OUTLINE OF EVIDENCE OF KARINDA TAYLOR (FIRST PEOPLES' HEALTH AND WELLBEING)

DECEMBER HEARINGS 2022 (CHILD PROTECTION)

7 DECEMBER 2022

I BACKGROUND

1. I am a Wamba Wamba woman, born and raised on Country in Northwest Victoria.
2. I am a registered nurse and midwife (non-practising), and have over 15 years of experience in Aboriginal health. I have worked in various clinical, strategic leadership and management roles across Aboriginal Community Controlled Health Organisations (**ACCHOs**), State government, and regional and metropolitan hospitals, with a focus on improving care for Aboriginal women and babies. I believe connection to culture, kin and a sense of belonging are vital to overall health and wellbeing.
3. I have been the Chief Executive Officer of First Peoples' Health and Wellbeing (**FPHW**) since 2019.
4. I am also a member of the Australian Anti-racism in Perinatal Practice (**AAPP**) Alliance. AAPP is an Aboriginal-led initiative comprising First Nations and non-Indigenous academic and industry experts with an interest in generating knowledge and action to improve First Nations women's experiences and outcomes in the perinatal sector in Australia.
5. In addition to my professional experience, I have first-hand personal experience of the child protection system, having been a kinship carer in the past.

II ABOUT FIRST PEOPLES' HEALTH AND WELLBEING (FPHW)

6. FPHW is an ACCHO aiming to improve access to affordable primary health care in urban Melbourne. It provides a trauma informed, culturally safe Aboriginal health service, made up of comprehensive primary care, mental health and trauma counselling teams.
7. In 2018, the organisation expanded to set up a clinic in Thomastown, an area with unmet primary health care need. FPHW currently has clinics in Frankston and Thomastown. The clinics provide culturally appropriate, comprehensive primary health care.
8. FPHW commits to an Australia First Peoples' definition of health, adopted under the National Aboriginal Health Strategy (1989):

> *Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.*

III BIAS AND RACISM UNDERPINNING THE CHILD PROTECTION SYSTEM

Assumption that Aboriginal people are inherently "high risk" and bad parents

9. The child protection system operates under the assumption that Aboriginal people are inherently "high risk" and bad parents, and then interprets all of their behaviour through that lens.

10. One example is that Aboriginal people are clinically classified as "high-risk" as a basis for excluding them from standard maternal healthcare. This is framed as being about healthcare for Aboriginal people, but it is not – it is about risk mitigation for hospitals, so they don't get sued or lose a baby and get investigated.

11. Aboriginal women are classified as "high risk" when pregnant, with the effect that they are often not able to birth at their nearest hospital. In my area, in Pakenham, an Aboriginal woman cannot birth at the two nearest hospitals and would have to travel to over 40km to Clayton for a hospital that will take her. The "high risk" classification is also used to justify a higher level of monitoring throughout pregnancy. This is not because of a proper assessment of the woman's healthcare needs, but simply because she is Aboriginal.

12. As noted in an article I co-authored, 'Identifying and dismantling racism in Australian perinatal settings: Reframing the narrative from a risk lens to intentionally prioritise connectedness and strengths in providing care to First Nations families' published in the *Women and Birth* journal on 27 April 2022 (available at **Attachment 1**):

> *A pregnancy deemed to be high-risk results in increased monitoring and intrusive examinations which may necessitate a woman being separated from her family and community. In many cases, rurally based First Nations women are forced to remain hospitalised in urban maternity units until they give birth. Declining the recommended medical treatment and discharging against medical advice, or 'accidentally' birthing on Country by "going bush" in pregnancy until labour has commenced are risky options due to the constant threat of child protection removal that some First Nations parents nevertheless take.*[1]

Treatment of socioeconomic position

13. There is an assumption that certain financial indicators – such as not having a car – automatically make someone a bad parent. Where someone has the luxury to go walking everyday with their children, purely for their wellbeing, this will be noted as positive parenting behaviour. But if an Aboriginal parent goes walking for a practical reason, like going to the shops to buy milk and bread, they are seen as a bad, inattentive parent.

Racial profiling, failure to understand Aboriginal communities

14. I have also seen situations where healthcare workers will racially profile Aboriginal patients. This leads to Aboriginal families receiving inadequate healthcare. For example, I had one client who was told she could not go home with her new baby unless she confirmed she had a bottle steriliser. Bottle sterilisers are not mandatory, and no non-Aboriginal parent would be told they could not take their baby home unless they had a steriliser.

15. When I spoke to the midwife, it became clear she assumed that my client did not have running water and therefore needed a steriliser. My client lived in a major regional Victorian city, but because she was Aboriginal the midwife assumed she did not have access to running water. This happened nearly 10 years ago, but it still sits with me.

Deliberate efforts to confirm negative stereotypes

16. I have seen child protection workers deliberately provoking Aboriginal parents into reacting badly (for example, aggressively) so that they can confirm their biases and substantiate their reports and recommendations.

17. As I highlighted in the article set out at **Attachment 1**:

> *[A] western paradigm dominates the design and delivery of mainstream healthcare services in Australia, with a focus on reactive rather than preventative healthcare and a narrow conceptualisation of health and wellbeing that negates many of the social, cultural, economic, spiritual and political drivers of ill health. This includes perinatal services, where the dominance of a bio-medical model has seen an increase in the medicalisation of birth.*[2]

[1] Attachment 1, p 3, citing C Felton-Busch, *Birthing on country: an elusive ideal?* Contemporary Nurse 33 (2) (2009) 161-162.

[2] Attachment 1, p 2, citing P Dudgeon, *Aboriginal and Torres Strait Islander women and mental health*, In Psych 2017; 39(1).

[Within] the Maternal, Child and Family Health sector, there is limited understanding of individual, structural and ideological racism, and a lack of insight into how these forms of racism manifest in practice with families from First Nations backgrounds.[3]

Oversurveillance

18. The child protection system places unreasonable expectations on Aboriginal parents and expects them to jump through hoops. This does not happen to non-Aboriginal parents.

19. There is a real issue of oversurveillance of Aboriginal parents.

20. Higher expectations are placed on them, and they are often required to report regularly to child protection and/or to healthcare services. This is frequently inconvenient and burdensome for the parents, and a drain on the resources of support services such as FPHW.

21. There is also a serious power imbalance between child protection and mainstream support services. The judgemental and patronising approach of child protection creates fear, takes Aboriginal mothers' voices away, and undermines their confidence and ability to advocate for themselves.

22. As I noted in the article at **Attachment 1**:

    [S]ome First Nations women will have biological and social circumstances that place them at risk, as will women who are non-Indigenous. However, a detailed, nuanced individual assessment is required to ascertain this, undertaken in ways that challenge assumptions and bias. In order to gather the information necessary to make such an assessment, health professionals need to establish trusting relationships with First Nations women and families.[4]

23. In my view, undertaking an assessment in this way would ensure that the child protection system adapts its expectations on a case-by-case basis, with regard to parents' individual circumstances.

Pre-judgement (and bias towards intervention and removals)

24. in my experience, child protection workers from the Department of Families, Fairness and Housing (**Department**) are often prejudiced and have a bias towards intervention and removals in the case of Aboriginal parents. This is especially so where Aboriginal parents have a:

    - Child protection history (either their own, or they have another child in care);
    - Childhood trauma (such as childhood abuse); or
    - Disability (often the characteristics of their disability are used against them, rather than accommodated with appropriate supports).

25. I have observed how the child protection system will simply wear Aboriginal parents down until they break and have no choice but to give up. This all happens under the guise of child protection workers simply following a formal process. There have been instances where Aboriginal mums are baited or goaded by child protection workers before critical events – such as going to court or meetings with the Department.

26. There is also very high level of over-surveillance of Aboriginal mothers in the hospital system. This creates a real power imbalance and takes the voice of these women away

The hard work of Aboriginal parents is overlooked

27. The Department and child protection workers do not sufficiently recognise, encourage, and reward the hard work that Aboriginal parents put in. They also fail to recognise the support systems that Aboriginal parents already have in place, or could have in place, that would help them to keep their family together.

28. I see clients who are proactively doing everything they can to manage their own issues so that they can keep their families together. Yet when child protection workers observe them putting coping mechanisms into action, they interpret this negatively and use it against the parents.

[3] Attachment 1, p 2.

[4] Attachment 1, p 3, subheading 'The inherent risks of seeing only risks'.

IV KINSHIP CARE

29. The funding and resources that are allocated to kinship carers could be used to provide the early support necessary to keep kids at home. The critical importance of kinship care during pregnancy is highlighted in the article at **Attachment 1**:

> *Women of kinship can be vital sources of knowledge and support for young First Nations women during pregnancy, and can assist them to access pregnancy care in a timely way. From an Indigenous perspective, women's business includes supporting other women through pregnancy and birth, thus highlighting the inherent strengths of First Nations cultures and kinship systems and creating a supportive environment in which women may feel safer to identify their cultural identity.*[5]

30. In addition to my professional interactions with child protection, I have been a kinship carer. I will unfortunately never do it again. It was an awful, traumatising experience.

31. The child protection workers were intimidating, condescending, judgemental, and overly directive in their approach. I have never felt more exposed or judged – and I have a high level of education and stable home environment. My husband and I were living in a four bedroom house at the time and the child protection workers did not think it was appropriate for us to let our three-year-old daughter share a room with a six-month-old baby because they were different genders. Given they were so small and both sleeping in cots, I didn't think there was any issue with them sharing a room.

32. My experience demonstrated to me exactly why many families look to circumvent the entire child protection system and go into informal kinship care arrangements. I don't blame them. My own short-term experience was traumatic enough despite my professional background and experience dealing with the child protection system.

V INFORMATION SHARING

33. Expectations around information create an enormous reporting and resource burden on ACCHOs. Even though child protection hold 99% of the resources, they still expect ACCHOs to help them. It's not uncommon for us to receive an email at 7.30am asking us to provide information before a 10am court hearing.

34. Conversely, we have a lot of difficulty obtaining and accessing information from child protection. Information sharing between child protection services (and other government bodies) is critical to the work ACCHOs do. Not having this information can hinder our work and prevent us from being able to deliver our services to those who need it.

35. I feel that we ACCHOs are treated like Mickey Mouse. There have been notifications where an Aboriginal mum was written up for failing to attend antenatal appointments – but we weren't given any information to be able to assist.

VI THE UNBORN NOTIFICATION SYSTEM

36. There is a huge problem with the unborn notification system.

37. From the outset, reports to child protection can be made on completely spurious grounds without proper, comprehensive risk assessments being undertaken.

38. The focus should be on addressing any issues and risk, and then closing the child protection file before the baby is born. This would be the best way to ensure the baby is safe and that the family can stay together. But we often see that these unborn notifications sit on the hospital file, with no action taken until the birth.

[5] Attachment 1, p 3, citing T Reibel, L Morrison, D Griffin, L Chapman, H Woods, 'Young Aboriginal women's voices on pregnancy care: factors encouraging antenatal engagement', *Women Birth* 28 (1) (2015) 47-53; and P Daylight, M Johnstone, Women's business: report of the Aboriginal Women's Task Force. Service, Australian Government Publishing, Canberra, 1986.

39. Very often the first person in an Aboriginal mum's birthing suite is a child protection officer without her being afforded any connection with other culturally appropriate support systems.

40. These decision-making processes (which are rarely rigorously examined or critiqued) are highlighted in my article at **Attachment 1**:

> *High numbers of notifications made in-utero before a baby is born (known as 'unborn reports'), mean that sometimes a child protection practitioner will arrive in the birthing suite to meet the baby before the woman's own family has had the opportunity. This is often the first time the family has been made aware of the notification, negating the opportunity for prevention and early intervention.*[6]

41. Without this behaviour being properly challenged, it becomes a part of the organisational culture even if so-called progressive policies and practice guidelines are in place.

42. It is enormously traumatising for mothers to have a child protection officer as one of their first visitors at hospital as a new mother. Sometimes the child protection officer is literally the first person, other than a doctor or nurse, that a new mum sees.

43. If we had advance notice that an unborn notification had been raised, we could reach out to the mother and family and offer early services and supports that are designed to set them up for success. But the system operates in a very secretive way. This is supposedly because the mums are considered a 'flight risk'.

44. The only way ACCHOs are able to find out about unborn notifications is by relying on relationships with the Department. The ability to do this varies by region and results in inconsistent outcomes for mums.

45. Set out at **Attachment 2** is an interim report published in July 2022 by First Peoples' Health and Wellbeing titled 'Supporting Aboriginal and Torres Strait Islander families during the Early Years'. The report recommends the allocation of case management support services to better assist a mum where an unborn report is made:

> *Case management support: culturally responsive case planning and advocacy, delivered by a consistent Aboriginal and Torres Strait Islander person (e.g., "journey walker"), particularly to facilitate early intervention and address key risk factors when there are unborn reports, or to refer mothers to specialist support to address their own health concerns or needs that may compound their capacity to parent e.g., mental health, disability, alcohol and drug use).*[7]

46. This proposal holds the child, family, and community at its core. It removes the unhelpful secrecy that currently pervades the system (driven by the child protection system) and instead promotes health and wellbeing informed by culture.

VII IGNORANCE IN HOSPITAL SYSTEM

47. I have also observed ignorance in the hospital system regarding the Aboriginality of the mothers and families they support.

48. This is particularly the case in Frankston, where FPHW have an office. I have come across healthcare staff who are surprised to hear that there are Aboriginal people living in their area.

49. If these staff are ignorant that they even have Aboriginal patients or that Aboriginal people live in their area, then how can they possibly be providing culturally appropriate care?

50. As noted in an article I co-authored, 'Separated at birth: Racism and unconscious bias in perinatal health services' published in the *Monash Lens* on 27 April 2022 (available at **Attachment 3**): "We are constantly getting feedback that [Aboriginal women] they're just not being listened to".

[6] Attachment 1, p 3, citing JM Ussher, R Charter, C Parton, J Perz, *Constructions and experiences of motherhood in the context of an early intervention for Aboriginal mothers and their children: mother and healthcare worker perspectives,* BMC Public Health 16 (620) (2016) 1-12.

[7] Attachment 2, p 34.

VIII EMBEDDING A POSITIVE STRENGTH-BASED APPROACH

51. There is a need to embed a positive strength-based approach to working with Aboriginal families. We need to do more than just add a cultural lens – we need to embed a cultural understanding into absolutely every fibre of what we do. You can't just add it on when it suits you.

52. At its core, a strength-based approach is about self-determination. It is about understanding, respecting and acknowledging the strengths of our cultural ways instead of seeing our parenting as worse than a Western or mainstream approach. It is about recognising and looking to highlight the strengths of parents, families and communities, instead of focusing on looking to criticise them. It is about acknowledging the work that they are doing and the measures they are already putting in place, and looking for ways to support them to be even stronger by connecting them with culturally-appropriate supports and services such as those provided by ACCOs.

53. I have highlighted this approach in the article at **Attachment 1**:

> *These realities along with the failure of successive governments to invest in changing the culture of non-Indigenous (mainstream) perinatal services in any meaningful way, warrant reframing the narrative around risk for First Nations women. Intentionally prioritising anti-racist practice and connectedness will improve maternal (and family and community) social and emotional wellbeing. This leads to questions regarding the most effective pathway for creating such a shift. As one of the key universal health care providers for families in the perinatal period, Maternal, Child and Family Health services are a prime setting for responsive care. Maternity units are another important site. The documented barriers to nurses and midwives building connectedness with First Nations women who experience social and emotional wellbeing challenges include a lack of cultural humility and competence, limited knowledge of cultural safety and policies to facilitate it; inadequate social emotional wellbeing knowledge and confidence, competing work demands, practitioner attitudes and attributes and the physical environment. These need to be urgently overcome through re-prioritisation, policy development and implementation, education and adequate sustainable resourcing. The preventative impact of redressing power imbalances to build trusting relationships with women in the perinatal period makes this of crucial importance.*
>
> *Harnessing the knowledge and experience of a collaboration of experts from industry and academia who can plan the pathway for systemic change in this sector, is a much-needed step to progress this work. This has already been called upon by numerous First Nations academics, nurses and midwives. Identifying the priority issues and needs, before defining a process for implementing structural and cultural change within perinatal health settings is a process that must be driven by First Nations peoples, with authentic collaboration between First Nations and non-Indigenous health experts, perinatal health academics, policy makers and clinicians. This includes First Nations Units within hospitals, particularly maternity hospitals that already provide cultural oversight, training of mainstream staff, support for other First Nations health practitioners, and advocacy work on behalf of First Nations women and their families.*[8]

IX CASE STUDIES AND COMPLAINTS

54. On 30 August 2021, I wrote a letter to the Department, formally expressing my concerns regarding the Department's non-compliance with policies and procedures that are supposed to protect Aboriginal families and children. A copy of this letter is at **Attachment 4**.

55. In this letter, I detailed two examples where Department policies were not followed and I made recommendations for how the cases could have been handled.

Case Study #1 – Unborn notification 1

56. Child protection workers asked a FPHW psychologist to make an unborn report about one of our pregnant clients. This client had four other children who were in their father's care with child protection involvement, but this pregnancy was with a different father.

[8] Attachment 1, p 4.

57. We conducted our own internal assessment, involving our treating team and psychologist, and it was agreed that no one had any significant concern for the wellbeing of the unborn child and therefore no report was warranted under the mandatory reporting requirements. Though we did not have any concerns for our client's parenting abilities, we were concerned she did not have appropriate housing and we were working with her to try and resolve this. Throughout the pregnancy, we made multiple attempts to get support from housing services, but none were able to assist until the baby was born.

58. This client was willingly and proactively engaged with our GPs and psychologists throughout her pregnancy and was also engaging in antenatal care with the Koori Maternity Service.

59. When our client birthed, a hospital social worker become involved and contacted child protection due to the housing concerns. As child protection had done with FPHW, child protection asked the social worker to make a notification on the newborn child – which the social worker did.

60. At no point were we contacted, and we only became aware of the notification when our client called us in a highly distressed state. Had we been consulted about our client's engagement and progress, we would have been able to provide information essential to assessing risk – and we would have been able to highlight our client's many strengths. By not engaging with us as the client's treating team, the child protection worker and social worker failed to undertake a comprehensive risk assessment and, in my view, did not respect our knowledge and capabilities as healthcare practitioners at FPHW.

61. The conditions placed on our client also made her life unnecessarily difficult – one of the conditions for being able to keep her baby was that our client have weekly face to face contact with FPHW – this meant she had to travel for over two hours on public transport once a week during a COVID lockdown.

Case Study #2 - Unborn notification 2

62. We had one client who was reported to child protection when she was five weeks pregnant because she had an argument with her partner. Her neighbours called the police. When the police came, they asked our client if she had been drinking. She responded that she had not been drinking, because she was pregnant.

63. She was not aware that the police then made an unborn report about her. This was in the very early stages of her pregnancy and was a standard argument.

64. By the time she had her baby, she was no longer with the partner. But when she gave birth, child protection turned up straight away.

65. At no point did anyone contact her during the remaining period of her pregnancy to attempt to assist her or offer her support. She had been seeing FPHW regularly throughout her pregnancy, but we were never contacted by child protection. She also has a case worker from the Victorian Aboriginal Child Care Agency because she grew up in the child protection system and, again, they were not contacted. A normal human conversation with a bit of respect could have resolved it. They waited until she had given birth.

Case Study #3 - In-home assessment

66. Another case study, which is not outlined in my letter to the Department, relates to when, in 2019, I supported an Aboriginal mother and her baby with an in-home assessment with the objective of keeping them together.

67. Despite the mum suffering from foetal alcohol spectrum disorder (**FASD**), the child protection workers did not appropriately consider her disability and were not culturally competent to make the assessment.

68. The child protection workers used her disability against her, instead of focussing on the strengths she had, including her many strategies for managing her FASD symptoms. The Department had babysitters placed in her home to supervise her – but these people were not culturally competent or FASD-informed, which left our client more vulnerable.

69. My client and her baby stayed with me for a week and I then wrote a report for the Court outlining her strengths.

70. This helped convinced the Court to overturn orders so that she could maintain her relationship with her child. I recall that the Magistrate reported that my report and the child protection worker's report could not have been more different – to the point that it was almost as if they had been written about two different people.

71. A copy of an article about this case is set out at **Attachment 5**.

List of materials referred to in outline of evidence:

Attachment 1: Rochelle Hine, Jacynta Krakouer, Jacinta Elston, Bronwyn Fredericks, Sue-Anne Hunter, Karinda Taylor, Tracey Stephens, Vicki Couzens, Esmai Manahan, Ruth DeSouza, Jacqueline Boyle, Emily Callendar, Helen Cunningham, Robyn Miller, Sue Willey, Kellie Wilton, Helen Skouteris, 'Identifying and dismantling racism in Australian perinatal settings: Reframing the narrative from a risk lens to intentionally prioritise connectedness and strengths in providing care to First Nations families' (2022) *Women and Birth*

Attachment 2: First Peoples Health and Wellbeing Interim Report, 'Supporting Aboriginal and Torres Strait Islander families during the Early Years' (July 2022)

Attachment 3: Jacynta Krakouer, Tracey Stephens and Karinda Taylor, 'Separated at birth: Racism and unconscious bias in perinatal health services' *Monash Lens*, 13 June 2022

Attachment 4: Letter from Karinda Taylor to Department of Families, Fairness and Housing, 30 August 2021

Attachment 5: The Guardian, 'Aboriginal woman wins battle to keep baby after six court appearances', 18 July 2019