



# DCP Practice Approach

## Foundational Theories and Knowledge Working with families of unborn infants Practice Paper

### 1. Introduction

This practice paper supports Department for Child Protection (DCP) practitioners working with families of unborn infants. This guidance reflects the best practice approach outlined in [DCP's Prenatal Safety and Support Model](#).

Infancy is a critical time in a child's physical, cognitive, social and emotional development. During the first 1000 days, the developing foetus and infant are at their most adaptable, but also their most vulnerable.<sup>1</sup> Infant brain development is rapid<sup>2</sup> and healthy brain development occurs when infants receive appropriate, predictable and consistent responses to their attempts to engage their caregivers. Early trauma can disrupt brain development, and negatively impact regions responsible for emotional regulation, memory, and stress responses.<sup>3</sup> When infants and children live in a chaotic, unpredictable and/or threatening environment their brains become hyperalert to danger and their cognitive and social development may be compromised.<sup>4</sup>

The development of attachment relationships with caregivers is a pivotal aspect of early infant development. Healthy attachment relationships offer infants and young children the safety to confidently explore their world, emotions and relationships, and supports healthy physical, emotional, social and cognitive development. Attuned, responsive and consistent caregiving supports the development of healthy attachment relationships. Conversely, poorly attuned, unresponsive and unpredictable care harms a child's ability to form a healthy attachment relationship and can have life-long impacts. For further information refer to the [Attachment Practice Paper](#).

Pregnancy is often referred to as a 'window of opportunity', whereby the anticipated arrival of a newborn infant acts as a newly found incentive to address risk factors.<sup>5</sup> Working with families during the perinatal period (from pregnancy to 12 months of age) offers a crucial opportunity to intervene early, prevent physical, psychological and emotional harm and, wherever possible, avoid infant's entering care.





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## 2. Department for Child Protection's role in working with families of unborn infants

Report on Unborn (RoU) notifications (commonly referred to as Unborn Child Concerns (UCC)), are non-mandatory notifications that may be received by DCP where there are concerns that an infant will be unsafe or at risk of harm once born. DCP does not have a legislative mandate to work with families of infants prior to birth.

A high-risk infant (HRI) is an infant up to the age of 12 months who is the subject of a screened in child protection notification raising concerns about their safety and/or risk of harm.

## 3. Practice considerations for working with Aboriginal and Torres Strait Islander families

*'For thousands of generations, Aboriginal and Torres Strait Islander families and communities have cared for and nurtured their children strong and safe in their culture'.<sup>6</sup>*

Aboriginal and Torres Strait Islander infants and children are precious to their families and communities. Aboriginal culture promotes the safety, wellbeing and development of children and young people. Upholding the best interests of Aboriginal infants, children and young people includes meeting their cultural, emotional, social, and psychological needs through doing everything possible to support their parents to provide safe care. Where this is not possible, active efforts must be made to ensure they are with their families as connection to family, culture and community is crucial to the best interests and wellbeing of Aboriginal infants and children.

Aboriginal and Torres Strait Islander children are significantly over-represented in child protection and in care compared to non-Aboriginal children. The underlying factors are complex, reflecting impacts of:

- the Stolen Generations
- the consequences of colonisation
- socio economic disadvantage
- intergenerational trauma and discrimination
- systemic racism and issues such as a lack of understanding of the cultural differences in child-rearing practices and family structure.<sup>7</sup>

Aboriginal and Torres Strait Islander families are often reluctant to engage with antenatal care due to fear their infants will be taken into care. Pre-birth reporting by health professionals can lead to "over surveillance" of Aboriginal and Torres Strait Islander families.<sup>8</sup> Aboriginal and Torres Strait Islander families may struggle to engage with child protection and health services due to fear, anxiety and intergenerational trauma, a lack of cultural safety and perceptions of racial bias.<sup>9</sup> Economic disadvantage and social exclusion can further impact engagement.<sup>10</sup> Avoidance of and difficulties engaging with health and child protection services may lead to misattributions, and be viewed as a lack of insight and/or co-operation increasing the likelihood of infant removal.<sup>11 12</sup> A lack of engagement with antenatal care must not be interpreted as a lack of care, concern or love for the infant.





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Racial bias can also influence decision making, including the need for removal, when negative assumptions are made about Aboriginal and Torres Strait Islander child rearing practices and family structures. Research has demonstrated that strengths within Aboriginal and Torres Strait Islander communities are often overlooked or minimised.<sup>13</sup> The strength of Aboriginal and Torres Strait Islander parenting practices and community structures including how infants and children are supported to develop attachment to multiple caregivers must be acknowledged and considered in assessment.<sup>14</sup> For further information about Attachment for Aboriginal and Torres Strait Islander infants and children, refer to [Emerging Minds and Healing Foundation Attachment/Connection Fact Sheet](#).

Culturally responsive practice with Aboriginal and Torres Strait Islander families requires practitioners to:

- acknowledge the widespread influence of colonialism on individuals and systems; and
- take responsibility for establishing the conditions for culturally safe practice<sup>15</sup>
- recognise the importance of connection to family, culture, community and Country for the social and emotional wellbeing of Aboriginal infants and children.

DCP practitioners are expected to undertake the following active efforts when working with Aboriginal and Torres Strait Islander families during pregnancy and infancy including:

- asking parents at the first contact if they, or other people in their family, identify as Aboriginal and/or Torres Strait Islander and developing detailed genograms
- consulting early and regularly with Principal Aboriginal Consultants and Aboriginal Family Practitioners
- recognising and respecting the differences in Aboriginal and Torres Strait Islander child-rearing practices, kinship structures
- providing early, timely support and intervention that prevents the need for Aboriginal and Torres Strait Islander infants to enter care
- identifying all opportunities for Aboriginal and Torres Strait Islander infants to safely remain in their family's care
- providing Aboriginal and Torres Strait Islander infants and their families with assistance to engage in formal and informal Aboriginal Family Led Decision Making.
- commencing thorough family scoping at the earliest opportunity to identify supports within the family and community to ensure the safety of the infant
- where placement is required, actively exhausting all placement options at the higher levels of the Placement hierarchy before considering lower hierarchy placements.

Refer to the [Family Led Decision Making for Aboriginal Families Practice Paper](#) and [Family Led Decision Making Framework](#) for further information.





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## 4. Practice considerations for working with families from culturally and linguistically diverse backgrounds

Culture has a significant impact on the way in which families prepare for birth, birth and parent. When working with families from a culturally and linguistically diverse (CALD) background, it is imperative to consider the diverse ways in which parents can safely care for their infants and ensure that culture and community is recognised as a strength.

Health systems and maternity care in families' countries of origin can differ markedly from Australian services. Some families from CALD backgrounds may feel strongly about maintaining traditions, rituals and roles from their countries or origin. DCP staff must seek to understand and respect these diverse cultural perspectives when responding to unborn child concerns.

It is important to be aware there can be socio-cultural service barriers for families from a CALD background when birthing and parenting in Australia.<sup>16</sup> Traditional support networks may be absent or diminished and there may be a lack of culturally accessible information about birthing and child rearing.<sup>17</sup> Consideration must be given to the challenges of limited English proficiency, unfamiliarity with Australian health and child protection systems, and fear of stigma or discrimination when seeking help.

Culturally diverse families in Australia have described experiencing isolation, loneliness, fear and anxiety in the perinatal period which is often exacerbated by limited social supports and the inability to engage in cultural practices that would involve female family members, from whom they may be separated.<sup>18</sup> Significant barriers can exist to accessing antenatal care including knowledge of services, language barriers, financial and practical support to attend appointments and cultural views on accessing formal medical care.<sup>19</sup> Families from CALD backgrounds are often unfamiliar with child protection processes and this lack of knowledge may compound anxiety when DCP is involved.<sup>20</sup> The role of fathers and extended family members may differ in the perinatal period to western approaches.<sup>21</sup> In addition, preparations undertaken in the lead up to the birth will vary widely between and within cultural groups, with high rates of infant mortality in some countries of origin impacting how parents prepare for the birth of their infant.

Assessing the diverse parenting practices that are often encountered when working with CALD families is complex.<sup>22</sup> Given the breadth of cultural diversity between and within communities, consultation with DCP Multicultural Services is crucial to support a culturally responsive and informed assessment. DCP Multicultural Services can provide cultural advice, resources, and community engagement strategies to guide assessments and interventions, ensuring supports are inclusive, safe, and responsive to each unborn infant's and family's unique cultural identity. It is imperative that all efforts are made to support families from CALD backgrounds to participate in family led decision making.

Refer to the [Working with cultural diversity Practice Paper](#) for further information.





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## 5. Practice considerations for working with young people under Guardianship

When a young person under Guardianship of the Chief Executive or their partner becomes pregnant, DCP has a crucial role in supporting them to provide safe care to their infant.

Planning, referrals and intervention should commence as soon as the pregnancy is known to ensure that there is as much time as possible for the young person to build the skills and resilience to support safe parenting.

For further information refer to the Case management and support for pregnant young people under Guardianship of the Chief Executive section in the [Intake, investigation and assessment chapter](#) of the Manual of Practice.

## 6. Best practice when working with families of unborn infants

### 6.1 Early intervention

Many government and non-government agencies in South Australia are responsible for supporting families where there are concerns regarding safety or risk of harm to an infant once born. In many cases the most appropriate response to an UCC is to refer the family for support. To ensure sufficient time for engagement prior to birth, referral must occur as soon as possible.

Whilst DCP does not have a legislative mandate to intervene with families during pregnancy, where there are serious concerns regarding the safety of an infant once born, early intervention, assessment and support is crucial. Responding as early as possible in the pregnancy decreases the likelihood of an infant entering care by:

- providing time to undertake a quality assessment and for parents to make changes to address child protection concerns<sup>23</sup>
- providing the best possible opportunity for family meetings, or a FGC to be held prior to birth.

In these cases DCP will undertake a Prenatal Assessment and, if required, a Prenatal Action Plan to identify what is required to address safety and/or risk factors prior to the infant's birth.

It is acknowledged there are circumstances where DCP is not made aware of concerns until late in the pregnancy or after birth and instances where parents do not consent to engage with DCP or other services and this will impact the capacity to intervene early.

Refer to the Report on [Unborn Response Pathway Guide](#) for information about criteria to guide referral to other agencies and allocation for pre-birth assessment by DCP.

### 6.2 Culturally responsive practice

Culturally responsive practice requires the acknowledgement of the positive influence of culture and cultural connection in the safety, wellbeing and healthy development of infants and children.<sup>24</sup> Cultural consultation





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and reflective practice are crucial contributors to practice that respects and values diversity in parenting practices.

Refer to section 3 of this paper for specific practice considerations for working with Aboriginal and Torres Strait Islander families and section 4 for specific practice considerations for families from CALD backgrounds.

## 6.3 Engaging families

Concern about being notified to DCP can be a significant barrier to families seeking antenatal care and being open about their needs and difficulties.<sup>25</sup> Research has identified that pregnant people who are notified to child protection experience feelings of stigma and find it difficult to trust professionals.<sup>26</sup> Stigma can be a particular issue for families of culturally and linguistically diverse backgrounds, as well as families in rural and remote areas, who may feel exposed living within smaller communities.

In prenatal work it is imperative that all efforts are made to work with both parents. Research highlights that fathers and partners are frequently overlooked or given less consideration than the pregnant person in both pre-birth assessment<sup>27</sup> and perinatal health services. Inadequate engagement of the other parent (whether the father, partner or same sex partner) can lead to missed opportunities to address risk factors, identify strengths and can leave partners feeling they lack support.<sup>28</sup> It also places disproportionate responsibility on pregnant people to address child protection concerns.

It is acknowledged it may not be possible to gain the cooperation of parents, however, all efforts must be made as soon as possible. Assertive engagement may be required to build cooperation. Respectful persistence and creative approaches to engagement should be used, including attempts to establish contact with the parents through agencies who are already working with the parents. [Relationship Based Practice](#) skills are crucial to establishing trusting relationships that promote effective intervention. For additional guidance about Assertive Engagement strategies, refer to the [Child and Family Support System - Assertive Engagement Practice Guide](#).

Where consent to work with DCP cannot be obtained, the parent's willingness to work with other services (for example, Intensive Family Support Services and other non-government services) should be explored. It is important that the fear and anxiety that may be experienced by parents when engaging with health services and DCP during pregnancy, and how this impacts their behaviour and engagement, is viewed as an understandable reaction.

Where parents do not agree to work with DCP, DCP practitioners should continue to:

- assess safety and risk of harm for the infant once born by requesting information from agencies who have worked or are working with the family via the Information Sharing Guidelines or section 150 of the *Children and Young People (Safety) Act 2017* (CYPS Act)
- scope family supports
- make additional attempts to engage the family where possible and appropriate.

## 6.4 Trauma responsive practice

A significant number of the parents DCP works with have their own experiences of trauma including complex, relational trauma in childhood and adolescence. The perinatal period is a particularly sensitive





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time. Memories of abuse, neglect or other traumatic experiences can arise and thoughts, feelings and behaviours associated with trauma surface or are exacerbated.<sup>29</sup> Distress can be triggered by factors such as:

- the intimate nature of pregnancy health care
- the care and attachment needs of the infant
- other stressors (for example, changes to socio-economic circumstances).<sup>30</sup>

Holistic assessment of safety and risk of harm requires DCP practitioners to consider both parents' experiences of trauma, as well as other risk and protective factors.

When working with parents who have older children in care, it is important to consider the trauma, grief and loss associated with the removal of their other children. DCP practitioners should consider:

- how these experiences may impact parents' behaviour, functioning and engagement with DCP and other service providers
- whether the DCP case worker for the older children can support the parent/s to engage in assessment of the infant's safety.

For further guidance refer to the [Trauma Lens Practice Paper](#).

## 6.5 Transparent communication

Inconsistent and/or insufficient information can lead parents to feel “out of the loop” and result in feelings of being deceived and potentially impact future engagement with DCP and other services.<sup>31</sup> A lack of timely planning and communication can be interpreted by families as insensitive and lacking empathy.<sup>32</sup>

Providing clear and consistent information about the child protection concerns and the actions required to address the concerns is critical.<sup>33</sup> Stress and trauma can impact capacity to understand and retain information, thus it is necessary to regularly revisit and reiterate the concerns.

DCP practitioners must clearly explain all child protection processes. It should not be assumed that parents who have had other children removed from their care have retained this knowledge. It is also imperative to ensure extended family and professionals (such as midwives or intensive service providers) understand the child protection concerns, and the actions required to address them. It is also important to consider whether the parents have any cognitive or literacy issues that may impact their understanding and communication is adapted accordingly.

There will be occasions where DCP practitioners hold significant concerns that informing the parents of the child protection concerns prior to birth will increase risk of harm to the infant due to:

- disengagement from antenatal and midwifery care; and/or
- the parents leaving South Australia to avoid departmental involvement.

Withholding this information from the parents is a significant decision. It must be based on a strong evidence base. The concern must be greater than a general concern about disengagement, and would generally include circumstances where:

- the parent/s have previously evaded child protection authorities by moving between jurisdictions
- the families have strong connections interstate and financial means to relocate.





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This decision must be informed by consultation with a practice leader and Principal Aboriginal Consultant (where relevant).

Refer to the Manual of Practice section Undertake a Prenatal Assessment for information for guidance regarding recording the decision to not inform parents of child protection concerns prior to birth.

## 6.6 Family Led Decision Making

Family Led Decision Making is a process where families are supported to lead the development of plans to keep their children safe. To enable effective Family Led Decision making, it is essential that all parties have a shared understanding of the child protection concerns.

Practitioners must make active efforts to support all families to engage in Family Led Decision Making throughout DCP intervention. This can be through formal mechanisms such as a referral for a FGC or through other mechanisms, such as arranging family meetings.

Family Led Decision Making is particularly important when working with Aboriginal and Torres Strait Islander families. DCP practitioners must take active efforts to support families in these processes. Refer to the [Family Led Decision Making for Aboriginal families Framework](#) for further information.

## 6.7 Connecting families with support

Plans to address child protection concerns must be developed in partnership with parents, clearly documented and shared with parents and service providers. Where referral to external services is required, this should occur as early as possible during pregnancy to ensure sufficient time for progress to be made to address the child protection concerns<sup>34</sup>.

When planning for intervention, it is essential to be mindful of the number of services and appointments the parent/s are required to attend. Pregnancy can be tiring and overwhelming, and parents can disengage if there are too many demands, and/or they do not feel clear about the purpose of intervention.<sup>35</sup> DCP practitioners should consider quality of intervention over quantity and prioritise the most critical risk factors for intervention.

## 6.8 Continuity of care

Wherever possible it is best practice to have the same practitioner/s working with parents throughout the pregnancy. Where DCP is planning to work with the family after the infant is born, co-working with the DCP case worker who will be allocated to the case once the infant is born can be a useful approach to supporting continuity and relationship building. Practitioners should also advocate for continuity of care with other services.<sup>36</sup>

## 6.9 Early family and community scoping

Family and community scoping is broader than scoping for a placement for an infant. It starts with scoping for supports that can assist the parent/s to keep the infant safely at home. It must commence as soon as possible with the development of a detailed genogram and ecomap in partnership with the family.





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For Aboriginal and Torres Strait Islander infants, a Principal Aboriginal Consultant must be consulted for advice about the approach to scoping and a referral to [Taikurtirna Warri-apinthe](#) submitted (with the consent of the parents).

For families of CALD backgrounds, consultation with DCP Multicultural Services is strongly recommended.

## 7. Safety and risk assessment for unborn infants

When DCP allocates an UCC, practitioners must complete a Prenatal Assessment to identify strengths, safety concerns, risk factors and protective factors. For guidance about the assessment of safety and risk of harm, refer to the [Prenatal Assessment Framework](#). If safety concerns and risk factors are identified in the assessment, actions to address the concerns must be planned in partnership with the parents and documented in a [Prenatal Action Plan](#).

Refer to the Undertake a Prenatal Assessment in the [Intake, investigation and assessment chapter](#) of the Manual of Practice for further information about requirements.

### 7.1 Assessment considerations for unborn infants

#### 7.1.1 Antenatal care

Research demonstrates that pregnant people value antenatal care but may face multiple and complex barriers to accessing timely and regular care. For many pregnant people, a combination of factors can culminate in insurmountable barriers to accessing care, including:

- personal factors (fear, anxiety, overwhelm, lack of knowledge of services)
- the delivery of health services (location and accessibility, continuity of care, lack of flexibility)
- broader social-contextual factors (transport issues, employment, childcare responsibilities, lack of social support and language barriers).<sup>37</sup>

For families residing in rural and remote regions, there can be additional barriers to accessing antenatal care such as long distances to travel. This includes needing to travel to metropolitan areas for care, leading to disconnection from family and community.

Cultural factors may also influence whether formal antenatal care is accessed. Some pregnant people may be unaware that antenatal care is available. They may also access informal antenatal support from people within their community as would be typical practice in their country of origin.

Antenatal care is important for the health and wellbeing of the infant and the pregnant person, and adverse health outcomes can result from untreated medical issues during pregnancy. It is essential that barriers to accessing antenatal care are carefully considered during assessment. Unpacking the barriers will prevent misattribution of intention and ensure that pregnant people are not unduly penalised for barriers to antenatal care they have been unable to overcome.





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## 7.1.2 Domestic and family violence

Pregnancy is a period of high risk for the onset or worsening of domestic and family violence<sup>38</sup>. Pregnant people are more likely to experience all forms of violence, including physical and sexual assault, and psychological aggression.<sup>39</sup> Violence during pregnancy can be more extreme, posing a significant risk of harm to the pregnant person and unborn infant.<sup>40</sup> High levels of maternal stress can also impact the unborn infant's brain development.<sup>41</sup> Abuse during pregnancy strongly predicts abuse immediately following birth.<sup>42</sup> Exposure to domestic and family violence during pregnancy has been associated with a significantly higher risk of postnatal depression symptoms among pregnant people<sup>43</sup> and poorer attachment relationships between parents and infants.<sup>44</sup> It is imperative that all intervention ensures that perpetrators of domestic and family violence are held responsible for their behaviour. Refer to the [Domestic and Family Violence Practice Paper](#) for further information.

## 7.1.3 Alcohol and other drug use

The use of alcohol and other drugs (AOD) during pregnancy can have significant and long-term impacts on the unborn infant.<sup>45</sup> The prenatal effects of AOD use in pregnancy include premature birth, foetal distress, neurodevelopmental problems for the infant, risk of stillbirth and withdrawal symptoms upon birth.<sup>46</sup> In the longer term, the effects of AOD use during pregnancy include, but are not limited to:

- increased risk of sudden infant death syndrome (SIDS)
- impulsivity
- learning disabilities
- antisocial behaviour
- neurological deficits.<sup>47</sup>

The use of alcohol during pregnancy can result in Fetal Alcohol Spectrum Disorder (FASD) which causes life-long cognitive and learning disability and behavioural difficulties.

Regular use of AOD in pregnancy can result in Neonatal Abstinence Syndrome (NAS) which can include symptoms such as:

- poor sleep
- increased crying
- tremors
- vomiting
- diarrhea
- seizures.<sup>48</sup>

Different drugs will have different impacts on the unborn infant. Some infants experiencing NAS may require a longer stay in hospital and medical intervention.

Consultation and referral to Drug and Alcohol Services South Australia should be considered where there are concerns about AOD use.





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Where there are concerns an infant may have been exposed to AOD in utero, it is important that DCP practitioners clearly communicate the child protection concerns with the birthing hospital and seek advice on the infants medical and care needs.

Pregnant people using alcohol and other drugs can experience significant feelings of shame and find it difficult to trust professionals. This can compromise their engagement with antenatal care<sup>49</sup> and child protection. These factors underscore the importance of engaging empathically and non-judgementally with pregnant people who are experiencing difficulties with AOD use.

## 7.1.4 Mental health

Mental health issues are prevalent within the community. As many as one in five Australians have experienced a mental health issue. Many mental health issues may be minor or well managed and do not pose a risk to the safety and wellbeing of infants. In some circumstances unmanaged parental mental health issues can pose a risk to the infant once born including:

- neglect of basic needs and unsafe living environments (for example, hygiene, feeding, medical care, hoarding and squalor)
- impairment of emotional availability impacting emotional attunement of parents, which has a negative impact on emotional development and attachment<sup>50</sup>
- risk of physical abuse due to caregiver stress, inability to control impulses and mood instability
- challenges for parents in providing sufficient cognitive and sensory stimulation to support development leading to increased developmental vulnerability.<sup>51</sup>

It is noted that AOD use once an infant is born can have the same risks and AOD use and mental health issues often present together.

Mental health issues may present different risks and prognosis for improvement depending upon the nature, severity and chronicity of the concerns. Where a parent has a treating Mental Health team, it is crucial to consult with them. This consultation supports DCP practitioners to understand how the parent's unique presentation may impact the safety, wellbeing and development of their infant.

## 7.1.5 Parental disability

Where a parent has a disability, it is essential to not make assumptions about their parenting capacity based on diagnosis alone. The nature and significance of the disability and how it impacts the parent's capacity to keep the child safe and meet their physical, emotional and developmental needs must be considered on a case-by-case basis.

In addition to challenges in parenting due to the impact of their disability, parents with a disability can face a multitude of additional issues that may impact their parenting and functioning, such as:

- limited social support socio-economic disadvantage
- experiencing higher rates of domestic and family violence
- experiencing co-morbid mental health issues<sup>52</sup>





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Addressing these issues may improve the parent's capacity. Understanding how disability impacts capacity to parent is complex and referral for a Parenting Capacity Assessment should be considered.

## 7.1.6 Parental child protection history

A significant proportion of parents that come to the attention of DCP have a history of child protection concerns and a number may have been in care. Aboriginal and Torres Strait Islander people are significantly over-represented in reports to child protection.

This history can create vulnerabilities and impacts to parental functioning. It is important not to assume that a child protection history will mean that a parent cannot provide safe care. This underscores the importance of holistic assessment to determine how the parent/s are currently functioning, any changes that will ensure the safety of the unborn infant and how their child protection history may impact their capacity to provide safe care.

## 7.1.7 Interplay of risk factors

Most often the families that DCP works present with multiple risk factors. The combination and nature of risk factors can compound the risk of harm. Holistic assessment supports an in-depth understanding of the:

- interplay of risk factors
- social and systemic challenges faced by families in overcoming risk factors and providing safe care for their infant.

The vulnerability of infants to harm must be a key consideration when assessing safety and risk of harm.

## 8. Removal of infants from hospital

This section must be read in conjunction with the practice requirements outlined in the [Remove an infant from hospital](#) section of the Intake, investigation and assessment chapter of the Manual of Practice.

### 8.1 Parental experiences of removal

Removal of an infant is highly traumatic for parents and can result in feelings of shame, stigma, disenfranchised grief, social isolation and loss of identity.<sup>53</sup> Many parents report feeling powerless and unprepared for the removal of their infant.<sup>54</sup>

The trauma and stress associated with removal can exacerbate existing difficulties such as AOD use and domestic and family violence.<sup>55</sup> Parents whose children have been removed are considered to be at high risk of poor mental health outcomes such as:

- suicide attempts
- post-natal depression
- anxiety
- Post Traumatic Stress Disorder.<sup>56</sup>





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It is important that DCP practitioners understand that the inherent trauma associated with removal is likely to result in significant dysregulation for the parents. This dysregulation is to be expected, and it is important to ensure that non-compliant or aggressive behaviour is understood in the context of the distress and trauma associated with removal and not necessarily attributed to a lack of insight into the child protection concerns or an enduring unwillingness work with DCP and other services.

## 8.2 The importance of trauma responsive practice

All efforts must be made to plan for an approach to removal that minimises additional trauma or stress on the parents and empowers them to make decisions wherever possible.<sup>57</sup>

Trauma responsive approaches when placing infants into care include:

- recognising the impact of the parent's past and current trauma experiences on functioning and engagement
- working in partnership, developing goals collaboratively and valuing the parent's perspectives and choices
- clear and consistent messages from all services working with the family
- recognising and building on strengths and protective factors
- acknowledging the parent's and family's positive aspirations and love for the infant and including them in planning for the time around the removal
- supporting parents and family to create memories with the infant including bathing, taking photographs, collecting mementos
- supporting the expansion of social support.<sup>58</sup>

## 8.3 Planning in partnership

Ascertaining and including the parent's views during planning is a significant contributor to reducing the trauma associated with the removal.<sup>59</sup> Where removal of an infant is required, DCP practitioners must work in partnership with the parents and the birthing hospital to document an [Infant Safety and Support Plan](#) prior to birth.

Parents must be provided with clear and detailed information regarding child protection processes (for example, court, family contact). This information must be reiterated regularly to ensure the parents' understanding, even where they have had previous children placed into care.

Whilst it must always be the aim, working in partnership with parents will not always be possible. Parents may struggle to engage with DCP due to their distress surrounding the anticipated removal of the infant and/or prior involvement with DCP.

Where parents are reluctant to engage, DCP practitioners should use creative approaches to support their engagement. This may include:

- considering engaging them through services they are comfortable working with (for example, SA Health or Intensive Family Support Services)
- working with extended family
- revisiting the parents' willingness to work with DCP as the birth approaches





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- work with the birthing hospital to see if hospital staff can ascertain the parent's wishes and views.

## 8.4 Timing of engagement

The days following birth are a vulnerable time for the parents. DCP practitioners should delay engaging with the parents to develop a safety plan, sign a Voluntary Custody Agreement or invoke section 41 removal as long as possible whilst the infant remains safely in hospital. This gives the pregnant person time to recover from the birth and enables the parents to spend time with their infant.<sup>60</sup>

A delay may not always be possible if there are concerns that the parents may remove the infant from the hospital or pose a threat to the infant's safety whilst in the hospital. It should be noted however that this will usually be in only in the most exceptional circumstances.

Where it has not been possible to engage the parents prior to birth or it has been deemed unsafe to the infant to inform them of the intention to remove, the Prenatal Safety and Support Plan must be developed in partnership with the hospital. Once the infant is born, DCP should engage with the hospital to discuss an appropriate time to engage with the parents. Planning with the hospital should ensure the pregnant person is in a fit physical and mental state to meet with DCP and that both parents are supported.

## 8.5 Contact in hospital

Practitioners must work with the hospital to develop an Infant Safety and Support Plan that ensures, wherever safe and possible to do so, parents and other family members can spend as much time as possible with the infant. This time together enables skin to skin contact, breastfeeding<sup>1</sup>, bonding and for the parents and family creates memories. There is significant evidence that skin to skin contact after birth improves the short and long-term physical health and wellbeing of infants.<sup>61</sup> This contact is also important in reducing the trauma for parents and families and supports a connection that is important for potential reunification and future family contact. If parents do not wish to have contact with their infant, this must be respected and the parent encouraged to inform the hospital or DCP if they change their mind.

In determining a plan for contact in hospital, it is important to consider:

- potential risk of harm to the infant (typically low risk in a hospital setting, however, some serious mental health issues may present a risk to the infant)
- the safety that a controlled and supportive environment like a hospital can provide
- the infant's need for early physical contact
- the needs and wishes of the parents to establish a relationship with the infant.

## 8.6 Capturing memories

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<sup>1</sup> Where there are concerns about substance use during pregnancy and post birth, the decision to support breastfeeding must be informed by advice of a neonatologist.





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Parents should be supported by DCP and the hospital to create a record of their time in hospital with the infant. The parents should also be given the opportunity to consider if they would like keepsakes of the birth, such as:

- receiving a duplicate of the infant's birth card
- a blanket
- a video of the first bath or feed
- a lock of hair
- foot and hand prints
- photographs.

DCP practitioners and hospital staff should ensure parents are empowered to choose how memories are captured and provided with the necessary support and resources.

Photographs and other keepsakes of the birth must be retained for the infant. These should be provided to the carer for the infant's Life Story Book and copies retained in the infant's DCP records. Refer to the [Life story work and life story books Practice Paper](#).

## 8.7 Family contact post removal

Removal of an infant is likely to elicit a complex emotional response from parents. Not knowing when they will next see their infant is an additional source of distress.

Prior to discharge, the parents must be advised of the date and time of at least the first family contact. This first contact should be, wherever possible and appropriate, held within three days of discharge. Refer to the [Family contact for children and young people Practice Paper](#) and the [Support the child or young person to develop and maintain family and community connections through contact arrangements](#) section of the Manual of Practice.

Wherever possible DCP should support breastfeeding after discharge through expression of milk and/or breastfeeding during family contact. If there are concerns about substance use, consultation should occur with the infant's neonatologist or another appropriate paediatrician to establish whether breastfeeding is safe for the infant.

## 8.8 Post removal support

Ensuring that the parents have psychosocial supports in place before, during and after removal is imperative. Planning for post removal support should occur during pregnancy and in partnership with the parents and other services (for example, SA Health). Specialist services such as [Centacare - Breathing Space](#) should be considered where appropriate. As limited services are available, referral to a psychologist under a mental health care plan may be required.

## 9. Reflecting on practice

Practitioners are better able to develop skills when they engage in reflective practice as an individual, as well as with their leaders and team. All practitioners are encouraged to seek feedback about their strengths - based practice, and to reflect on and discuss their progress in supervision.





# DCP Practice Approach

In supervision or a team meeting, discuss one of your cases and consider the following:

- What was the approach to engagement with the family during pregnancy? Was it successful? On reflection, is there any other approaches that may have better supported the family to engage with DCP and other services?
- Was the father or pregnant person’s partner actively engaged during pregnancy? If not, what were the barriers to engagement and what might have worked to assist engagement?
- Were the parents clearly informed of the child protection concerns and processes? What strategies assisted in communicating these concerns effectively?
- Was early family scoping undertaken? How did this change the outcome for the infant and family?

## Document control

<b>Reference No./ File No.</b>			
<b>Document Owner</b>		<b>Lead Writer (position)</b>	
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6 February 2026	1.0	Replaces Working with Infants Practice Paper.

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