family, child protection agencies may choose to refer back to the agency as a way of addressing risk of harm issues. This is the case at American Indian Families Partnership, United American Indian Involvement and the Sheway Project whereby
engaging with their service may be included as part of the plan for families to address concerns as highlighted by child protection agencies and work towards the restoration of their children. Similarly Healthy Steps at Summit Healthcare in Phoenix Arizona reported that families had better rates of reunification if linked into support services at the time their child was removed.

One midwife interviewed in Auckland who works with pregnant women with substance misuse issues advised that considering women who return to a service despite the existence of child at risk issues and potential removal based on their other children being removed can also be a demonstration of the effectiveness of a safety net provided through an environment where women are treated with compassion and empathy.

**Difficult conversations**

A fundamental aspect of employing a relational approach as described previously in this report is to practice honesty in relationships with vulnerable Indigenous women and their families. This often means, where possible, letting women know people are concerned about them and the reasons why. I consider this to be particularly important when considering the past history of colonizing governments and non-Indigenous professionals who have historically made decisions for and about Indigenous women.

Several services visited were able to describe how they practiced honesty from their initial contact with a woman. Both the He Kamaka Waipoura team at Auckland Hospital and Taonga Support services emphasised that transparency can be practiced through establishing clear boundaries from the start around definition of role and responsibilities if child at risk issues are identified.

An Aboriginal midwife in Toronto described the trauma that often occurs when a vulnerable woman is not informed of concerns antenatally then child protection assesses her baby as being at risk following birth and subsequently removes the child. For this reason it is important to consider the role of notifying child protection services antenatally to prevent a crisis response occurring and subsequent additional trauma for Aboriginal families that may compound pre-existing grief and loss. The Whanau Care Unit at Wellington Hospital identified that assisting families to contact Child, Youth and Family early gave the parents the opportunity to both hear about concerns directly from child protection services and access support services to address those concerns. Similarly services such as ADAPT in Auckland, Sheway and FIR Square explained that they often advise women that if there is a history of child at risk issues for a family it’s better that child protection become aware of a new pregnancy earlier so that they can offer any potential financial support and resources and can see that the woman is working with services and engaging in her antenatal care.

Consequently, numerous professionals in Vancouver spoke of contacting child protection agencies first, often with the client present and/or at least with the client’s permission, with
the knowledge that child protection involvement is inevitable. Social Work staff at FIR Square clarified that the purpose of early contact is also to inform child protection agencies that families are engaged with relevant support services therefore actively addressing potential risk of harm issues and that it is ideal if the woman can lead this process of contact.

**Utilizing cultural support**

In situations where there are non-Indigenous health practitioners attempting to engage Indigenous women in primary healthcare services such as Antenatal Care or Child and Family Health Nurse baby checks utilising cultural support available is absolutely essential. Furthermore, in situations where risk of harm issues have been identified cultural support can also be a tremendous asset in navigating what can often be historically and emotionally charged interactions between non-Indigenous staff and Indigenous women and families.

Māori staff sensitively described how they have the capacity to speak to families frankly about any risk of harm issues that may be present and the possible threat of removal by child protection services. This may include assisting women to identify what they need to do to address concerns but also identify who they would like to care for their baby within their Whanau to avoid their baby having to go to an unknown foster carer.

In one instance I met a Māori health worker who visits a family at home first and explains the primary health service that is seeking to visit. They then return with the non-Indigenous primary health worker until the family feel comfortable with the worker visiting solo and the Māori health worker can then have intermittent involvement as the family is stable. Similarly, at a multi-agency level the inclusion of Māori health workers in the Te Aka Ora meeting results in a Māori perspective being heard during a structured formal discussion about families’ support needs. My observation was that this was an example of Bi-Cultural Practice in action and at a leadership level.

Linda Haultain, Social Work Professional Leader and Allied Health Director for Women and Children at Auckland City Hospital described placing a high value on cultural competence by ‘knowing our community and its resources as if it were our best friend. Knowledge of community, and relationships with elders will provide us with the guidance we need in difficult times’.

In the context of the aims of my fellowship difficult times can be described as both engaging Indigenous women and families on the brink of crisis and situations where health and welfare professionals have differing opinions regarding the about risk and support needs of Indigenous families.

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22 ‘Working with indigenous urban vulnerable pregnant women – A clinical leadership perspective’

7th April 2014. Written reflections provided by Linda Haultain
**Strengths based approach**

Another dominant theme that emerged during my fellowship was the value of engaging Aboriginal women through a strengths based approach. This can be a challenging task when working in partnership with child protection systems that are traditionally often deficit based and within hospital systems that can often be risk averse in nature.

One Māori Social Worker provided a key piece of advice which was that health and child protection practitioners need to identify a woman or family’s strengths as a matter of first priority when conducting an assessment of a child’s safety and possible risks. This means exploring what resources they have available to them firstly within their immediate whānau (family), then Hapu (sub tribe) and Iwi (tribe).

This may mean in circumstances where a child needs to come into care identifying family who have the capacity to care for the child at risk (and ideally who the parents seek to care for the child) and instead of viewing children living with grandparents as a negative, asking what is required to strengthen grandparents or other family members capacity to care for the child. This has some relevant implications for Australia where Aboriginal grandparents are increasingly asked to care for their grandchildren following formal and informal decisions that parents do not have the capacity to parent their child fulltime. Similarly, Taonga young parents service at the Te Hononga Trust described some of the strengths teenage parents can have and how it is important to identify these above the perceived adverse stereotype of the ‘struggling teen mother’. The philosophy of the service is based on this concept.

I was delighted to also observe methods of employing a strengths based approach at an assessment stage through a visit in Auckland to the Community Alcohol and Drug Services (CADS) Pregnancy and Parental Service (PPS). The PPS is a multi-disciplinary team which offers a range of interventions, long term case management and service coordination to socially marginalised substance using parents with the goal of improving health outcomes and reducing risk to clients and their children. When women first access the PPS service women they complete a strengths based questionnaire with staff as part of their initial assessment and formation of a case plan. The questionnaire asks a series of questions related to a women’s social and emotional history and consequently assists the woman in identifying her existing strengths and supports. Visiting this service proved to be relevant to the aims of my Churchill Project as their client group typically may be poorly engaged with services for a number of reasons including poverty, poor access to transport, fear of stigma and judgement and subsequent involvement of child welfare agencies. It was also worthwhile visiting a ‘mainstream’ service that services many Indigenous women. After observing the many ways a woman’s strengths can be incorporated into her antenatal care and future plans I concluded that adopting a strengths based approach is a key ingredient to ensuring that Indigenous women feel empowered not judged and therefore carries the potential to increase their engagement with a service.
Strategies for engaging vulnerable Indigenous women throughout pregnancy

During my Fellowship travel I had the opportunity to visit and hear about several different approaches to engaging urban Indigenous women at different points in their maternity journey and would therefore like to outline some of the positives of several of these strategies in the context of engaging Indigenous women in a risk averse climate:

**Home visiting**

There is a substantial amount of evidence surrounding the positive impact of being able to offer home visiting to vulnerable and marginalized families during pregnancy and early childhood. Many services visited spoke of the effectiveness of home visiting as a strategy to engage women as early as possible in both their pregnancy care and linking in with appropriate supports. A charge nurse interviewed at Middlemore Hospital in Auckland listed the provision of home visiting in the antenatal period and for six weeks postnatally as one of the most effective strategies for engaging Māori women. In addition, staff at Taonga Support Services also identified that for young women in particular offering home visiting can remove the barrier of not being able to access a health service due to lack of access to public transport.

Māori health staff interviewed also identified that home visiting also recognises that the client may feel more empowered and comfortable in their own space rather than a hospital environment. This is particularly relevant when providing trauma informed care and acknowledging that an Indigenous woman may have previously had negative experiences when she has attempted to access government services or may feel uncomfortable in a space where her culture is not visible or she feels alienated. In the same way, discussions with Māori staff about their capacity to speak to families directly about a primary health care workers request to visit highlighted for me the value in providing information face to face instead of just giving families numerous brochures about different services. Once again this is sensitive to the reality that women may already be overwhelmed by their social circumstances or fears about child protection involvement so giving them more information and asking them to make a choice may perpetuate feeling overwhelmed.

Other staff explained that home visiting gives health practitioners or support workers the opportunity to see the family home and assess whether there are any risks that need to be addressed to prevent statutory child protection involvement. Consequently, the counsellors at American Indian Families Partnership in Los Angeles are available to visit a woman’s home as part of creating a plan with the woman to

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23 Sustained Home Visiting for vulnerable families and children: A literature review of effective programs (February 2012) The Royal Children’s Hospital Centre for Community Child Health and Murdoch Children’s Research Institute
prepare for baby and remove any identified factors that may place the women or her children at risk of harm.

**Drop In**
Several services in the USA and Canada offered a ‘drop in’ service whereby women did not need an appointment to access case management services or primary health care. Staff at Maxxine Wright in Vancouver, where 40% of clients identify as Aboriginal, explained that structuring care around a ‘there when you need us’ approach had meant increased amounts of women accessing their service.

Staff at the Sheway Project in Vancouver shared similar experiences. My observation at Sheway was that when a service offers practical assistance, and women present due to practical needs & priorities, staff have the chance to provide ‘opportunistic’ healthcare. I also observed that a drop in service offers the opportunity for women to speak to other clients or women who have may have previously struggled with child protection involvement that happen to be at the service that day. Furthermore, not having rigid appointment times and being able to offer flexible access to medical and nursing staff is most beneficial for urban Aboriginal women who may have a chaotic lifestyle and spontaneously choose to present for antenatal care.

In Australia lateral violence has been identified as an increasingly concerning issue amongst the Indigenous community. Consequently, creating a space where urban Indigenous women can drop in to access health and support services and linger around and where women know what the boundaries are creates a safe space away from possible violence and community conflict. This was observed at many of the agencies I visited and spoke to in North America including the Sheway Project, Maxxine Wright, HerWayHome, Breaking the Cycle, American Indian Families Partnership, United American Indian Involvement and the Homeless Prenatal Program. Staff at American Indian Families Partnership and United American Indian Involvement explained that there are American Indians from tribes all over the USA living in Los Angeles. Whilst this diversity could contribute to division and conflict they are often instead unified through participating in health and wellbeing activities together and potentially strengthened by the celebration of American Indian culture that these services provide. Practitioners at FIR Square also identified that women can be unified through the experience of being a parent together and that this is fostered by services which focus on healthy pregnancy and parenting as the priority.

**Postnatal Care**
When women present to hospital with identified child protection issues it can understandably have an enormous impact on the way their admission is planned and managed. Postnatal care is often a space where focus on risk can dominate how

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women with identified child protection issues are cared for as the vulnerability of the newborn is paramount and more ‘concrete’ than antenatally. A particularly familiar and interesting scenario to learn more about during my fellowship was how postnatal care was provided in situations where an Indigenous woman’s baby had to come into care. This situation requires a tremendous amount of sensitivity as it is about acknowledging the grief and loss for the woman as a new mother losing her baby. At Auckland City Hospital following an ‘uplift’ or assumption of care women are offered a ‘watch’ whereby they get the chance to spend five days with their baby on the postnatal ward. This is arranged through a joint funding agreement with Child, Youth and Family Service (CYFS) where health pay for first 24 hours and CYFS fund the rest. Staff report that this arrangement assists with establishing breastfeeding and perinatal infant attachment which can be most beneficial in instances where a child is restored to their parents care down the track. Likewise, hospital social workers in Auckland and Toronto detailed the creation of ‘memory boxes’ or similar for mothers to take home with photos and mementoes of their newborn baby.

**Hopeful Practice Example**

*Comprehensive substance misuse support within an urban maternity hospital*

- **FIR Square – BC Women’s Hospital and Health Center, Vancouver**
  FIR Square is an inpatient ward that provides comprehensive antenatal and postnatal care to women who disclose substance misuse during pregnancy and seek to detox. The ward provides detox facilities, specialist medical and nursing care, addictions counselling, income advice, practical assistance and advocacy with child protection matters all in the one setting.
  The majority of referrals come from women themselves and women can be admitted from 15 weeks gestation. Up to 40% of women identify as Aboriginal.
  As FIR Square is an inpatient facility patients also get to know each other and therefore offer peer support to others.
  Women return to the ward following the birth of their baby and can remain there for a month whilst they receive assistance with mothercrafting. If a baby needs to be medicated for withdrawal the ward provides a space where this can happen but the baby can remain close to their mother therefore maximising maternal-infant attachment and breastfeeding outcomes.
  It is interesting to consider FIR Square in comparison to the current context in NSW where when women disclose substance misuse in pregnancy they are either referred to a generalist drug and alcohol outpatient service or a inpatient rehabilitation facility where they may need to wait a long time for admission thereby sustaining the risk of harm issues.


Establishing Woman’s Priorities
An interesting theme that I observed during my Churchill Fellowship was the need to address Indigenous women’s urgent practical priorities first and foremost and on occasion prior to providing antenatal health care. As identified previously Indigenous women living in an urban environment may have a chaotic lifestyle characterised by disconnection from community and family supports. This may result in less practical and emotional support resources being available to a woman during pregnancy and following birth.

Whilst visiting many drop in services for pregnant Indigenous women I was reminded of Maslow’s hierarchy of needs. A well-known framework for explaining an individual’s psychosocial needs commonly implemented by health and welfare practitioners around the world.

![Maslow's Hierarchy of Needs](image)

**Maslow’s Hierarchy of Needs**

Maslow clearly outlines that physiological needs and safety and security needs are a person’s primary priorities prior to the need to achieve as an individual or experience purpose. What’s more Maslow’s Hierarchy of Needs is congruent with many holistic Indigenous models of understanding health and wellbeing. Many Indigenous models such as the one from New Zealand included in Appendix B describe the multiple elements of a person’s health and wellbeing and include the physical environment when assessing a person’s overall wellbeing. After visiting many drop in services in the USA and Canada such as the Homeless Prenatal Program and the Sheway Project I was reminded of the fact that accessing antenatal care is going to be down a list of a woman’s priorities if they are homeless or have no food to feed their older children. For this reason I was impressed by
services which provided structural interventions through comprehensively addressing women’s practical needs. Staff at both the Sheway Project and FIR Square in Vancouver explained that by meeting the woman’s most urgent priority e.g. housing or bills they were then in a position to have a conversation about what would be required to take care of a baby and whether the woman was actually able to do so. Furthermore, in this context family support and crisis services often serve as a ‘soft entry’ point from which to provide healthy pregnancy and parenting services.

Witnessing the provision of practical services with a focus on healthy pregnancy and early parenting shone a light on aspects of care for vulnerable Aboriginal women in Sydney, Australia. Often when an Aboriginal woman discloses complex psychosocial needs antenatally she is referred out to generalist adult services according to her issues e.g. drug and alcohol, homelessness, mental health. Within the hospital environment her care can also be dominated by the assessment of potential medical or physical harm to the woman or baby. What stood out to me during my visits to services such as Homeless Prenatal Program, FIR Square, The Sheway Project and Breaking the Cycle was responding to a pregnant women’s significant psychosocial issues from a healthy pregnancy and early parenting framework that recognised the woman as a parent first and foremost e.g. not primarily as a woman with substance misuse issues at risk of relapse.

Providing structural interventions also addresses the reality that there may be factors which increase the risk of harm to a baby that pregnant Indigenous women have no control over e.g. a shortage of affordable housing, health of dependant family members and that it is therefore the responsibility of professionals to address these inequalities through providing practical resources available and advocating for the client.

Many agencies spoke of asking women what they need as a matter of priority at the point of initial engagement. Similarly, staff at the Sheway Project described not asking women to do things for you but asking women what they need you to do for them. This is congruent with the Trauma Informed Care approach detailed earlier in this report i.e. not overwhelming a woman with information or tasks she needs to complete.

Furthermore, staff at both Taonga Support Services and Sheway suggested that examining women’s priorities may mean asking the question ‘why are they coming to us?’ The team at Breaking the Cycle proposed that the answer often involves acknowledging that women want the best for their babies and working from that very foundation. FIR Square also held a similar view and explained that they focused on women as parents not as ‘ex-drug users’ and that women consistently responded positively to what they felt was a non-judgemental approach.

An additional foundation of this approach as outlined by staff at Maxxine Wright is acknowledging that you as the health practitioner are not the expert on women’s lives. Likewise the Homeless Prenatal Program in San Francisco practices from the basis that they
are helping women ‘get to where they want to be’. In addition, asking women what they need is a method of giving disempowered women back respect through returning decision making powers and honouring their right to choose. This can also be implemented when talking to women about potential child protection involvement. At FIR Square in Vancouver women are given the opportunity to think about whether they would like to contact Child Protection directly after they are informed of potential child protection involvement and associated concerns about risk to the unborn.

I was also fortunate enough to visit several agencies where Indigenous women have the opportunity to be the key decision maker in their care plan. At American Indian Families Partnership in Los Angeles they have structured case management in a way that ensures women lead the planning and when the case plan is reviewed six months later staff are able to review the plan with women this is where you were before and say ‘look how far you’ve come!. Similarly, at the Pregnancy & Parenting Service in Auckland women are required to participate in goal planning as part of their overall engagement with the service.

Hopeful Practice Example:

**Holistically addressing women’s priorities in downtown Vancouver**

- **The Sheway Project**
  Sheway is a Pregnancy Outreach Program (P.O.P) located in the Downtown Eastside of Vancouver. The program provides health and social service supports to pregnant women and women with infants under eighteen months who are dealing with drug and alcohol issues. Up to 90% of clients who access Sheway are Aboriginal and the majority of clients have child protection involvement. The focus of the program is to help the women have healthy pregnancies and positive early parenting experiences. Sheway is currently a partnership between Native Health, Coastal Health, Ministry of Child and Family Development and YMCA. Women can access prenatal and postnatal care on the premises through family physicians and community health nurses. There is also a First Nations Family Support Worker available.
  Each day at Sheway lunch is provided and often cooked by an ex-client of the service. Some of the additional practical services provided include weekly food packs, nutrition counselling & prenatal vitamins, provision of items for baby e.g. pram, nappies, formula, child and adult immunization, legal advice, drug and alcohol counselling and advocacy with accessing medical care and housing.
Collaborative partnerships for engaging vulnerable, pregnant, Indigenous women

As identified earlier a key observation of my Churchill Fellowship was that Multi-Agency partnerships are the key to creating a ‘safety net’ of support around vulnerable pregnant Aboriginal women. For this reason throughout my travels I sought out examples of effective collaboration and partnerships which enhanced the engagement of vulnerable Indigenous women in their pregnancy care.

Working with Child Protection Agencies

In NSW currently 1 in 10 Aboriginal children live in out of home care. This is one alarming statistic that reflects the reality that Aboriginal families have a substantial amount of contact with child protection services compared to non-Aboriginal children in Australia. Disturbingly, data indicates that for Māori families in New Zealand and Aboriginal families in Canada this is also the case. An influential driving force behind the aims of my Churchill Fellowship project was frustration at witnessing the overrepresentation of Aboriginal families in terms of families that have child protection involvement at RHW coupled with the overrepresentation of non-Aboriginal practitioners making decisions about the health and care & protection needs of those families.

Canadian First Nations advocate and First Nations Caring Society representative Cindy Blackstock suggests that the reality in Canada is that child protection has grown out of a colonial history and is therefore a colonial by-product whereby non-Aboriginal professionals continue to tell Aboriginal people how to parent. Similarly, several Child, Youth and Family Service (CYFS) staff interviewed in New Zealand identified the challenge of addressing child at risk issues within Māori families when CYFS involvement is often viewed as a form of institutional racism.

Consequently, both locally and internationally it is has been identified that in order to break down historical distrust of child protection services and engage vulnerable Indigenous families there is a need for more Indigenous governed child protection services or indeed Indigenous approaches/perspectives to child protection. During my fellowship I was

fortunate enough to observe several possibilities of this in practice and have defined these observations into three key areas:

1. Indigenous models of assessment and care

In New Zealand Child, Youth and Family Service (CYFS) staff access the Tuituia Framework for assessment of both Māori and Non-Māori families referred to CYFS. The Tuituia framework found in Appendix C is based on the concept of “Tuia ngā āhuatanga o te ao o te mokopuna kia whai oranga! Weaving together aspects of the mokopuna (young person) world to enhance wellbeing”28. Tuituia, the name given to the framework, was chosen because it tells the story to reinforce the practice. CYFS guidelines state ‘Given that more than half of all children and young people who engage with Child, Youth and Family identify as Māori, it is critical that our framework reflects Māori perspectives of wellbeing leading to responsive practices for mokopuna and whānau Māori’29.

The framework identifies the collective nature of caring, and positions mokopuna (young people) within their (genealogy). CYFS staff interviewed explained that this is an important custom for Māori families and communities as they regard children as “a reflection of one’s ancestors”. In this way the Tuituia framework is a key example of valuing and respecting the Māori view of life, whanau (family) and children and implementing this view through bi-cultural child protection practice. The framework is significantly influenced by the work of Dr Leland Ruwhiu30 (2009) which makes clear the importance of the following:

- engaging with children, young people and families/whānau through listening, understanding and respecting cultural difference
- valuing the contribution of whakapapa and cultural narratives to restorative healing processes through the generations
- reaffirming the ability and capacities of family/whānau to engage in self-determination and providing support to do so
- recognizing that the cultural wisdom embedded in Māori ideological and philosophical beliefs can generate solutions or resolutions to Māori welfare concerns31

The Tuituia framework is also an example of an Indigenous view of life and wellbeing that is fundamentally holistic in nature. This is conducive to both building a picture of where the child is located within family and community and identifying what supports are already in place. Consequently, the model is of great benefit for safety and risk assessment of all children.

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28 Tutuila Framework, Child, Youth and Families Services (CYFS)
29 Child, Youth and Family Practice Guidelines (available at www.cyf.govt.nz)
31 Ruwhiu, (2009)
1. **Indigenous specific child protection services**

In many parts of North America there exist separate, specific child protection services or agencies for First Nations Families. Aboriginal Guidelines underline the philosophy of service provision of these agencies. One such agency is the Vancouver Aboriginal Child & Family Services Society (VACFSS). VACFSS have a mandate that were possible they must have at least 51% First Nations staff. Four elders are employed full time within the agency and are therefore available for consultation around child protection issues and participation in case conferences. VACFSS staff also reported that they were currently exploring the possibility of involving elders in the intake process so that an elder can be part of the initial response to a risk of harm concern not just involved at the point where things reach a crisis level and a child may need to come into care.

**Hopeful Practice Example:**

*Providing child protection services with Aboriginal cultural & spiritual needs in mind*

- **Vancouver Child and Family Services Society (VACFSS)**
  
  VACFSS is responsible for child protection services for Aboriginal children, youth and families in Vancouver. All services are culturally based and make use of traditions and practices that strengthen cultural identity. Families are respected for their strengths and knowledge and for this reason their input is sought as much as possible in decision making.

  VACFSS have several ways to responding to identified risk of harm concerns through collective decision making. One process that demonstrates cultural respect for the family’s voice is Family Decision Making Conferences whereby following discussion with professionals a family is given the chance to discuss concerns amongst themselves and come up with a plan which they then bring back to professionals. Food is also an essential part of the family led conference!

  VACFSS also facilitate culturally appropriate ceremonies for difficult child protection events such as when a child comes into care, when a parent chooses to relinquish care of child and when a child is restored to their parents care.

Interestingly, some staff in cities that had specific Indigenous child protection services identified that in the context of risk of harm issues for an unborn and the chance of that child coming into care sometimes there was no significant difference having a Child Protection agency that is Indigenous specific as what made an agency most effective was whether they had the capacity to respond to cases prenatally.

Similarly, staff at VACFSS and Pregnancy Outreach Program in Toronto acknowledged the importance of recognising that it is a woman’s choice as to which service she accesses and assumptions should not be made that a woman will have a preference for Aboriginal staff based on her Aboriginality.
2. Specific processes and policies for Indigenous families within mainstream child protection systems

When a Māori child comes into care in New Zealand Child, Youth and Families are mandated to search extensively for a Māori carer within Whanau (family) then Hapu (sub-tribe) and Iwi (tribe). Similarly, in the USA case workers are required to locate an American Indian carer within a child’s tribe under the Indian Child Welfare Act. Whether this occurs or not currently is a matter of contention however it acknowledges the need for Indigenous children to remain as closely linked to their culture as possible. Currently in NSW there exists similar legislation under the Children and Young Persons (Care and Protection) Act 1998 – Section 13, however limitations appear to exist with regards to identifying possible Aboriginal carers beyond immediate family. The shortage of Indigenous carers in Australia, New Zealand, USA and Canada makes it all the more paramount that if assumption of care is identified as a possibility antenatally potential family or extended family carers are identified as early as possible.

I also learnt of instances at a leadership level where the specific needs of Indigenous families within a child protection intervention were acknowledged and the professional wisdom of Indigenous community members or specific agencies sought. In New Zealand Māori elders can be involved in CYF consultation processes that concern matters such as locating appropriate placements for Māori children or permanency planning. Similarly, in Los Angeles the Department of Child and Family Services supervisors meet with supervisors from United American Indian Involvement every couple of weeks to discuss cases including current families in crises.

Sharing of information

A strong theme which emerged consistently throughout my Churchill Fellowship was the professional challenges that often emerge around the sharing of information between agencies. Within the NSW context communication and collaboration between agencies has become essential practice and a key priority since the 2006 Special Commission of Inquiry into Child Protection Services in NSW and the subsequent implementation of the Keep them Safe reforms.

One of the main catalysts for the NSW Government initiating an inquiry into child protection services in NSW, and for the reforms to the child protection system arising from that inquiry was a case where a seven year old girl died in tragic circumstances that suggested significant physical neglect and abuse. Following her death and the Royal Commission the NSW Ombudsmen then conducted a review and discovered there were seven agencies involved with the young girl’s family yet none of them knew about each other’s active involvement and that this may have led to vital information not being shared. The Ombudsman
identified significant problems with information exchange in a child protection context and remarked

‘it is important to be reminded about what can go wrong for children when agencies fail to work effectively, fail to work together, and fail to take shared responsibility for the care and protection of children’32

Both the inquiry and the Ombudsman’s review observed that areas such as serious and chronic neglect, parental substance abuse, serious mental health issues and high risk domestic violence matters, were particularly suitable for coordinated cross-agency work. Subsequently, in May 2009 the NSW Government passed the recommendations of the ‘Keep Them Safe’ review, many of which concerned improved exchange of information between agencies. What these recommendations recognised is that information sharing is vital to establish the ‘big picture’ of what is happening for a child or a pregnant mother and is particularly essential in cases of risk of cumulative harm.

I discovered that within each country I visited health and welfare professionals had alarmingly similar sad stories of instances where a child, often with Indigenous heritage, had died from abuse or neglect and different agencies had been involved yet not known about each other’s involvement. Health practitioners in New Zealand explained that since 2010 protocols around the exchange of information between agencies were guided by a Memorandum of Understanding that exists between Police, Child, Youth and Family (CYFS) and Health. This has contributed to both increased Police collaboration around family violence and the targeted response to information sharing through the introduction of Child, Youth and Family Services (CYFS) liaison workers within hospitals. The CYFS role is for consultancy purposes and provides health staff with the opportunity to liaise with CYFS directly about a family’s history and current risk of harm concerns. My observation was that in many cases having a child protection consultancy role within the hospital also means recognising health staff as lead carers and by exchanging information where possible avoiding the need for further CYFS involvement for assessment purposes.

Another essential factor to take into account when considering the exchange of information between agencies is the individual woman’s rights and needs with regards to the exchange of personal information. One community midwife in New Zealand advised of the principal of informed consent whereby women are given the option for their information to be exchanged. This is the ideal however difficult in situations where significant risk of harm issues exist and professionals need to share information to ensure others have the ‘big picture’. It is in these circumstances that the Te Aka Ora Forum uses a human rights perspective in its approach to discussing a woman’s information. This involves asking the question ‘does a woman know she’s being discussed?’ and handling information in a sensitive and productive manner through ensuring that only the practitioners that need to hear the information are present. As an observer this approach appeared to be respectful of the individual woman’s struggle with adversity and indicated a capacity for the team to

32 ‘The Death of Ebony: The need for an effective interagency response to children at risk’ NSW Ombudsman Special Report to Parliament, October 2009
approach each woman’s needs from a strengths based perspective. This made me question whether structuring a meeting with a ‘safety net’ strengths based focus had an indirect positive impact on the ways in which non-Indigenous staff attempted to engage Indigenous women.

Other agencies visited had addressed the need to exchange information and the subsequent need to advise the woman of this through the creation and use of consent to release information forms. One useful example of this was Breaking the Cycle (BTC) in Toronto. Staff at BTC are honest from the beginning about who they are sharing information with through providing a form where women can see a list of agencies their information may be discussed with e.g. probation and parole and establishing why that information may need to be exchanged. After learning more about this form and observing similar processes at other agencies visited I found it useful to consider that women still access services in the knowledge that their information may be exchanged with statutory agencies. This therefore highlights the immense value of honest relationships and transparency at the point of first contact and how women will return to a service where they feel respected. As mentioned previously many agencies spoke of where possible calling Child Protection with women and honestly sharing with the woman what information you are sharing. This is related to not being scared to mention risk of harm issues and imminent child protection involvement and respectfully having a difficult conversation about dangers and risks present. Staff at HerWayHome in Victoria, Canada and United American Indian Involvement explained that early contact with child protection services when their involvement is imminent can also enable staff to supportively journey with the woman through the process of child protection assessment and intervention and meeting the expectations of child protection agencies.

Māori social workers at Wellington hospital described the importance of telling child protection positive details about a family when exchanging information so that they have positives to put beside other historical info. This can be difficult when there is lots of negative information or child protection is focused on the risks however is another part of building the ‘big picture’ of strengths and concerns. Sharing information is relevant to engaging high risk Indigenous women as it is about where possible preventing a crisis response and responding to risk of harm concerns collaboratively in order to address health and welfare inequalities and prevent these inequalities from continuing on through generations. In this context the long term outcome of preventing cycles of harm is less Indigenous children in care and therefore increased trust and partnership between Aboriginal families and government services resulting in better health outcomes and long term increased participation in education and the workforce.

**Working with what you’ve got**

A similar narrative I encountered in the majority of cities visited was inadequate and inconsistent government funding for both Indigenous maternal and infant health and
perinatal child protection services. In some cities the key services responding to high risk families received the majority of their funding from non-government benefactors. Unlike NSW or many other Australian states there was also an absence of any specific federal or state Indigenous health strategy in most cities I visited. Similarly, in nations such as the USA no universal health care results in additional financial and systemic obstacles to women accessing primary health care services. Given these challenging structural and systemic limitations it was interesting to learn how agencies met the practical and psychosocial support needs of Indigenous pregnant women and their families in a restricted political and financial climate. The answer appeared to exist in the form of simultaneously making the most of existing partnerships and making effective use of other methods of assistance available such as grants or community philanthropy.

The co-ordinators of American Indian Families Partnership explained that they were acutely aware of not overlapping with other services in Los Angeles and consequently not using limited resources inefficiently. This meant that they had established partnerships with other support services for American Indians in Los Angeles centred on the specific services that they could provide that American Indian Families Partnership couldn’t. Subsequently, creating a network with fluid communication and information about what specific services can provide is an effective way to avoid overlap and avoid both the potential for families to become confused and overwhelmed by too many services and thus disengage altogether. It is also a way to ensure that limited resources are being used to their full potential.

During discussions with health practitioners that provide universal services the need to utilise what is already in existence with regards to mainstream healthcare also became apparent. The very nature of services that are universal e.g. school education, antenatal screening, early childhood baby health checks means that every woman regardless of culture is offered or even required to attend the service. For this reason accessing universal or mainstream services may carry less stigma than programs that are specifically targeted to ‘high risk’ families. At Summit Healthcare in Phoenix Arizona every family of a newborn baby is offered a newborn behavioural observation and neurodevelopmental assessment through the Healthy Steps program. This includes access to experts in child development, early learning and breastfeeding who can visit families both in hospital and at home. In recent years the service has observed a significant increase in Native American families accessing the service. One health worker suggested that this increase may suggest that Native American families are actively choosing prevention options over other traditional services which may be perceived to be more of a ‘Band-Aid’ service that responds to the issues as they are identified in a crisis. This is congruent with a strengths based approach that comes from the basis that women want the best outcome for their children.

In the context of partnerships and linking up vulnerable Indigenous women and families with the most appropriate service utilizing mainstream services also often involves educating and resourcing mainstream services so that they have the capacity to provide a
culturally competent service to Indigenous clients. United American Indian Involvement in Los Angeles and First Things First in Phoenix regularly conduct education sessions to inform staff of the intergenerational effects of trauma and the historical events which have contributed to this trauma.

Providing peer support
Another key resource to be utilised in the context of limited resources is peer support for women. The benefits of providing the opportunity for past and current clients to meet and support one another within a service cannot be underestimated particularly with regards to initially engaging Indigenous women in a service. I was privileged enough to witness this first hand at several services including the Sheway Project, FIR Square and Breaking the Cycle. At both Sheway and Breaking the Cycle following structured group or case management time women gather for a lunch made of fresh donated food. Staff often also participate in lunch at the same time. What stood out for me was how providing a ‘soft’ safe space for women to come and go and share a meal together in the same space where structured groups or case management occurs is a valuable way to simultaneously meet women’s practical and social needs whilst providing a comfortable space to discuss any potential risk of harm issues. Staff at Sheway in Vancouver also explained how women who have accessed a service previously and may still be present at the service can ‘get real’ with other women about their lifestyle in a way that staff cannot.

Harnessing the wisdom of elders & wider Indigenous community
My fellowship travels involved speaking to both non-profit agencies and government funded agencies who regularly consult elders of the Indigenous community regarding what the needs of vulnerable women and families are.

At American Indian Families Partnership staff regularly ask elders what the needs of the community are and where possible involve them in child protection processes and providing support to women at the program. Similarly, in Phoenix Arizona there are 22 different tribes all with different customs and ceremonies for events such as cremation, coming of age. First things First Early Childhood support service have adapted to this through employing a process whereby they access communities through individual tribal councils. This includes contacting a tribal council to explain the prenatal and postnatal supports the service provides and establishing how they can serve the community. It was inspiring to hear of the partnership through which First Things First participate in discussions with tribal councils and community representatives via ‘visioning’ together what the needs of individual children are.

Likewise Summit Healthcare staff reported that respecting feedback from elders and the community is often about making adaptions to government models to fit with what individuals or communities need. This is a useful example of finding culturally competent
ways of engaging pregnant Indigenous women within the resources and structures of a mainstream health service

Practitioners at HerWayHome also identified how a community’s needs are not ‘static’ and as such staff cannot rest on their laurels following initial consultation with a community. This highlighted for me the fact that the needs of Indigenous communities and individuals may be fluid and change in accordance with wider societal change making it essential that strategies for engaging Indigenous women in their healthcare are constantly reviewed.
Building the future

Indigenous workforce development

Providing care to Indigenous families with child protection issues or indeed engaging any vulnerable family includes recruiting and maintaining a highly skilled workforce. For many reasons the ideal practitioners to work with Indigenous women are Indigenous people themselves. New Zealand, USA and Canada all face similar challenges to Australia with a significant shortage of qualified Indigenous health and child welfare staff. Reflecting on this issue I was led to the question what is required to build and sustain the Indigenous workforce?

Similar to the current Australian context in New Zealand due to a chronic shortage of Indigenous health and child protection professionals Māori health staff are often stretched across different areas which then impacts on their capacity to respond to referrals or provide ongoing intensive support to families. After the opportunity to reflect with peers from New Zealand around this issue I became aware of the responsibility non-Indigenous staff have to contribute to building up the Indigenous workforce through sharing their inherent ‘wealth’ of knowledge, skills and resources. For this reason a key step in supporting the development of the Indigenous workforce is through the provision of student placements and mentoring opportunities.

As previously identified Indigenous staff that can be upfront with families about identified risk of harm issues can be of tremendous benefit when working with clients with complex psychosocial needs or multiple vulnerabilities. Many Māori health staff interviewed described how they often go into the homes of Māori families where child at risk issues have been identified and speak to them frankly about the issues, child protection involvement and the likelihood that their child will be removed by CYF. Interestingly many of these staff were also able to describe how they did this with the knowledge that they had a team behind them and ultimately if they required it the support of senior managers. Consequently, it is important to consider the support needs of Indigenous staff to perform these challenging tasks and maintain their role, particularly when it may involve regularly facing the reality of risk and adversity in their own communities.
Establishing cultural competency for non-Indigenous practitioners

Due to the reality of significant health inequalities and socio-economic disadvantage Indigenous people often have an increased need to access mainstream health and welfare services. As it is predominantly non-Indigenous practitioners who will care for Indigenous clients within these settings it is essential that non-Indigenous health practitioners are equipped with the skills and knowledge to provide culturally competent care within a clinical environment.

European occupation cannot be reversed. Most non-Indigenous Australians cannot return to the countries their ancestors emigrated from. Consequently, examining cultural competency is often about how we work in the here and now addressing the past with the knowledge that we are facing the future together. This is important to ensure that reconciliation is not turned into an issue that is the sole responsibility of Aboriginal Australians. A necessary step in this process is therefore to engage in what is offered referred to as ‘adaptive work’, a process of self-reflection about your own culture and its view of others. Once again this is an area where New Zealand shone through a demonstrated commitment to building bi-cultural practice competencies within the non-Indigenous workforce. One definition of cultural competence I was referred to was

33Maddison.S (2011) Beyond White Guilt, Crows Nest, Australia, p8
‘Cultural competence refers to the ability of workers to navigate the interface between their own cultures and those of their clients, while a foundation of clinical expertise is fundamental to ensuring that Māori receive a quality service response that is consistent with best practice, as is expected for all New Zealanders.  

Senior practitioners in New Zealand also suggested that cultural competency is a personal factor based on individual experiences. For this reason if staff are educated at university or have the opportunity at university or in the workforce to learn from Māori clients and staff then this can contribute to experiential knowledge of Māori culture and help foster understanding and awareness.

In this context it is also interesting to consider staff education as a component of service provision to Indigenous families. Staff at United American Indian Involvement and First Things First regularly provide education to other health and welfare professionals regarding aspects of caring for Native American families with a history of trauma. This comes from a basis that many professionals have not received adequate cultural competency training and may not be aware of the significant historical factors, such as the residential school system and associated trauma, that contribute to current psychosocial issues faced by Indigenous communities. Staff at Maxxine Wright explained that it’s important not to ‘rest on your laurels’ with regards to staff training as there is often a high turnover of staff within health and welfare agencies so it’s essential to remain aware that not all staff have historical knowledge or have had the opportunity to attend previous training.

In the context of being in the majority by being practitioners of European ancestry white professionals also have a responsibility to ‘give voice’ in clinical planning meetings to Indigenous women who may feel defeated or struggle with obstacles to accessing health care and family support services based on feeling alienated and overwhelmed. This needs to be done in a way that enhances both Indigenous women’s participation in their care, advocates for the women’s health and wellbeing and increases the cultural competencies or capacity of non-Indigenous staff to care for Indigenous families.

**Maternal & infant health opportunities: apart or together?**

In many parts of the USA legislative and geographical boundaries contribute to American Indian communities living in areas separated from the rest of a city or town. As a visitor this appears to almost create an environment of segregation whereby non-Indigenous communities and professionals do not have to consider the ongoing impact of European occupation or the current health inequalities faced by the Native American community because they are not as visible or accessing the same health services. A key advantage of Indigenous communities having separate legislation is that there is increased self-governance and community controlled decision making. A challenge is that vulnerable

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woman may not feel comfortable coming forward due to confidentiality or politics and concerns related to a tightknit community. Whilst this is more of an issue for rural and remote communities I consider it relevant to the aims of my Churchill Fellowship as it involves reflecting upon what contributes to the views of non-Indigenous practitioners and community members (i.e. visibility of Indigenous culture) and how this impacts ways of engaging Indigenous families.

In New Zealand, through means of bi-cultural practice and nationwide health and education policies the majority of services for Māori and non-Māori families appear to be well integrated including links between Maori specific services and mainstream health services. Thus, when you strengthen a response to one culture you effectively strengthen the whole. Fascinatingly, I was also informed of instances in some New Zealand cities where Maraes were becoming holistic hubs for social and emotional wellbeing needs of the whole community.

In many ways it is my view that Australia exists within the middle of a spectrum of separate or integrated service provision for Indigenous families. Regarding services specifically for Aboriginal families my Churchill fellowship travels were extremely useful in identifying that Australia is fortunate to have many federal and state government initiatives which actively Aboriginal Maternal and Infant Health inequalities e.g. Close The Gap, Building Stronger Foundations and do so in partnership with mainstream health services.

**Sustaining Services for Vulnerable Families**

Caring for vulnerable Indigenous women and families involves vicariously being exposed to significant amounts of trauma and adversity. For this reason the social and emotional health and wellbeing of staff and teams is a factor which can have a significant impact on the way services engage Indigenous women and families with identified child protection issues. Many observations and discoveries along the way during my Churchill Fellowship revealed that it is not necessarily elaborate well-resourced programs that produce or sustain best practice and staff wellbeing. It is relationships within teams and a clearly defined purpose or shared approach to working with vulnerable families.

I observed and learnt of teams which practice affirming behaviours with one another regularly and that have clearly established boundaries with regards to role definition and what the service can provide. A key sustaining factor observed was also the ability to be adaptable and willing to change according to what both the individual client or the wider community needs. In addition teams where staff supported each other through sharing workloads and tasks or regularly ‘checked in and out’ with one another about difficult cases appeared to be resilient in the face of significant systemic challenges and daily encountering confronting health inequalities.
In a similar way I observed that staff could be supported through systems in place that support identification of potential risk of harm and encouraged sharing of information in a sensitive, compassionate way that honours a woman’s strengths and rights. This was demonstrated at the Pregnancy and Parenting Service (PPS) at the Community Alcohol and Drug Service in Auckland where notifying child protection occurs as team decision (CADS) and at the Te Aka Ora meeting at North Shore Hospital.
Conclusions & Recommendations

My Churchill Fellowship proved to be tremendously valuable in highlighting what is already done well in Australia whilst simultaneously providing new insights into the Australian context and learning of examples of innovative practice with vulnerable Indigenous families internationally that have implications for Australia. Moreover, much of the new awareness I gained during my Fellowship provides new insights into the support needs of not just Indigenous women but indeed all vulnerable pregnant women living in an urban environment.

Many of my reflections and recommendations may seem obvious to experienced health practitioners however this is a reflection of the aims of my fellowship project in itself. The chance to travel to many different services within a diverse range of cities within several different nations was a fantastic opportunity through which to be reminded of the fundamentals of best practice when attempting to engage clients at a very vulnerable time in their life. My Churchill visits provided an awareness of the simple truth that the provision of compassionate, empathetic, non-judgemental care cannot be underestimated and should remain a priority in the provision of maternal and infant healthcare.

Following reflection on my observations and the themes that emerged throughout my fellowship I have identified recommendations for culturally competent ways of engaging pregnant Indigenous women with child protection issues in their healthcare. Below is a summary of some of the recommendations I believe can be implemented at a local, state and federal level:

- Ensuring that mainstream and universal health care services have visible signs of Indigenous culture e.g. artwork, maps identifying country, language. Not only does this reflect a value of respect for Indigenous culture and reduce disconnection from the strength of cultural identity it may also assist in Aboriginal women feeling more accepted and comfortable within a clinical space. Use of Reconciliation Action Plans (RAP) within individual health services may be used to facilitate this.

- Acknowledging Australian Aboriginal culture in everyday practice e.g. beginning meetings and case conferences with an acknowledgement of country regardless of whether there are Indigenous people present or not.

- Establishment of professional core competencies for social work and health practitioners specific to bi-cultural practice in an Australian context. Bi-cultural
competencies should be reviewed yearly and the opportunity for non-Aboriginal practitioners to regularly reflect on their practice from a bi-cultural perspective provided.

- Utilizing partnerships with elders in the local community to listen to the changing needs of Indigenous women and families and feedback to the community what mainstream healthcare services can provide.

- Aiming to have cultural support e.g. Aboriginal health workers or older members of the community present at case conferences and meetings where Indigenous families are required to make decisions about the care and protection of their children.

- Creation of a social and emotional wellbeing framework, similar to Tuituia, that reflects an Aboriginal understanding of social and emotional health and wellbeing and is specific to the assessment of safety and risk to an unborn child. This has the potential to be developed at a state-wide level or individual site level for purposes of culturally sensitive case planning within a large maternity hospital.

- Application of trauma informed care principles in case planning to acknowledge the presence of transgenerational trauma within urban Indigenous women’s lives and how this impacts both their capacity to engage with health services and their extended families ability to support them in pregnancy and parenting.

- Increased focus on home visiting Aboriginal women antenatally as part of identifying any potential risk of harm issues prior to child protection involvement and meeting women and their families in a space where they feel comfortable.

- Increased support for parents following the assumption of a baby into care. This can include acknowledging the loss through creating mementoes, postnatal face to face visits and ongoing phone contact.

- There is a need for services that are constructed to address risk of harm issues whilst being led by Indigenous women’s needs and priorities and the recognition of woman as parents. In Sydney, due to the absence of pregnancy specific crisis services and the current pathway of referral to more generalist services there is a requirement for a ‘one stop shop’ style service for ‘high risk’ Indigenous and non-Indigenous women that is based on a healthy pregnancy and early parenting focus where women with child protection concerns can drop in and access the following:

  - Practical items for baby
  - Food!
  - Antenatal and postnatal checks
  - Prenatal education
  - Financial and legal advice
  - Public Transport Tickets
  - Qualified case management
  - Mental Health Support
  - Housing advocacy
• Safe space to have contact visits with older children that may be in care
• Aboriginal support staff
• Child developmental assessment

In instances where family and extended family are required to care for an Aboriginal infant there is a need for agencies to strengthen their capacity to do so through practical and emotional assistance and generally finding out what the carers support needs are to ensure that the child can remain connected to their family and culture.

At the Royal Hospital for Women I see the recent introduction of Perinatal Family Conferencing as a positive step towards family participation in case planning and responding to risk of harm concerns and believe that strategies for engaging Indigenous families such as those outlined at VACFSS can be integrated into this process.

Ensuring that multidisciplinary case discussions encourage information sharing between agencies as a means of ‘wrapping support’ around a family and that this is done in a strengths based way that is sensitive to a woman’s private information.

Facilitation of ongoing education to non-Indigenous healthcare staff around the impact of transgenerational trauma on the lives of Indigenous women including assisting staff to identify the interpersonal skills that they already have for caring and nurturing clients in distress.

Ensuring adequate peer support and supervision for Aboriginal staff required to have ‘difficult conversations’ with vulnerable Aboriginal families.

Identifying opportunities for non-Indigenous staff to share their knowledge and skills as a means of building up and sustaining the Indigenous workforce e.g. student placements, internships.

The creation of an international network for health and welfare practitioners to share innovative examples of practice, information and resources with other practitioners working with Indigenous families with child protection issues.
Further information about services referenced

Culturally specific supports for Indigenous pregnant women

American Indian Families Partnership  http://indianfamilies.org/
Anishabwe Health  http://www.aht.ca
Native Women’s Resource Centre  http://www.nwrct.ca
Seventh Generation Midwives Toronto  http://www.sgmt.ca

Crisis support services for vulnerable pregnant women

Sheway  http://sheway.vcn.bc.ca/about-sheway/program-overview/
HerWayHome  http://www.viha.ca/children/pregnancy/herwayhome.htm
Maxxine Wright  http://www.atira.bc.ca/maxxine-wright-community-health-centre
Homeless Prenatal Program  http://www.homelessprenatal.org/

Government Initiatives e.g. health and child protection

Child, Youth and Family Services hospital liaison

FIR Square – BC Women’s Hospital and Health Center
http://www.bcwomens.ca/services/pregnancybirthnewborns/hospitalcare/substanceusepregnancy.html

Vancouver Aboriginal Child and Family Services Society (VACFSS)
http://www.vacfss.com
<table>
<thead>
<tr>
<th>Country (overall pop)</th>
<th>Out of Home Care</th>
<th>Family Violence</th>
<th>Incarceration</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand (14.6%)</td>
<td>52% out of home care placements are Maori children</td>
<td>7 x women, 4 x children Maori hospitalised for assault compared to Pakeha women. 49% Maori Women experience Violence compared to 24% non-Maori</td>
<td>51% total prison population</td>
<td>9 year life expectancy gap between Maori women and non-Maori women. 50% Maori population smoke compared to 20% non-Maori.</td>
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<tr>
<td>USA (1.2%)</td>
<td>2% children in foster care system are American Indian</td>
<td>2.5 x more likely to be raped or sexually assaulted than women in the USA in general population. More likely to suffer injuries requiring hospitalisation</td>
<td>3.1% male population incarcerated</td>
<td>American Indian/Alaskan Native infant death rate second highest in country and 48.4% higher than amongst white American mothers. Suicide rate is 1.73% times higher than general pop.</td>
</tr>
<tr>
<td>Canada (4%)</td>
<td>Nearly 50% children in care are Aboriginal. 0.4% Aboriginal living in Out of Home Care (OOHC)</td>
<td>Aboriginal women 3.5 x more likely to experience violence than non-Aboriginal women (2004)</td>
<td>23.2% total prison population. 33.6% women’s prison population</td>
<td>Type 2 diabetes 3-5x higher amongst First Nations population. Tuberculosis infection rates 8-10x higher.</td>
</tr>
<tr>
<td>Australia (3%)</td>
<td>1 in 10 Aboriginal Children in NSW living in OOHC. Aboriginal children 8x more likely to be the subject of substantiated risk of harm reports</td>
<td>Aboriginal women 27 x Aboriginal men 38 x more likely to be hospitalised for spouse/family violence than others</td>
<td>30% prison population</td>
<td>Life expectancy gap between Aboriginal population and non-Aboriginal population 10.6 yrs. for males and 9.5 yrs. for females. Between 2006-2010 Aboriginal infants died from SIDS at twice the rate of non-Aboriginal infants.</td>
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</tbody>
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**Appendix A – A reflective snapshot of psychosocial statistics for Indigenous populations in Australia, New Zealand, USA and Canada**
Appendix B - A Maori model of health and wellbeing
Appendix C – Tuituia framework for assessment of child at risk issues

(provided by Child, Youth and Family Services New Zealand)