

An Aboriginal-led, systemic solution to Aboriginal baby removals in Australia: Development of the Bringing Up Aboriginal Babies at Home program

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ABSTRACT

The increasing rate of statutory Aboriginal infant removal in Australia, which has reached almost 10% of live births in the state of Victoria, is a crisis motivating radical change in child protection pathways. This paper describes the problem analysis and design phases of an Aboriginal-led systems change project intended to ensure Aboriginal infants are raised safe and strong in family, Community, and culture by creating a response capable of shifting underlying system factors. Dialogue and deliberation processes involving 27 practitioners working within Aboriginal health and social care programs in the Bayside Peninsula Area of metropolitan Melbourne, the traditional land of the Bunurong people, was the overarching method used to develop a shared understanding of the problem of Aboriginal infant removals and reach a consensus about what to do in the local system. The themes that emerged during problem analysis reflect a risk/bias theoretical perspective, and in the design phase, it was deemed necessary to reduce both child safety-related risk as well as bias in the child protection system that responds to risk. The ensuing Bringing Up Aboriginal Babies at Home program has a clear systems theory of change, and a service blueprint describing how it is going to be implemented. Bringing Up Aboriginal Babies at Home practice resonates with other programs that have evolved independently in Australia and in other western child protection jurisdictions to reduce infant removals, including building trust for engagement, inspiring hope, openness and transparency, activating extended networks of formal and informal supports, and close collaboration with antenatal and child protection services. Program evaluation will determine whether Bringing Up Aboriginal Babies at Home (BUABAH) can be implemented with fidelity, tackle identified system flaws, reduce the number of Aboriginal infants taken into statutory care and become sustainable.

1. Introduction

There has been a recent pattern of growth in rates of statutory newborn and infant removal in developed countries across the world (Wise & Corrales, 2021; Hestbaek et al., 2020; Bilson & Bywaters, 2020), and in Aotearoa, New Zealand and Australia, this increase is accounted for by an increase in the rate of Indigenous infants removed (Keddell, 2019; O'Donnell et al., 2019).

The rate of removal for Māori infants in Aotearoa, New Zealand increased sharply between 2015 and 2017, to 10.2 per 1,000, then reduced by more than half in 2019–2020 to 3.9 per 1,000, as the result of

rapid reform following a high-profile case known as the 'Hawkes Bay case' (Keddell et al., 2022). By contrast, the rate of statutory removal of Aboriginal and Torres Strait Islander (hereafter, and with respect, Aboriginal¹) infants in Australia has continued an upward trajectory from 25.7 per 1,000 in 2014–15 to a peak of 47.3 per 1,000 in 2020–21 ($n = 859$) (AIHW, 2016, 2017, 2018, 2019, 2020, 2021, 2022a). The rate of Aboriginal infants admitted to care is highest in the state of Victoria, at 89.0 per 1,000 in 2021–22 ($n = 149$), 16 times the rate of non-Aboriginal infants at 4.0 per 1,000 ($n = 425$) (AIHW, 2023). The rate of Aboriginal infants aged less than one year admitted to care in 2021–22 in other states and territories ranged from 20.1 per 1,000 in in

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¹ The term 'Indigenous' is used when referring to Indigenous populations internationally.

the Northern Territory to 68.7 per 1,000 in South Australia.

Austerity and related cutbacks to preventative services for vulnerable families and a greater tendency to issue court proceedings following the tragic death of Peter Connelly ('Baby P') at the hands of his family, have played a role in the observed increase in newborn and infant removals in the UK (Broadhurst *et al.*, 2018). In Aotearoa, New Zealand, the increase in Māori infant removal occurred in the context of a progressively 'child-centric' child protection orientation (2011), which resulted in more resources for children already in the care of the state, without resources to assist families before children were removed (Hyslop & Keddell, 2019). Increased need as the result of cultural losses and social disadvantage that Māori have experienced since colonisation compounded by individual biases and structural racism in the child protection system are also thought to contribute to the increased removals of Māori infants (Keddell *et al.*, 2022; Keddell, 2022).

In Australia, six state and two territory governments provide child protection services. From the mid-2000s jurisdictions began introducing legislative provisions for accepting unborn child reports to child protection, although Tasmania is the only jurisdiction where there are mandatory reporting requirements. New South Wales, Queensland, Western Australia, and Tasmania have statutory provisions for investigation during pregnancy to determine whether an unborn child will need protection after birth. Australian states and territories do not recognise the legal personhood of a foetus in utero, which means that child protection has no statutory authority to intervene during the unborn phase. Until then, family assistance is provided on a voluntary basis (Cashmore & Taylor, 2023; Wise & Corrales, 2021).

Over-representation of Australian Aboriginal children in child protection notifications and out-of-home care (OOHC) services have prevailed despite national policy frameworks and policy and practice addressing this issue (Steering Committee for the Review of Government Service Provision, 2019; SNAICC, 2022). In the state of Victoria, for example, the Aboriginal Child Specialist Advice and Support Service (ACSASS) provides expert advice and case consultation to child protection about culturally appropriate intervention in respect of all reports regarding the abuse or neglect of Aboriginal children and regarding significant decisions in all phases of child protection intervention (<https://providers.dffh.vic.gov.au/aboriginal-child-specialist-advice-and-support-services-31263>). Aboriginal Family-Led Decision-Making (AFLDM) is the preferred decision-making process for Aboriginal children who have been substantiated as having suffered, or being likely to suffer, abuse or neglect, and ACSASS should be involved in AFLDM meetings and all formal decision-making processes (<https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/aboriginal-children/aboriginal-family-led-decision-making-program>). However, through the ACSASS program, Aboriginal people do not have decision-making responsibility, and a 2016 Inquiry (Jackomos & Buchanan, 2016) indicated that ACSASS involvement is lower than intended at each child protection phase and significant decision point.

Socioeconomic inequities are a significant driver of Aboriginal overrepresentation in child protection. Child protection disproportionately intervenes with children from low socioeconomic backgrounds (AIHW, 2023). Although there are no national Aboriginal-specific data on access to social care services broadly, investment in culturally relevant social care services is insufficient to meet the needs of perinatal Aboriginal families enduring socioeconomic disadvantage, mental harm and disruption to their family, culture, and self-determination as the result of colonisation and ongoing stressors (SNAICC, 2022; Turnbull-Roberts *et al.*, 2021). Aboriginal women/couples are also thought to underutilise health and social care services antenatally due to an entrenched and pervasive fear that their children will be taken into care, and/or reject the involvement of child protection, due to a lack of cultural safety and responsiveness, and perceptions of racial bias (Davis, 2019; Wise & Corrales, 2021; Langton *et al.*, 2020; Chamberlain *et al.*, 2021).

Discriminatory reporting practices by health professionals in contact

with pregnant Aboriginal women (SNAICC, 2022), and over-surveillance of at-risk unborn babies, through procedures such as 'high risk birth alerts', are also argued to increase reporting of unborn Aboriginal children to child protection, thereby increasing the probability of Aboriginal infants being the subject of a child protection investigation (Wise & Brewster, 2022; Chamberlain *et al.*, 2022).

Research and the testimonies of Aboriginal people affected by child protection intervention also support the view that racial bias among health professionals who report unborn Aboriginal children to child protection, and child protection practitioners who make removal decisions, contribute to the current large overrepresentation of Aboriginal infants in OOHC (Chamberlain *et al.*, 2022; Harnett & Featherstone, 2020; Davis, 2019; Douglas & Walsh, 2013). This is supported by Australian research, where, Indigeneity of the unborn child has been shown to be an additional and unique predictive risk factor for unborn child reporting and infant removal (O'Donnell *et al.*, 2019). As is the case in Aotearoa, New Zealand, assessment of risk to Aboriginal children undertaken in isolation by the statutory authority is said to lead to over intervention, because child protection practitioners attach too much weight to information about prior child protection system contact and do not place sufficient importance on culture as a factor of protection and the strengths of women/couples and family life (e.g., Wise & Brewster, 2022; Flemington *et al.*, 2022; Harnett & Featherstone, 2020).

Aboriginal practitioners within child protection and Aboriginal Community Controlled Organisations (ACCOs) have also indicated that the behaviours of parents during an investigation, which they interpret as a trauma or fear response to the presence of child protection, may cause child protection practitioners to view them as uncooperative, or to be a demonstration of parents' denial of their parenting difficulties or minimisation of child protection concerns, thereby influencing the direction of intervention towards removal (Oates, 2020; Wise & Brewster, 2022; Chamberlain *et al.*, 2022).

While sometimes required in the child's best interests, for women/couples, other family members and Community, Aboriginal infant removals cause terrible suffering, which may exacerbate and perpetuate intergenerational trauma. Aboriginal infants entering care are also exposed to the risk of unstable care and sequential attachment disruptions resulting from placement churn and failed family reunification (Granqvist *et al.*, 2017; Gee, 2016). The proportion of children placed with Aboriginal relatives or kin, or other Indigenous carers is also unacceptably low across all jurisdictions (AIHW, 2022b). As identity, belonging and cultural connection is conferred through family, extended family, and kinship networks, infant removal may have long-term detrimental impacts to Aboriginal children's sense of identity and overall wellbeing (SNAICC, 2022).

The unacceptably high rate of Aboriginal infant removals and its negative sequelae demonstrate the urgent need for a new intervention for this population to prevent further intergenerational trauma. The remainder of this paper is dedicated to describing the aims, methods, and results of an Aboriginal-led system change project intended to ensure Aboriginal infants are raised safe and strong in family, Community, and culture by creating a response capable of shifting underlying system factors.

2. Aims

Aboriginal people have a collective right to self-determination and self-management in child welfare matters (Australian Government, 2020; UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples, 2007), and Aboriginal community control in service design and delivery and Aboriginal authority in child protection are the building blocks for Aboriginal self-determination in child welfare. ACCOs are grounded within and managed by local communities. They support and advocate for the needs of Aboriginal children, young people, and their families, and are increasingly able to exercise authority in child protection matters involving Aboriginal children. The Victorian

Aboriginal Child and Community Agency (VACCA) is the lead Aboriginal child and family welfare agency in Victoria, with over 40 years' experience and expertise as an ACCO, bringing a unique perspective, experiences, and knowledge to child welfare challenges (Luke et al., 2022).

In collaboration with Social Work at the University of Melbourne (UoM), VACCA was successful in obtaining funding over three years from the Out-of-Home Care Philanthropic Funders Network to design a new approach to prevent Aboriginal infant removals in Victoria and undertake a small-scale rapid pilot. The Bayside Peninsula Area (BPA) of metropolitan Melbourne, the traditional land of the Bunurong people, was the site selected for the project, because in this area rates of unborn child reports and Aboriginal infant removal were above the state average, and there were key implementation enablers; VACCA has a strong service presence and staff were highly engaged in the idea of implementing a new response to reduce Aboriginal infant removals.

VACCA and the UoM adopted systems change as a theory of change to respond to the problem of Aboriginal infant removals. Systems change is based upon complexity and systems theory's understanding of complex nonlinear organisations and how they change over time. Change is expected to happen by understanding, and changing the structure or conditions of a system that are responsible for the problem (Wise, 2021). Various systems change models and approaches exist, but they all involve the same basic steps; define a problem, understand the system responsible for the problem, find leverage points, design system change strategies, build implementation capability, apply action, and learn for continuous improvement (e.g., Foster-Fishman & Watson, 2012). The Mobilising change Agents for Better Lives (MABL) model articulated by Author 1 (Wise, 2016) and Foster-Fishman and Watson's ABLe change framework (ACF) (2012) was used as a reference in the current system change project.

The main aim of this paper is to describe the methods and results from the 'problem analysis' and 'design' phases of our system change project to reduce Aboriginal baby removals in the BPA of metropolitan Melbourne.

3. Methods

Understanding the problem of Aboriginal infant removals and designing a systems-level solution was undertaken through dialogue and deliberation processes (Holman et al., 2007), specifically two 2-hour online workshops, with Aboriginal stakeholders in the BPA. Due to the COVID-19 pandemic and time and resource constraints, dialogue and deliberation processes were conducted online. Dialogue processes have been used for many years to learn from stakeholders and research about problems or issues affecting human service systems and to support action at the system level (Boyko et al., 2014). Dialogue is also a traditional method for information sharing and decision making among Indigenous cultures and was thus considered a culturally appropriate way of engaging Aboriginal stakeholders in the BPA.

3.1. Participants

Leveraging from the established relationships of VACCA practitioners in the BPA, Aboriginal stakeholders were invited to participate in the two online workshops. Participants had knowledge or experience of the issue of Aboriginal infant removals as service providers and Community members.

A total of 27 professionals within local antenatal care, maternal and child health, patient care (Aboriginal health liaison officers), family support services, family violence services, drug and alcohol services, justice, Aboriginal child protection programs, OOHC, youth services,

community health services, and gathering places² were ultimately engaged in the systems change project. In addition to the professionals representing Aboriginal practice, programs and services in the BPA, an Aboriginal mother with lived experience of infant removal was consulted on the system factors responsible for Aboriginal infant removals. This participant was identified by VACCA practitioners through the Aboriginal family preservation and reunification response delivered by VACCA in the BPA (<https://www.vacca.org/page/services/child-en-and-families/family-support/aboriginal-family-preservation-and-reunification-response>). Child protection practitioners from the BPA, and midwives at the local birthing hospital were also consulted during the design stage to create a sense of ownership of the solution and more effective implementation as a result.

3.2. Tools and procedures

3.2.1. Problem analysis: Understanding the system responsible for Aboriginal baby removals

The aim of the problem analysis stage of our systems change project was to explore aspects of the local health and social care system responsible for Aboriginal infant removals and to identify powerful system causes that might be targeted for change. This was achieved during the first online dialogue and deliberation workshop facilitated by Author 1.

To help participants understand the issue and those affected, Author 1 prepared and circulated an evidence brief, which presented research and data regarding the characteristics of women and fathers/partners who have had an Aboriginal infant placed in OOHC and the system factors affecting the problem. Author 1 also presented the perspective of a mother who had an infant removed from her care, based on an interview that was conducted prior to the online workshop.

The six system characteristics identified by Foster-Fishman and colleagues (Foster-Fishman et al., 2007) was also introduced to participants by Author 1 to focus the dialogue on system factors responsible for Aboriginal infant removals. The six system aspects were mindsets (attitudes, values, and beliefs), components (range, quality, effectiveness, and location of services), connections (relationships across different system components and actors), policies (policies, practices, procedures, and routines), resources (human, financial and social), and power (how decisions are made and who participates). Padlet (<https://padlet.com/>) was used during the online sessions as a tool to record, and display information and ideas onscreen in real time.

Using breakout rooms in Microsoft Teams, breakout session facilitators supported small group discussions about system factors contributing to the problem of Aboriginal infant removals. Using the information recorded on Padlet, small group learnings were incorporated into a discussion with the full group to develop consensus, or a shared understanding of the system causes of Aboriginal infant removals. As a full group, participants also identified one or two powerful system causes in each of the six system domains that are either influential enough or connected enough to leverage systemic change (Foster-Fishman & Watson, 2012).

3.2.2. Design

The design phase involved a process of defining solutions, converging on a feasible and implementable solution, and, once the solution had been agreed upon, service design utilising service blue-printing. During the second online workshop facilitated by Author 1, Aboriginal stakeholders in the BPA identified strategies to tackle powerful system causes that emerged out of the first online workshop. To focus participants on change goals, powerful system causes were reframed as desired system conditions which, if brought about, would

² Gathering Places are community owned and operated places that provide opportunities for people to connect and deliver services.

prevent Aboriginal infant removals. In small groups, using breakout rooms in Microsoft Teams, participants were guided to use the ‘how might we’ technique to identify ways to bring about desired system conditions. Ideas for action were recorded on Padlet in real time by breakout session facilitators (see Table 1).

To be effective, system change strategies need to be implementable as well as powerful (Maani & Cavana, 2007). Following the second online workshop, five VACCA practitioners involved in the online workshops (the VACCA local implementation team) considered each of the ideas for action against a set of pre-determined questions and made recommendations on which action or actions to pursue. The questions were: Is it important to people with a lived experience of infant removal? Is it feasible to implement within the proposed timelines and funding envelope? Does it tackle system causes? Is it compatible with other child and family reforms and priorities? Can it be combined with other solutions? Could it create any negative unintended consequences? Is the idea sustainable beyond the period of funding?

Ultimately, several ideas for action were combined into a single strategy; a case management program called Bringing Up Aboriginal Babies at Home (BUABAH). To test the feasibility of the BUABAH program, identify implementation barriers and enablers, and cultivate an enabling context for implementation, practice activities and resources deemed necessary to achieve desired outcomes were taken back to the full Aboriginal stakeholder group, and discussed with child protection practitioners and midwives at the local birthing hospital who were ultimately involved in the delivery of the intervention (Kilbourne et al., 2007).

Service blueprinting (Bitner et al., 2008; <https://www.vic.gov.au/service-blueprint>) was used to develop the initial service idea into a developed concept. Service blueprinting presents the activities, roles and responsibilities, relationships, and interdependencies of a service in a precise and highly specific manner; to make the initial idea more concrete and actionable. Service blueprinting results in a visual picture of the service process that everyone can see and understand. Steps in the service process (from initial contact to service closure) are mapped out. For each step or stage in the service process, the timeframe, the client’s journey or interaction with the service, the actions or tasks undertaken by professionals (seen and unseen by the family) and support processes (tools and systems that support service delivery) are added.

The BUABAH service blueprint was refined over a series of iterations. Author 1 and the VACCA local implementation team developed a base design involving the service steps on which child protection practitioners and staff at the local birthing hospital were able to elaborate and iterate in a series of group conversations and individual meetings. Key design decisions (such as caseload, referral protocols, where the BUABAH maternal and child practitioner would be located) were made during design meetings. In an on-line environment, Padlet was used to create the service blueprint and support participation throughout the design process. Service blueprinting continued until the final solution was working well for all implementers. A short version of the BUABAH service blueprint with artwork produced by VACCA is shown in Fig. 1.

3.3. Ethical considerations

The VACCA implementation team provided Aboriginal oversight of the dialogue and deliberation process. Our approach was guided by principles of informed consent and confidentiality. All participants were contacted via email by senior VACCA staff, and at beginning of each workshop participants were asked to be respectful of others’ privacy and not share details of others or their stories outside of the workshop. To promote an atmosphere of safety, the workshops were chaired by the VACCA Director of Client Services in the southern operations division, and only Aboriginal people, or trusted people working within local Aboriginal services, were invited to attend the workshops. To help participants regain a sense of calm and safety after discussing a painful issue, workshop two ended with a few minutes quietly watching a

Table 1

System Factors Responsible for Aboriginal Infant Removals and Ideas for Action.

System cause	Why is it happening?	Desired system conditions	Proposed solutions
Unnecessary reports	- Over-surveillance of Aboriginal women and fathers/partners with a history of child protection involvement. - Implicit racial bias towards Aboriginal women/couples in the decisions of non-Aboriginal people who make reports to child protection. - Lack of skills and resources within antenatal services to respond to the psychosocial needs of women/couples having an Aboriginal baby. - Lack of confidence among health practitioners in the availability of community services and using child protection as a service gateway.	- Non-Aboriginal health practitioners make timely referrals to Koori¹ Maternity Services²/ACCHOs for antenatal care and to ACCOs for psychosocial needs. - Non-Aboriginal health staff consult with an Aboriginal practitioner before reporting concerns to child protection. - Women having an Aboriginal baby are confident accessing antenatal care and disclosing their Aboriginal identity.	- Co-locate Aboriginal child and family practitioners in maternity settings. - Promote awareness of Koori Maternity Services and early intervention/prevention services among health professionals and Aboriginal women/couples. - Promote transparency regarding unborn child reports to child protection.
Child protection risks not addressed prenatally	- Lack of resources within ACCOs to respond to the psychosocial needs of women/couples having an Aboriginal baby including an inexperienced workforce. - Community services sector “overwhelmed” with family violence and child wellbeing referrals. - Delays in identifying needs prenatally and time constraints in providing services and support. - Lack of resources within child protection to respond to unborn child reports with advice and assistance to women having an Aboriginal baby. - Difficulties developing and sustaining supportive relationships with	- Women/couples having an Aboriginal baby are familiar with Aboriginal services and receive high-quality, culturally attuned prevention support from the early stages of pregnancy. - Aboriginal families access culturally responsive supervision/residential placements for the entire family following birth to preserve the family when needed.	- Enhance referral pathways from maternity service to programs within ACCOs. - Establish pathways from The Orange Door³ to programs within ACCOs. - Transparent involvement of Lakidjeka⁴ as early as possible. - Enhanced Lakidjeka response (following an unborn child report) - Parenting program designed and delivered by ACCOs for all expectant women/couples. - Trauma and cultural awareness training for all child protection practitioners. - Aboriginal

(continued on next page)

Table 1 (continued)

System cause	Why is it happening?	Desired system conditions	Proposed solutions
Unnecessary removals	Aboriginal women/couples in child protection practice. - Information gathering tools designed to assess the likelihood of harm and safety that are inaccurate for Aboriginal children. - Implicit racial bias towards Aboriginal women/couples in child protection decision-making. - Practitioners within ACCOs and women/couples not present during child protection case planning. - Power imbalances between child protection and practitioners within ACCOs and families in child protection decision-making. - Lack of culturally responsive residential services for entire family following birth.Short hospital stays following childbirth (two days)	Child protection works with practitioners within ACCOs and the family where there is risk of significant harm concerns for the unborn baby and there is an open child protection case.	residential service with wraparound culturally appropriate support and safe space. - All child protection case planning decisions regarding unborn Aboriginal babies escalated to child protection Director BPA. - AFLDM as case planning process where there is child protection involvement. - Cultural awareness training for all child protection practitioners.

¹ An Aboriginal person, especially one from Victoria and southern New South Wales.

² The Koori Maternity Services program offers flexible, inclusive, culturally appropriate maternity care to Aboriginal and Torres Strait Islander women in Victoria.

³ The Orange Door provides help for people experiencing family violence, or who need assistance with the care and wellbeing of children and young people.

⁴ ACSASS is called Lakidjeka at VACCA. Lakidjeka is a Yorta Yorta word meaning ‘the child’ or children.

Dadirri meditation (https://www.youtube.com/watch?v=tow2-tR_ezL8). Author 1 consulted with the VACCA implementation team on all aspects relating to the workshop format and content to ensure a culturally safe process. The link to action was made clear at the start of the process. VACCA gave a commitment to workshop participants that ‘talk’ would lead to action within the scope of the project, and that participants would be kept informed about the progress of the project and associated impact.

4. Findings

4.1. Circumstances of Aboriginal families who have an infant removed

Stakeholders involved in the workshops indicated that families involved in Aboriginal infant removals have adversities which intensify the complexities of parenting (Mc Elhinney et al., 2021), notably unemployment, educational disadvantage, poverty, homelessness/housing insecurity, and for mothers, intellectual disability, and family violence. These challenges are exacerbated by a lack of practical and emotional support during pregnancy, during hospital stay for labour and child-birth, and after discharge from hospital. Stakeholders also said that Aboriginal families who have had an infant removed into care do not have strong connections to Aboriginal family, Community, and culture, which can build a strong Aboriginal identity and belongingness (Gee et al., 2014). Stakeholders associated women/couple’s social isolation and cultural disconnection with their recent relocation into the BPA and a lack of opportunity to connect with family, Community and culture while growing up in OOHHC.

Stakeholders also said that expectant mothers at risk of having an Aboriginal infant taken into care may hide or conceal their pregnancy, and generally avoid antenatal care, and do not seek out social services (including seeking help when experiencing family violence) and do not identify as Aboriginal. This is due to concerns that professionals would make an unborn child report to child protection, or because they have had poor experiences with mainstream services throughout their life. It was also known prior to the workshops that many Victorian Aboriginal infants entering care do not have a father named on their birth certificate. Stakeholders said that this was because the presence of the father may affect professional judgement of the immediate safety of the infant, or it could be related to child support payments and income support payments. Participants also said that expectant Aboriginal women are confused by child protection processes, are often not alerted to child protection concerns during pregnancy, and fear engagement with child protection authorities.

4.2. System causes of Aboriginal baby removals

The discussion of system characteristics that drive Aboriginal infant removals resulted in a long list of factors that were related to all six system conditions identified by Foster-Fishman and colleagues (2007). These system causes were grouped under three themes: unnecessary unborn child reports to child protection; child protection concerns not addressed prenatally; and unnecessary removals.

Surveillance bias was thought to contribute to the over-representation of Aboriginal children in unborn child reports. Specifically, participants indicated that expectant Aboriginal women are “surveilled” by child protection, because they are in OOHHC, or because older children are open with child protection. Participants said the large number of unborn child reports to child protection included ‘unnecessary reports’ that resulted from mandatory reporter racial bias and decision-making in a context where health professionals are unable to respond to complex psychosocial needs within their own service, are unfamiliar with community-based social care programs, perceive a lack of availability of community services and have a false perception that child protection practitioners can provide families priority access to services.

Participants also connected ‘unnecessary removals’ to racial bias in child protection, or differential assessments and case decisions. Child protection practitioners were thought to make negative assumptions about Aboriginal family structures and child-rearing practices and Aboriginal women/couples and their capacity to protect and make changes to achieve safety. Participants also said that in risk assessments, practitioners attach too much weight to historical factors such as substance misuse history or prior involvement with the child protection system, and not enough importance on the strengths of women/couples

Bringing Up Aboriginal Babies at Home Program

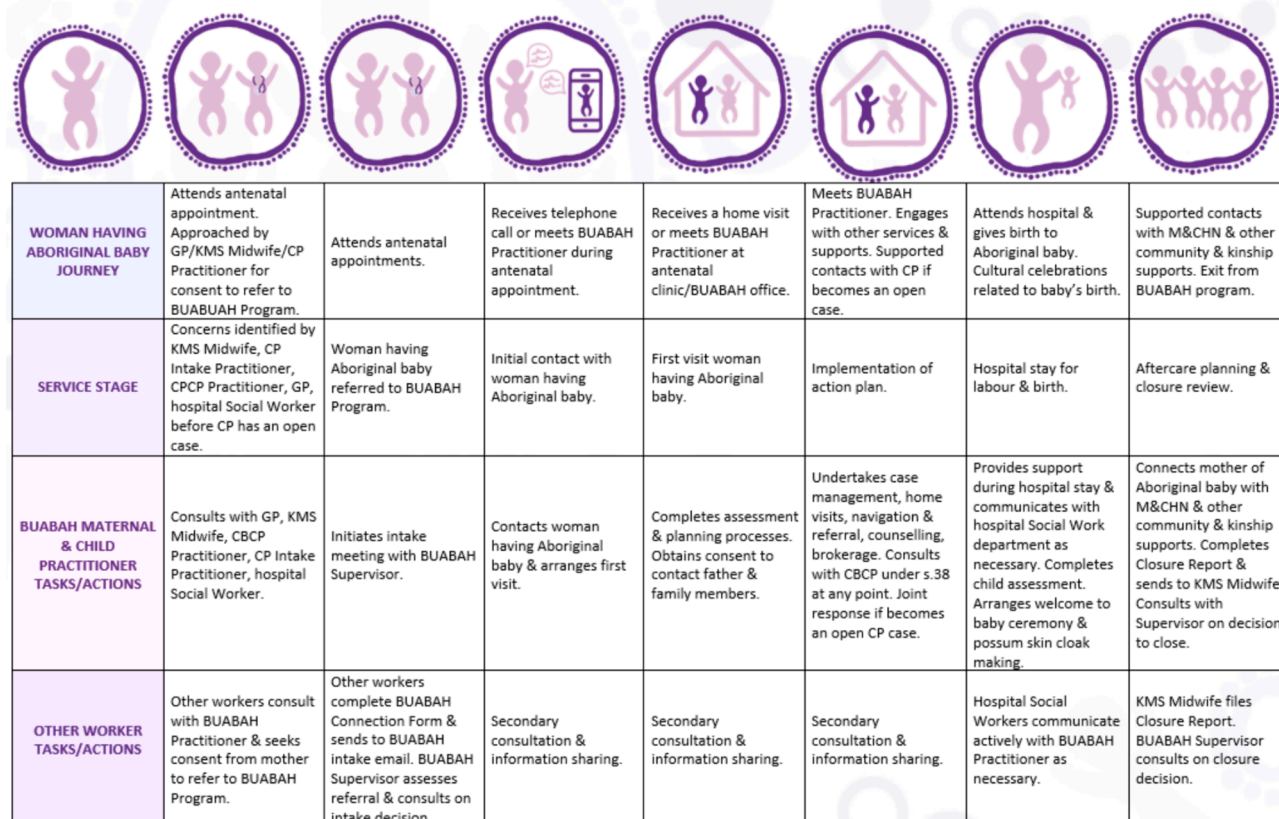


Fig. 1. The BUABAH Service Blueprint. Artwork produced by VACCA.

and family life, thus estimating the level of risk Aboriginal infants face to be higher than is the case. Marginalisation of Aboriginal families and practitioners within ACCOs in child protection assessment and decision processes was another element said to contribute to racial bias influencing child protection decisions.

The social care system was seen to be ineffective in breaking the unwanted connection between adversity and Aboriginal infant removals due to human and financial resource constraints and poor connections between system actors. Antenatal care, child protection and social services delivered by ACCOs were seen to be working in silos. Stakeholders said that late/untimely reporting of child safety concerns to child protection and difficulties developing and sustaining supportive relationships with Aboriginal women/couples in child protection practice caused delays in identifying needs and referring Aboriginal perinatal families to culturally appropriate social services early in pregnancy. Lack of access to preventative services was also attributed to government expenditure in child protection that is disproportionately allocated to protective intervention, a lack of proportional or equitable funding for ACCOs to deliver culturally based social care to perinatal Aboriginal families, an inexperienced Aboriginal community services workforce, and a community service sector that is overwhelmed with demand.

4.3. Proposed solutions

During workshop two, stakeholders identified several strategies to address the prioritised system causes and bring about desired system conditions (Table 1). Strategies to avoid unnecessary reports to child protection from sites of antenatal care included co-location of an Aboriginal child and family practitioner in mainstream maternity settings, communicating the availability of culturally appropriate maternity care to expectant Aboriginal women and the availability of

community-based supports to health practitioners, and ensuring health practitioners who make an unborn report to child protection are transparent and open with the women/couples about their concerns and any referral made to child protection.

To address child protection concerns prenatally, stakeholders suggested better connections between maternity care, mainstream community services, child protection and ACCOs, an enhanced Aboriginal response following an unborn child report to child protection, a new Aboriginal parenting program for expectant women/couples, and training to support child protection to adopt a trauma-informed approach to child protection practice. Stakeholders also saw the need for a new Aboriginal residential service following birth to prevent removal where there are significant harm concerns for a newborn. To mitigate racial bias in removal decisions, stakeholders proposed escalation of all child protection decisions involving Aboriginal infants to the Child Protection Director BPA, cultural awareness training for all child protection practitioners, and AFLDM as the case planning process where there is child protection involvement during the unborn phase.

Table 1 shows the three main explanations for the disproportionate number of Aboriginal infant removals, their system causes and a culturally informed response.

4.4. The Bringing Up Aboriginal Babies at Home program

To prevent child protection involvement during the perinatal period, a culturally responsive maternal and child program accessible early in gestation, and ideally prior to an open child protection case, called Bringing Up Aboriginal Babies At Home (BUABAH), was agreed upon by the VACCA local implementation team to implement several strategies across all three thematic areas described in Table 1. To attend to culturally incongruous and negative encounters with child protection

practitioners and non-Aboriginal health professionals during pregnancy, labour and birth, cultural responsiveness training tailored for the perinatal period for child protection and health professionals also formed part of the action plan.

The BUABAH program was guided by five 'desired system conditions': (i) women having an Aboriginal baby are confident accessing antenatal care and disclosing their Aboriginal identity; (ii) non-Aboriginal health professionals consult with an Aboriginal child and family practitioner before reporting child safety concerns to child protection; (iii) non-Aboriginal health practitioners make timely referrals to Koori Maternity Services or an Aboriginal Community Controlled Health Organisation (ACCHO) for antenatal care and to ACCOs for psychosocial needs; (iv) women/couples having an Aboriginal baby are familiar with Aboriginal services and receive effective, culturally attuned prevention support from the early stages of pregnancy; and (v) child protection decision-making is inclusive of Aboriginal families and practitioners within ACCOs, at the point of child protection intake and where there is an open child protection case.

Program activities, practice approach and resources thought to lead to the achievement of desired outcomes were identified by the VACCA local implementation team in consultation with the Aboriginal stakeholder group, child protection practitioners and midwives at the local birthing hospital. BUABAH was conceived as an intensive case management program for pregnant women/couples with complex psychosocial concerns. Case management is delivered within a culturally grounded approach, integrating Aboriginal traditions and rituals, and cultural practices that reflect Aboriginal values, beliefs and worldviews, and ways of being and doing.

The psychosocial care journey of women accessing the BUABAH program is illustrated in the service blueprint in Fig. 1. After a doctor qualified in general medical practice (GP), midwife from the local birthing hospital, child protection intake practitioner or a community-based child protection practitioner identifies concerns about risk of harm the unborn child may experience after birth, with the mother's consent, they complete a 'Connection Form' and send it to the BUABAH intake email address. Within 24 h VACCA assesses the referral and makes an intake decision, ensuring the mother is in their first or second trimester of pregnancy (no later than 24 weeks pregnant). After intake, the BUABAH practitioner contacts the mother via telephone or in-person at the antenatal clinic to arrange a first visit. At the first contact, the BUABAH practitioner explains the purpose of the BUABAH program and using VACCA's culturally appropriate assessment and planning tools, identifies risks, and goals that the mother is going to meet during pregnancy.

Following the first visit, the BUABAH practitioner implements the tailored support plan. The BUABAH practitioner provides care coordination, service navigation, and a range of non-clinical supports that focus on building capacity and cultural connections. Working from a holistic and relational worldview, the BUABAH practitioner conducts frequent visits and provides a high level of support and monitoring. Brokerage is available to the BUABAH practitioner to fund items that meet women's immediate or essential needs (e.g., rent and bond) and to assist engagement.

The BUABAH practitioner works closely with local service providers, including community-based child protection as needed. Interface with community-based child protection can include risk-based consultations. If it does become necessary to 'escalate' or invoke statutory procedures to ensure the safety of the baby at birth, the BUABAH practitioner attends meetings with child protection practitioners to support the woman/couple and ensure culturally informed assessments and decisions. The BUABAH practitioner also assists with the identification of relatives/kin where removal is planned prior to birth. Following birth, the BUABAH practitioner arranges the gifting of a possum skin cloak and Welcome to Country ceremonies (cultural celebrations related to the birth of a baby) and coordinates the mother's exit from the BUABAH program. The BUABAH practitioner's task at case closure is to ensure the

mother is connected to the maternal and child health service and other community and kinship supports or is transferred to VACCA's intensive family preservation and reunification response program.

In keeping with the intensive nature of the service, the BUABAH practitioner manages a caseload of up to five women. As well as working in caseload, the BUABAH practitioner attends regular meetings with hospital social workers regarding pregnant Aboriginal women with complex psychosocial concerns and provides secondary consultation in cases where a concern about the future safety of an unborn Aboriginal baby has been referred to their department. The BUABAH practitioner also provides secondary consultation to community-based child protection during the intake phase and where there is an open child protection case.

Fig. 1 shows the key stages of the BUABAH service alongside the client's journey, and the actions and tasks of the BUABAH maternal and child practitioner and other key workers.

5. Discussion

There are stark disparities between Aboriginal and non-Aboriginal in infant removals requiring urgent action to prevent further intergenerational trauma. With philanthropic funding, VACCA and the UoM had the opportunity to undertake an Aboriginal-led system change project to ensure Aboriginal infants are raised safe and strong in family, Community, and culture. This paper provided details of the problem analysis and design phases of the system change project, which involved understanding the problem of Aboriginal infant removals and designing a systems-level solution through dialogue and deliberation processes with representatives from local Aboriginal programs in the BPA of metropolitan Melbourne.

Aboriginal infant removal is an exceptionally complex issue, and where and how racial disproportionalities in child protection systems are occurring continues to be studied and debated. This project highlights the value of adopting a systems approach to understanding and addressing child protection challenges (Wise, 2021). By placing the problem in the context of the overall system, it was possible to reach agreement on why the pattern of Aboriginal infant removal is occurring and identify wise actions to shift them. While this approach was new to stakeholders, an urgent and important issue combined with a space designed for safety and trust, expert facilitation, and the use of culturally appropriate methods sustained effective engagement on this occasion.

It is unclear whether in-person workshops, the involvement of other stakeholders, such as participants within mainstream services, greater involvement of service users, or the use of other system thinking methods such as causal loop diagrams (Adam, 2014), would have produced a different or more complex picture of the system surrounding Aboriginal infant removals. However, there was considerable overlap in the issues that emerged during the first dialogue and deliberation workshop and other explorations into the causes of racial disproportionality in child protection.

The themes that emerged in the current project reflect a risk/bias theoretical perspective, meaning both risk and individual professional bias contributes to racial disproportionality in infant removals, as well as bias that is structured into tools designed to assess the likelihood of harm. This resonates with previous research and inquiries conducted in Aotearoa New Zealand and Australia, which attribute disproportionality in reports and removals involving Indigenous children to; disproportionate need exacerbated by a lack of preventive, proactive and integrated services prenatally, over-surveillance of pregnant Indigenous women and fathers/partners with a history of child protection involvement (surveillance bias), biases in the decisions of mandatory reporters and child protection practitioners, and tools that inappropriately classify Indigenous children as high risk of harm, leading to unwarranted removals of infants from their parents (Kaiwai et al., 2020; Keddel, 2022; Davis, 2019; Douglas & Walsh, 2013; O'Donnell et al., 2019; SNAICC, 2022; Wise & Brewster, 2022; Chamberlain et al., 2022;

Harnett & Featherstone, 2020).

Identification of the underlying drivers of Aboriginal infant removals enabled consideration of potential change actions. To reduce Aboriginal infant removals, stakeholders deemed it necessary to address factors of risk as well as bias in the child protection system that responds to risk. The ultimate solution was to reshape the system so that the pattern of late identification/reporting and statutory intervention (an intervention or child protection response) is replaced with early identification and referral to a culturally based, relational intervention of care and support capable of responding to the psychosocial issues that disproportionately affect Aboriginal families (a prevention response). Training tailored for the perinatal period also formed part of the action plan, to help health professionals and child protection practitioners understand the historical and ongoing impact of colonisation on Aboriginal communities and to recognise and address their own unconscious biases.

Aboriginal stakeholders involved in the current project also advocated for an Aboriginal designed and delivered universal parenting program for all expectant women/couples, and others have made similar calls for expanded access to culturally appropriate universal and targeted parenting programs to help Indigenous parents acquire parenting knowledge, skills, and strategies (MacDonald et al., 2024). However, programs that aim to prevent Aboriginal infants from entering OOH, have a unique place in the prevention continuum. Pre-birth OOH prevention programs address a range of factors that increase the likelihood of harm in advance of a child being born, ensuring that women/couples receive the support and services they require to be able to care for infants effectively. They often work with women/couples living with complex trauma and its impacts.

Service blueprinting was used to develop the initial service idea into a developed concept. Although the project did not engage service users in the service design stage to check that the program met their needs, service blueprinting plots the service experience over time as a starting point, mapping what users are interacting with over the journey. This helped the program developers to understand the experience service users will have. Building the blueprint, or how the service user experience is delivered end-to-end, was also a valuable process for enhancing collaboration with child protection and pregnancy care services, who contribute to a single service user experience. The blueprint will also help prepare for implementation by ensuring that support structures are ready prior to implementation. The service blueprint will also be used to track success and point out weaknesses or failures in design that can be the basis of continuous improvement.

Just like pre-birth prevention programs that have evolved in other parts of Australia, Canada, and the UK to respond to the problem of infant removals (<https://www.swslhd.health.nsw.gov.au/parvan/PFC.html>; Wise & Brewster, 2022; Barlow et al., 2016), BUABAH practice centres on the cultivation of a positive working relationship between practitioners and women/couples, inspiring hope, openness, and transparency about factors that pose a risk to the future safety of a child, activating extended networks of formal and informal supports to strengthen safety, and close collaboration with antenatal and child protection services (Dion et al., 2022; Wise & Brewster, 2022; Chamberlain et al., 2022).

The strength of BUABAH's design is yet to be empirically tested, and evaluating the amount of change BUABAH will bring about in system behaviour is difficult. Aboriginal stakeholders also made several suggestions for action that were not possible to implement within the project timeline and budget. In this regard, organisations might consider other ideas for action suggested by Aboriginal stakeholders, such as a universal Indigenous parenting program for expectant parents, an Aboriginal residential service for parents and babies, and updating child protection practice tools so that the likelihood of harm and safety is assessed through a cultural lens.

6. Conclusion

The large and increasing rate of statutory Aboriginal infant removal in Australia, which has reached 10% of live births in the state of Victoria, is a crisis motivating radical change in the identification, prevention and responding to child protection issues during the perinatal period to prevent further intergenerational trauma. Through a process of dialogue and deliberation, practitioners from local Aboriginal programs in the BPA of metropolitan Melbourne were able to develop a shared understanding of the problem of Aboriginal infant removals and reach a consensus about what to do in the local system. The BUABAH program has a clear logic within the local system as it is understood by practitioners within local Aboriginal programs, and the service idea has progressed into a developed concept through a process of service blueprinting. BUABAH is also resonant with other programs that have evolved independently in Australia and jurisdictions in the UK and Canada to reduce infant removals. However, program evaluation is needed to determine whether BUABAH can be implemented with fidelity, tackle identified system flaws, reduce the number of Aboriginal infants taken into statutory OOH and become sustainable.

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CRediT authorship contribution statement

Sarah Wise: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing. **Jason King:** Conceptualization, Writing – review & editing. **Julie Sleight:** Conceptualization, Project administration, Investigation, Writing – review & editing. **Stella Omerogullari:** Conceptualization, Project administration, Investigation, Writing – review & editing. **Lorne Samuels:** Conceptualization, Investigation, Writing – review & editing. **Alicia Morris:** Conceptualization, Writing – review & editing. **Trezalia Skeen:** Conceptualization, Investigation, Writing – review & editing.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Jason King, Julie Sleight, Stella Omerogullari, Lorne Samuels, Alicia Morris, and Trezalia Skeen were employed by the Victorian Aboriginal Child and Community Agency when the work described in the article was done. Sarah Wise has a research relationship with the Victorian Aboriginal Child and Community Agency. Sarah Wise collaborates with the Victorian Aboriginal Child and Community Agency on research projects. Sarah Wise undertakes research services for the Victorian Aboriginal Child and Community Agency under contract and sub-contract arrangements.

Data availability

No data was used for the research described in the article.

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