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'Keeping Ourselves Safe From the System': Perinatal Care Model Considerations for Aboriginal and Torres Strait Islander Families Intersecting With Child Protection

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ABSTRACT

It is the priority of Aboriginal and Torres Strait Islander communities, and Australian governments, to provide infants with enriching environments in which they may thrive. This is particularly critical during the perinatal period. Yet, an increasing number of notifications and interventions by child protection authorities are occurring in the first year of life. This research reports parent, service provider and researcher perspectives about systemic considerations on a community-led preventative, perinatal care model for Aboriginal and Torres Strait Islander families at risk of child protection involvement. Reflexive thematic analysis of discussions with 22 parents and 80 practitioners from across Australia is included, with 61% of participants identifying as Aboriginal and/or Torres Strait Islander. Three themes were generated: (1) Child Protection is a Colonial System, (2) Risk-Averse Practice within Child Protection and Allied Systems, (3) Centring Aboriginal and Torres Strait Islander Peoples and Knowledges is Vital. Our analysis suggests that dominant Western ideologies, processes, and structures that underpin secondary and tertiary interventions (e.g., bureaucratic processes) present inherent barriers to Aboriginal-led interventions. Honouring Aboriginal and Torres Strait Islander knowledges, sovereignty, and leadership are crucial to supporting Aboriginal and Torres Strait Islander families to thrive, in turn reducing child removals.

1 | Introduction

1.1 | Background

Aboriginal and Torres Strait Islander peoples have nurtured strong, healthy children for millennia (Chamberlain et al. 2025; Dudgeon and Bray 2019). While there is significant diversity among Aboriginal and Torres Strait Islander peoples, cultural practices and governance systems that define relational responsibilities and promote holistic community care are common (Chamberlain et al. 2022; Ramsamy 2014). However, in Australia, as in other settler-colonial contexts such as Turtle Island (North America) (Rocha Beardall and Edwards 2021; Blackstock 2007) and Aotearoa New Zealand (Cleaver 2025), colonisation has imposed systems that have disrupted cultural practices and established ongoing harms

to First Nations peoples, including forced child removal (Human Rights and Equal Opportunity Commission 1997; Krakouer 2023).

Aboriginal and Torres Strait Islander children constitute 41% of all children in out-of-home care (OOHC), despite representing only 6% of the total child population in Australia (SNAICC 2024). Removal of Aboriginal and Torres Strait Islander children remains linked to colonisation, historical injustice, systemic racism and intergenerational trauma (Yoorrook Justice Commission 2023). This includes the 'Stolen Generations', which refers to a period whereby approximately 10%–30% of Aboriginal and Torres Strait Islander children were forcibly removed for assimilatory purposes between the 1910s–1970s (Haebich 2000; Human Rights and Equal Opportunity Commission 1997). Hospitals played a significant role in removals during the Stolen Generations period, with deception used as part of infant removals (Human Rights and Equal Opporunity Commission 1997), leaving a legacy that continues to impact perceptions of trust and safety of hospitals today. This is evident in the *Bringing Them Home* report (Human Rights and Equal Opportuntiy Commission 1997) and other reports and media (Human Rights Watch 2025; Perpitch 2025; Richards 2024) that have made visible contemporary practices in hospitals regarding Aboriginal and Torres Strait Islander child removals.

In recent decades, there have been increased efforts to recognise and rectify ongoing harms associated with Aboriginal and Torres Strait Islander child removal in Australia. Notably, the government has made a commitment to achieving socio-economic equity through the national 'Closing the Gap' (CTG) agreement, which includes a target (Target 12) to reduce the over-representation of Aboriginal and Torres Strait Islander children in OOHC by 45% by 2031 (Commonwealth of Australia n.d.). Similarly, in alignment with Target 12, the *Safe and Supported* Aboriginal and Torres Strait Islander First Action Plan 2023–26 outlines a collaborative, multi-disciplinary and multisector framework for enhancing the safety and wellbeing of Aboriginal and Torres Strait Islander children (Commonwealth of Australia 2022). However, despite being a national priority, the over-representation of Aboriginal and Torres Strait Islander children across child protection and OOHC continues to worsen, including during infancy (Commonwealth of Australia 2022; Productivity Commission 2025a; SNAICC 2024).

1.2 | Child Protection During Pregnancy

Globally, there is growing concern about the increasingly younger age at which children are being removed, with rising numbers of infants (aged under one) removed by statutory child protection systems (Alrouh et al. 2019; Broadurst et al. 2018; Burrow et al. 2024; Chamberlain et al. 2022; Keddell et al. 2021; O'Donnell et al. 2019). In Australian jurisdictions accepting prenatal child protection notifications (New South Wales, Western Australia and Queensland), an increase in notifications was evident between 2012–2019 for all children, with rates four times higher for Aboriginal and Torres Strait Islander infants (O'Donnell et al. 2023). This is corroborated by recent data demonstrating Aboriginal and Torres Strait Islander infants are eight times more likely to receive child protection services compared to non-Indigenous infants nationally in 2022–23 (182.2 per 1000 compared to 22.4 per 1000) (Australian Institute of Health and Welfare 2025).

Prevention of child protection involvement is a critical element of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP), and one allied health systems[1] and practitioners can support during pregnancy. The ATSICPP is in child protection legislation throughout Australia and aims to uphold Aboriginal and Torres Strait Islander people's priorities, including cultural connection, self-determination, and prevention through supporting families and communities to safely care for their children (Human Rights and Equal Opportunity Commission 1997; SNAICC 2017). However, there is insufficient focus on prevention in child protection nationally, with the cost of child and family welfare services[2] in Australia around $10.2 billion annually in 2023–24, with only 15% of this expenditure going to family support services (including intensive family support services) (Productivity Commission 2025b). Prevention remains an area of community priority for change, particularly given enduring concerns about over-representation and non-compliance with the ATSICPP (SNAICC 2024).

There is supporting evidence on the effectiveness of Aboriginal-led preventative maternal, child health and family support strategies in reducing child protection involvement. For example, a perinatal pilot programme developed with an Aboriginal Community-Controlled Organisation (ACCO) in Melbourne, Victoria, implemented a case management model to provide culturally responsive and continuous support throughout pregnancy (Wise and Brewster 2022). The programme successfully diverted 63% of infants from a child protection investigation (Wise and Brewster 2022). Other programs, led by ACCOs such as the maternal and child health service Birthing in Our Community programme in Brisbane, Queensland (O'Dea et al. 2024) and the Nabu Aboriginal family preservation and restoration programme in Nowra, New South Wales (SNAICC 2021) provide holistic, wraparound support, including continuity of care and community hubs that house multiple services and practitioners for families to access. These have also demonstrated effective, holistic outcomes in preventing child removal to OOHC. Evidently, Aboriginal-led maternal and child health services are well placed to provide preventative wraparound support. Investment in Aboriginal and Torres Strait Islander community-controlled services and workforce is also essential and has been highlighted as a national priority in *Safe and Supported* (Commonwealth of Australia 2022).

Removal of Aboriginal and Torres Strait Islander babies is traumatic, with families often not receiving support to prevent or manage trauma associated with removals, and some practitioners are susceptible to moral injury (Burrow et al. 2024; Critchley 2020; Lawrie 2024; Yoorrook Justice Commission 2023). There is a dual need to not only drive systemic change that can enable prevention, but also to ensure that practice relating to perinatal child protection involvement is undertaken in a way that can minimise distress and trauma.

However, the effectiveness of community-led strategies will be dependent on adequate resourcing for implementation and their integration with current systems. We set out to gather perspectives of families, practitioners and researchers closely involved in child protection regarding the feasibility of a novel model of perinatal support to help improve decision-making when responding to challenges that families face, preventing unnecessary infant removal, and improving health and well-being outcomes for Aboriginal and Torres Strait Islander families navigating complex circumstances during the perinatal period.

1.3 | Present Study

This paper draws on data from two large, sequential Aboriginal-led research projects—Healing the Past by Nurturing the Future (HPNF) and Replanting the Birthing Trees (RBT) (Chamberlain et al. 2019, 2024).

The pilot project HPNF was developed through a comprehensive four-year Aboriginal participatory action research and co-design process that sought to identify the main areas of concern in the support provided for Aboriginal and Torres Strait Islander families experiencing complex trauma (Chamberlain et al. 2019). Child protection intervention was identified as a key concern in the HPNF project, and consequently, developing an integrated perinatal model of care for Aboriginal and Torres Strait Islander families at risk of child protection involvement became a sub-focus of both the HPNF and RBT research projects. This integrated model of care aimed to draw on the collective wisdom of a range of community members and professionals selected by the family, rather than having decision-making solely within child protection services (referred to as a 'Wise Counsel' model of care).

We inquired about the acceptability, feasibility, and usefulness of the care model, but participants shared deep and important insights about contemporary systemic factors. This paper reports on the organisational, social, cultural and colonial factors discussed by participants; insights on the integrated model of care will be reported elsewhere. This paper aims to inform and enhance current and future models of care, practice and policy, while maintaining a critical stance on systemic factors that can constrain the success of child protection-focused preventative models of care.

2 | Methods

2.1 | Study Design

We conducted a qualitative study using semi-structured discussion groups with parents and service providers (2022) and two key stakeholder workshops (Workshop A in 2022, Workshop B in 2024). The discussion groups were held across three Australian jurisdictions (Northern Territory, South Australia and Victoria), and the key stakeholder workshops were held in Victoria. Facilitators for discussion groups and workshops were Aboriginal and non-Indigenous researchers either employed under, or involved as investigators in, the HPNF and/or RBT projects.

2.2 | Positionality Statement

Data analysis for this paper was undertaken by non-Indigenous researchers (NMB, SO) under the supervision and guidance of Aboriginal researchers (JK, CC, PG). Aboriginal oversight was prioritised throughout, including the provision of critical input on analysis and interpretation for non-Indigenous researchers (NMB, SO). The lived experiences, professional backgrounds, and cultural knowledges of Aboriginal researchers (JK, CC, PG) shaped the study's design, data collection and analysis, while the positionality of non-Indigenous researchers (NMB, SO) also shaped data analysis and interpretation. HH, JF, KJ, and MOD are also non-Indigenous researchers. Authors include Aboriginal and non-Indigenous academics with backgrounds in child protection, midwifery, public health, psychiatry, psychology and social work. One author is a Lived Experience Advisor. Full author positionality statements are included under Acknowledgements. Aboriginal authors had final decision-making authority over themes and findings, as well as the final manuscript.

2.3 | Sampling and Recruitment

For the Parent Discussion Groups (PDG), we used convenience sampling, recruiting parents through existing community networks within the project team and ACCOs, where they received care. Workers at the ACCOs contacted parents either face-to-face or over the phone if they met the following criteria: (1) self-identify as Aboriginal and/or Torres Strait Islander, (2) aged 16 years or older, (3) able to provide informed consent, and (4) they or their partner are currently pregnant or have a child up to five years of age.

For the Service Provider Discussion Groups (SPDG), we employed purposive sampling. SPDG participants were eligible if they met the following criteria: (1) involved in the care of Aboriginal and Torres Strait Islander parents (health and social care, e.g., perinatal care workers, maternal child health workers), and (2) 18 years or older. Workshop participants were contacted based on the researcher's networks, including recommendations from within the researcher's networks. Some participants in the SPDGs and workshops had prior relationships with the research team (e.g., through employment or connections at community organisations), while others were employees from relevant organisations and purposefully invited based on their professional role, subject matter experience and/or expertise. Participants in the SPDGs and workshops were contacted by email. Researchers with expertise in child health and child protection also participated in the workshops. Note-takers and project staff ($n = 13$) were present at the workshops but are not included as participants.

2.4 | Ethical Considerations

All data collection activities had institutional ethics approval from the St Vincent's Human Research Ethics Committee (HPNF project—St Vincent's HREC approval no. 239/22; RBT project—St Vincent's HREC 148/23). Both HPNF and RBT projects are Aboriginal-led and developed according to the National

Health and Medical Research Council Indigenous Research Excellence criteria guidelines for ethical research conducted with Aboriginal and Torres Strait Islander peoples (Chamberlain et al. 2019). All participants were informed about the purpose of the research and provided written informed consent. No participants withdrew after providing consent.

2.5 | Data Collection

Data were collected via semi-structured discussions during discussion groups and workshops (see question guide in Appendix A). All questions asked were reviewed by Aboriginal and non-Indigenous staff within the project team. Authors JK, RG, and PG each served as facilitators during the data collection process at least once, while author CC facilitated at all four points of data collection. The discussion groups and workshops were predominantly facilitated by female Aboriginal interviewers (73%). Discussions were held face-to-face except for Workshop A, which was conducted online due to COVID-19. The PDGs were organised by and held at ACCOs, while SPDGs were held at a venue agreed upon by service providers. Workshop B was held at a function venue in Melbourne, Australia.

The PDG's, SPDG's and Workshop A included multiple sessions and covered a range of different topics related to the project. However, the data used in this paper come from a single session specifically focused on the model of care. Workshop B was a two-day workshop and is the only data source entirely dedicated to discussing the model of care. The PDG's, SPDG's and Workshop A were recorded for transcription. Handwritten notes, electronic notes, and posters were taken for analytical reasons during Workshop B.

2.6 | Data Analysis

We used reflexive thematic analysis (RTA), following the six-stage process outlined by Braun and Clarke (2022). For PDG, SPDG and Workshop A, audio recordings were transcribed (NMB). For Workshop B, notes were collated (NMB). NMB and SO listened to all the audio recordings; NMB also read all the notes taken from Workshop B and made reflective notes as part of the RTA process. Familiarisation and notes taken throughout the RTA process shaped the interpretation and analytic narrative. NMB generated codes using NVivo, which was used for organisation and analysis. NMB regularly presented the codes and interim themes to colleagues (SO, CC, JK) for group coding and theme generation. NMB and SO regularly engaged in deep reflection and discussion of themes during theme development. Findings were iteratively and collaboratively constructed, and reviewed during coding, theming and write-up with supervision from senior Aboriginal authors (JK, CC). Thematic maps were utilised to visually display and develop themes. The themes were shared with the broader authorship group, primarily consisting of Aboriginal academics, practitioners, and a lived experience advisor, for review.

Aboriginal perspectives (CC, JK) were integrated throughout the entire analytic process. Collaborative analysis was necessary due to the involvement of non-Indigenous researchers and allowed for nuanced engagement with diverse data sources across two years. It also enabled an inductive, experiential approach that identified both semantic (explicit) and latent (implicit) meanings (Braun and Clarke 2022).

3 | Results

A total of 102 participants[a] took part in the study. The characteristics of participants are detailed in Table 1. Service provider participants included health (e.g., nurses), family support (e.g., social workers), and child protection professionals (e.g., caseworkers).

As Figure 1 highlights, three themes and nine sub-themes were generated.

3.1 | Theme 1: Child Protection Is a Colonial System

3.1.1 | Subtheme: Child Protection and Allied Systems Are Experienced as Unsafe

Several participants reflected on whether cultural safety can inherently exist within child protection and allied systems, such as health. One reason for this is the power imbalances that exist between families and practitioners within and outside child protection services:

> It's one of the only ways that families will start to heal, is when that power imbalance is addressed. It's because that power imbalance is one of the pivotal things that is getting children removed.
>
> (SPDG participant)

Participants discussed systemic barriers in allied systems that impact families, such as limited appointment times and rigid service inclusion criteria. Additionally, participants reported that some Aboriginal and Torres Strait Islander families avoid allied services due to an absence of safety, as well as distrust and fear of child protection involvement. One parent also suggested that even when child protection services are involved, families may continue to avoid child protection due to an absence of safety, distrust and fear.

> Well young mothers if their kids are at risk, if they've got an allegation against them they won't open the doors - number one.
>
> (PDG participant)

Ultimately, these responses suggest that child protection and allied systems, which are often the places families are required to access to get support, are also the environments where families are experiencing additional trauma and distress:

> Women are needing to keep themselves safe from the system that is intended to care for them.
>
> (Workshop B participant)

TABLE 1 | Characteristics of participants ($n = 102$).

Participant characteristics	Total *n* (%)				
	Parent discussion droups ($N = 21$)	Service provider discussion groups ($N = 20$)	Workshop A ($N = 40$)	Workshop B ($N = 28$)	Total ($N = 102$)[a]
State					
Australia Capital Territory	—	—	1 (2%)	—	1 (1%)
New South Wales	—	—	3 (7%)	1 (4%)	4 (4%)
Northern Territory	8 (38)	10 (50%)	1 (2%)	—	19 (19%)
Queensland	—	—	2 (5%)	8 (29%)	10 (10%)
South Australia	9 (43)	3 (15%)	9 (23%)	—	21 (20%)
Tasmania	—	—	2 (5%)	—	2 (2%)
Victoria	4 (19)	7 (35%)	19 (48%)	17 (61%)	40[a] (39%)
Western Australia	—	—	3 (8%)	2 (7%)	5 (5%)
Self-identifying as Aboriginal and Torres Strait Islander					
Aboriginal and Torres Strait Islander	21 (100%)	7 (35%)	22 (55%)	18 (64%)	62[a] (61%)
Non-Indigenous	—	13 (65%)	18 (45%)	10 (36%)	40[a] (39%)
Gender					
Female	18 (86%)	20 (100%)	35 (88%)	24 (86%)	91[a] (89%)
Male	3 (14%)	—	5 (12%)	4 (14%)	11[a] (11%)

[a]Participants and facilitators who attended both workshops are counted only once in the total. Raw numbers of participants were used for calculating the total. Seven duplicates (five Aboriginal women, one non-Indigenous woman and one Aboriginal male) are removed from the total. A parent and lived experience advisor attended a workshop. So, in total, 22 Aboriginal and Torres Strait Islander parents informed our findings.

3.1.2 | Subtheme: Control of Services, Information and Decisions by Child Protection

Participants highlighted how child protection has its own distinct ways of operating and utilising statutory power, including ultimate decision-making powers, exclusive funding, services, and programs only accessible with a child protection referral:

> ... money and support is behind child protection's door.
>
> (Workshop B participant)

It was emphasised that families should be able to access support before and without child protection involvement. Some also spoke about child protection decisions being made without prior consultation or notice, leading to families and their practitioners feeling ambushed by child protection decisions.

> This morning... a mother was told that child protection have just changed their mind and tomorrow when we go to court, they are going for [another] order. Just like that.
>
> (SPDG participant)

3.1.3 | Subtheme: Colonial Load

'Colonial load', sometimes referred to as 'cultural load', is an impact of colonialism that imposes additional and often unrecognised burdens (unrecognised by non-Indigenous people) on Aboriginal and Torres Strait Islander people, like experiencing racism (Weenthunga Health Network 2023). Participants discussed the additional load placed on Elders, Aboriginal Liaison Officers (ALOs) and Aboriginal-specific services. This included the same group of Elders being consulted, repetitive consultations over decades with little change, and ALOs and Aboriginal-specific services delivering culturally responsive care for entire populations and healthcare settings (e.g., hospitals). Consequently, participants highlighted the need for allies to redistribute the colonial load to the non-Indigenous majority. It was also noted that decolonisation is required to *'stop trying to fit into systems' (Workshop B participant)* and instead *'focus on building from cultural ways up, [and] not trying to fit into Western models' (Workshop B participant).*

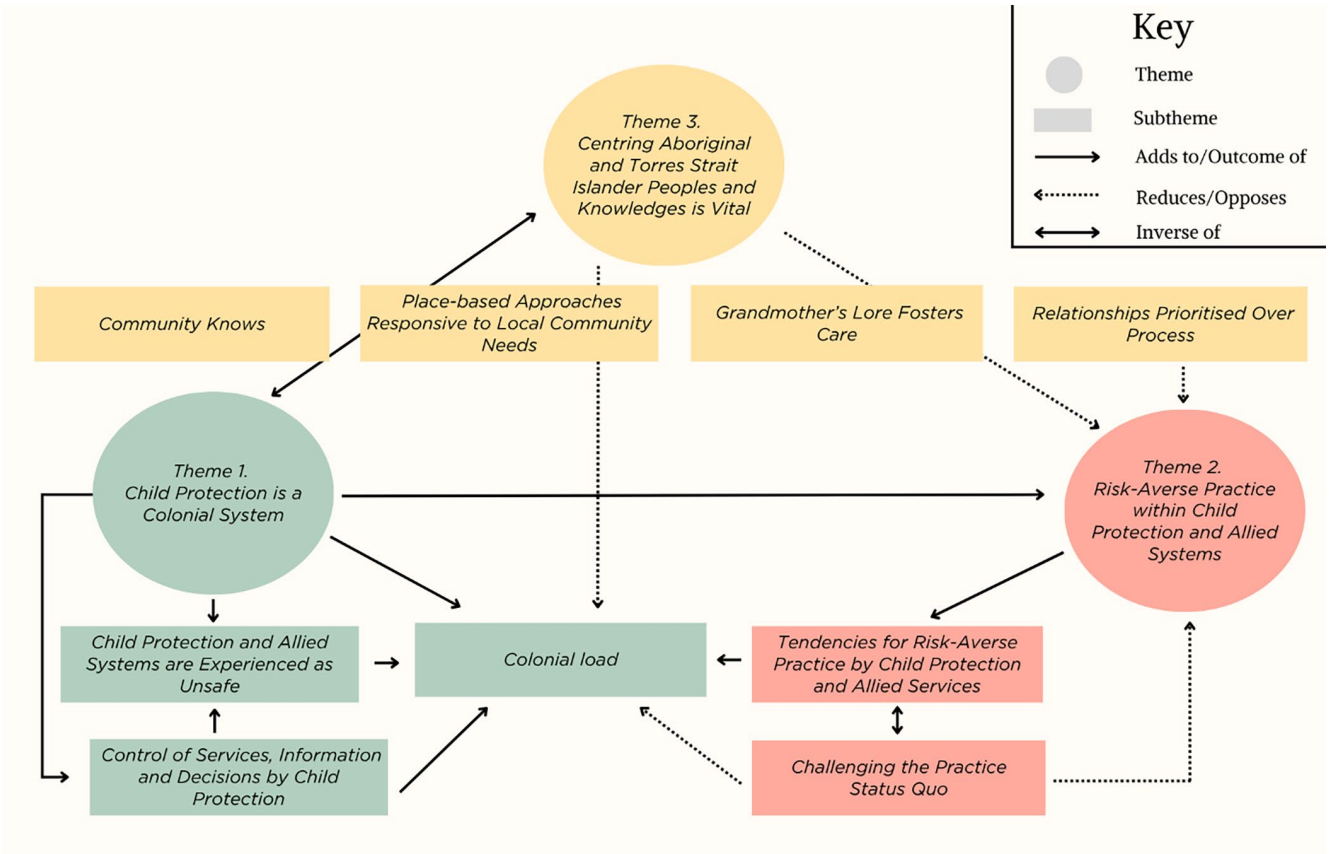

FIGURE 1 | A thematic map illustrating the relationships between three themes and nine sub-themes, identified using reflexive thematic analysis. The themes and sub-themes are highly interconnected. Centring Aboriginal and Torres Strait Islander Peoples and Knowledges is Vital (theme three) appears as the inverse of Child Protection is a Colonial System (theme one). While risk-averse practice within child protection and allied systems (theme two) emerges as an outcome of theme one.

3.2 | Theme 2: Risk-Averse Practice Within Child Protection and Allied Systems

3.2.1 | Subtheme: Tendencies for Risk-Averse Practice by Child Protection and Allied Services

While a few participants acknowledged the presence of child protection and allied practitioners who work with families to manage risk before considering notification or removal, others described practitioners displaying explicit racism:

> ...my daughter said, 'There's this one social worker at the hospital who's so racist'... This one bloke, he was really racist. He was quick to report, report, [and] report.
>
> (PDG participant)

Some participants focused on the behaviours of allied health practitioners, highlighting that allied practitioners may think they are doing the right thing when submitting a child protection notification, but *'sometimes have no idea how devastating that notification is' (Workshop B participant).* Others spoke of allied health practitioners notifying child protection as an initial intervention to mitigate the risk to themselves:

> ...the go-to, the kneejerk is child protection referral because then I've absolved myself as a practitioner of that responsibility.
>
> (SPDG participant)

Sometimes, this occurred without wraparound and/or preventative supports being utilised first:

> My [family member] works at [a social service]... the hospital knows that she was their worker but they didn't get in touch with her. They just took the baby – got welfare involved.
>
> (PDG participant)

Participants also discussed families not having the opportunity to show parenting 'capacity' before notifications and removals occurred:

> One of the difficulties about the perinatal period... in some cases the parent hasn't had a chance to even demonstrate their parenting capacity yet. We're making judgments about potential future risk, and we know that those can be very subjective judgement

> calls that are made, and certainly child protection systems are risk averse.
>
> (Workshop A participant)

Many consistently identified inadequate education and training for child protection and allied health practitioners as an underlying reason driving these behaviours:

> ...as someone who's worked in child protection for many years, the thing that's sorely lacking is the knowledge of diversity in child rearing between Indigenous families and the standard Anglo-Western style of parenting. In my experience... these very young child protection workers, often just out of university... they have no idea what you know and they have no tolerance for any type of parenting style that's not aligned with the Anglo style.
>
> (Workshop A participant)

Participants also discussed that a single risk factor could be wrongly assumed to indicate broader risk, with Aboriginality itself sometimes cited as a risk:

> Parent A: 'Why do they think they've all got complex needs just because there's one issue?' Parent B: 'It's because they're Aboriginal!'
>
> (PDG participants)

3.2.2 | Subtheme: Challenging the Practice Status Quo

Participants discussed practices they hoped to see from child protection and allied practitioners. Rather than focusing on an ideal practice, some emphasised that this should already be occurring. The practices mentioned included having honest, transparent, and timely conversations with families, recognising strengths, fostering curiosity and working towards preventing notifications or removals in the first instance. Participants spoke about the importance of prioritising discussions with family before removal:

> The family always knows. 'I'm giving [bub] to aunty, I'm giving [bub] to mum so I can get my shit together' ... but then the child gets removed before it happens.
>
> (PDG participant)

While collaborating with child protection services was often described as difficult and, at times, entirely undesired, some service providers reflected on positive outcomes. Child protection workers were potentially more willing to adopt 'creative' safety plans or diverge from the 'practice status quo' when successful interagency collaboration between child protection and allied services occurred:

> Putting the services in ... we've done that a few times. Like this mum had - I think it was her tenth baby... she got all of them removed and she was already red-flagged because you've already had all your past kids removed... So when she had baby we sat around with DCP [Department for Child Protection] and put a safety plan in place and she's still got her baby to this day...
>
> (SPDG participant)

Some participants also described examples of allied health professionals (e.g., ALOs, midwives) actively advocating for families and pushing back against child protection services:

> ... us in the birthing program, we could say 'okay well can we do this to support and see the families more often' ... We've done that a lot of times and parents got to keep their babies.
>
> (SPDG participant)

3.3 | Theme 3: Centring Aboriginal and Torres Strait Islander Peoples and Knowledges Is Vital

3.3.1 | Subtheme: Community Knows

Participants emphasised listening to Aboriginal and Torres Strait Islander communities about child protection issues. Rather than *'continuously trying to reinvent the wheel' (Workshop B participant)*, community *'know what works' (Workshop B participant)*:

> If you listen to community... the knowledge that is in community.
>
> (Workshop B participant)

Many stressed that communities should decide who is involved in decision-making, acknowledging family and community diversity. This included the importance of navigating *'complicated and changing family dynamics' (Workshop B participant)* as well as *'community politics' (Workshop A participant)*. When sovereignty is honoured, communities know how to mitigate harm and facilitate healing.

3.3.2 | Subtheme: Place-Based Approaches Responsive to Local Community Needs

Participants emphasised the need for approaches to be responsive to local needs and acknowledge and respond to the diversity within and between communities, thus opposing 'one-size-fits-all' strategies:

> ...to have something that's a framework but isn't pan Aboriginality, but it really honours place-based relationships and decision making.
>
> (Workshop A participant)

> It's very much going to depend on the local context and the culture of the First Nations peoples where that's happening and the families.
>
> (Workshop A participant)

A few participants also discussed the challenges arising from jurisdictional misalignment with Traditional Country boundaries (such as the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands, which are home to 26 remote communities across multiple state borders (Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council 2023)):

> People have family from different places and different mob and move around a lot so [they] need care that is tailored to their experiences.
>
> (Workshop B participant)

3.3.3 | Subtheme: Grandmother's Lore Fosters Care

Grandmother's Lore encompasses knowledge passed down by senior Aboriginal women (Dudgeon and Bray 2019). It is sacred and intricate, incorporating aspects such as relationships, governance, communal care, and responsibilities for Aboriginal and Torres Strait Islander women, in particular (Dudgeon and Bray 2019). Grandmother's Lore has specific relevance to pregnancy, childbirth, and parenting practices (Dudgeon and Bray 2019). Multiple participants discussed the importance of Grandmother's Lore to enable culturally grounded strategies in addressing child protection matters, particularly reinforcing relational responsibilities to children and communities:

> Our proper way as Elders is to take responsibility for everyone in our community.
>
> (Workshop B participant)

Some participants, including one Elder, also highlighted the importance of Grandmother's Lore to reclamation of identity, place, belonging and healing, a poignant point in the context of cultural disconnection associated with child removal and colonisation:

> You cannot have identity without belonging. That is what the whole principle of Grandmother Lore is about, bring[ing] people home...reclamation.
>
> (Elder, Workshop B participant)

Participants also reiterated the importance of recognising broad networks of care across families in addressing child protection concerns, consistent with Indigenous relationality and kinship:

> That's why they've got to start with the family, because if my granddaughter's there having a baby... There's always somebody within the family.
>
> (PDG participant)

3.3.4 | Subtheme: Relationships Prioritised Over Process

It was discussed that at times, impersonal, process-driven approaches were taken in child protection; participants urged practitioners to prioritise building relationships:

> Rather than talking about everybody in front of them, which happens in so many meetings, and that is going to trigger, it's like, 'you are talking about my life here, and my baby. I don't know you. I haven't met you. You haven't come and sat when I've been losing it.
>
> (SPDG participant)

Participants highlighted the fundamental importance of *'taking time to know the family and create relationships' (Workshop B participant).* Insights included the importance of *'communal care' (Workshop B participant)*, trust *('can't do anything without trust', 'making that really safe space for parents', Workshop B participants)* and engaging in a respectful, open and trauma-informed way to tackle hard conversations.

4 | Discussion

We set out to ascertain a wide range of perspectives regarding the design and development of a perinatal model of care to support Aboriginal and Torres Strait Islander parents and families at risk of child protection involvement during and after pregnancy. However, our findings highlight a range of systemic factors that require deep consideration. Participants were highly cognisant of how child protection and allied systems operate in risk-averse ways that can result in decisions being made without transparency. This echoes previous work highlighting a lack of transparency in child protection decisions made during the perinatal period (Davis 2019; Lawrie 2024; Trew et al. 2023), whereby serious psychological harm (including long-term trauma, grief and loss) can be experienced by mothers and families subjected to coercive state-sanctioned infant removal (Human Rights Watch 2025; Lima et al. 2025) and moral harm can be encountered by those involved in such decisions (Critchley 2020).

Access to services, understandings of risk and control by, and within, child protection were also at the forefront of participants' minds, highlighting that the context within which a perinatal model of care operates may be impeded by broader systemic issues. This is not surprising given Aboriginal and Torres Strait Islander peoples' historic experiences with infant removal, such as those throughout the Stolen Generations. Our findings echo concerns noted by Davis (2019) in the *Family is Culture* review, where contemporary removal practices have resonance with the past, for example, by invoking fear of services or parents and family not being aware of child protection's intended actions. Participants highlighted the importance of challenging the status quo regarding how child protection and allied systems operate to mitigate risk. At times, service providers were able to positively impact child protection decisions for families, albeit such influence appeared not to be the norm. This highlights that parents, families and service providers at times end up shouldering additional responsibility to ensure child protection is operating appropriately and safely—as also echoed in major state-based systemic inquiries and reviews (Davis 2019; Lawrie 2024; Yoorrook Justice Commission 2023), and that risk-centric practice is the norm (Hine et al. 2023).

Our findings highlight that participants were aware of the limitations to developing a perinatal model of care within current child protection or allied systems in Australia, which are steeped in colonial logic and risk mitigation (Krakouer 2023; Strakosch 2024). The way in which child protection systems operate—arguably to correct parental 'deviance' and 'dysfunction' (Rocha Beardall and Edwards 2021)—privileges Western norms, which results in risk being viewed in particular ways (Connolly 2017) where power imbalances between the State and parents—and some services—are evident.

Indigenous ways of knowing, being and doing were positioned by participants in our research as the way forward to realising change within the perinatal period for Aboriginal and Torres Strait Islander families intersecting with child protection services. Prioritising Indigenous ways of knowing, being and doing as the inverse of themes one (child protection is a colonial system) and two (risk averse practice) is also pertinent. The importance of Grandmother's Lore, relationships (and relationality more broadly), and local solutions tailored to community contexts—as designed by communities to respond to local needs—were highlighted by participants as paramount to any future solutions for Aboriginal and Torres Strait Islander peoples regarding infant removals. Indeed, Indigenous-led models of care within child protection and allied systems in Australia, such as the Garinga Bupup trial (Wise and Brewster 2022) and Birthing in Our Community (O'Dea et al. 2024), have demonstrated reductions in Aboriginal infant removals and improved practice that centres care for mothers going through perinatal child protection processes and proceedings. This is consistent with broader appeals by Aboriginal and Torres Strait Islander peoples for self-determination in child welfare, including recommendations for the transfer of jurisdiction to Aboriginal and Torres Strait Islander communities (Human Rights and Equal Opportunity Commission 1997) and more recent policy commitments by all Australian governments for the transfer of authority to Aboriginal and Torres Strait Islander communities (Commonwealth of Australia 2024). In this context, the centring of notions like Grandmother's Lore reasserts legitimate Indigenous legal frameworks by which Indigenous peoples exercise collective self-governance (Napoleon 2007). This central positioning emphasises not only the ongoing relevance of these legal frameworks in resolving contemporary issues, but reinforces the importance of structural recognition of legitimate community-based processes for the interpretation and application of these frameworks, reasserting Indigenous legal institutions that have been fractured and delegitimised, but not destroyed, by colonialisation (Napoleon 2007). The reassertion of these institutions is important to improving decisions about Aboriginal and Torres Strait Islander children, parents and families.

4.1 | Prevention, Complexity and the Role of Maternity Services

It is certainly possible for maternity services to bear greater responsibility regarding decisions to report to child protection during pregnancy (Hine et al. 2023). This needs to occur with full knowledge and understanding that Aboriginal families can experience child protection intervention as violent (Newton et al. 2025; Strakosch 2024). Scholars have drawn attention to the reality that child protection systems are underpinned by colonial and carceral logics that can unfairly target Indigenous people (Rocha Beardall 2025; Rocha Beardall and Edwards 2021; Libesman et al. 2024; Newton et al. 2025). Thus, maternity services should simultaneously challenge the child protection system status quo while providing adequate services and supports during pregnancy for Aboriginal and Torres Strait Islander parents and families. Our findings demonstrate that relationship-building is critical to the latter, along with working with Aboriginal and Torres Strait Islander communities in place-based ways during and after pregnancy. Yet this requires maternity services to work with complexity, and wrap services around families, with approaches such as integrated care, multi-agency agreements and wraparound service provision potentially able to respond more effectively for parents and families (see for example, SNAICC 2021; O'Dea et al. 2024).

While not explicitly stated by participants, one factor underpinning discussions about systemic issues may have been an awareness of complexity within the perinatal period when child protection is involved. As highlighted by O'Donnell et al. (2019) and evident within the Garinga Bupup trial (Wise and Brewster 2022), mothers involved with child protection during pregnancy may live with multiple complexities in their lives, such as mental health worries, family and domestic violence, substance use worries, and homelessness or housing instability. International literature in this area highlights a range of factors that may impact contact with child protection during pregnancy for mothers; the intersection of these various factors, in addition to bias, service demand and lack of availability of services, may increase the likelihood of infants being removed by child protection (Broadhurst et al. 2015; Broadhurst and Mason 2013; Marsh et al. 2017; O'Donnell et al. 2019).

Preventative efforts during pregnancy and the early parenting period must not be relegated solely to child protection. Prevention requires a multifaceted approach, acknowledging and addressing systemic limitations, coupled with holistic responses that can enable families and communities to heal, particularly in the perinatal period. There are no simplistic solutions; prevention means working with complexity to enable effective support, time, and family- and community-centred control to defend families against concerns held by child protection. It also requires recognition of the limitations of child protection systems and the services provided by child protection for Aboriginal and Torres Strait Islander families.

While working alongside child protection to influence decision-making, it is also important to remember that the child protection system was not originally designed with the intention of being healing for families. Although child protection systems have changed and continue to do so, the persistence of practice standards that cause trauma for Aboriginal and Torres Strait Islander families demonstrates the entrenchment of systemic issues that can cause harm. Change to current practice is needed, but this must not occur at the expense of transformative change to child protection and allied systems that operate within colonial contexts in risk-averse ways that can cause harm to Aboriginal and Torres Strait Islander parents, families and communities more broadly.

5 | Strengths and Limitations of This Research

A key strength of this project is its Aboriginal leadership, design, and oversight which ensures that the research is grounded in the perspectives, knowledge, and priorities of diverse communities. Aboriginal and Torres Strait Islander researchers played a central role in all stages of the conceptualisation, collection, analysis, and write-up, reinforcing cultural integrity and self-determination within the research process. Another key strength is the large number of participants who took part in this research, from diverse locations throughout Australia across four different points of data collection.

A limitation of this paper is that gathering systemic commentary on perinatal child protection systems was not the original intention of the study. As a result, the question guides were not ideally structured to delve into the complexities within and about perinatal child protection. Yet, participants organically shared valuable insights about this topic, and given the richness of the discussions, we have decided to present the findings across two papers. This paper focuses on systemic considerations when designing a care model, while the subsequent paper will be specific to insights about the care model (e.g., principles, values). The latter offers greater insights into the original research question.

Instead, our findings show that participants had concerns about the way that child protection operates as a limitation to any model of care being developed, and that embedding Indigenous ways of knowing, being and doing is needed as a first priority. This data tells an important narrative about awareness of the limitations to change within child protection systems, and within colonial systems generally that work alongside child protection (e.g., health systems, hospitals). Thus, before any model of care can be developed, the context must be critically examined so that the success of a model of care is not constrained by systemic factors. This was a narrative that needed to be privileged, particularly since it highlights the importance of Indigenous self-determination and systemic transformation to realising the kind of practice change that is needed in the perinatal child protection context.

Limited gender diversity of participants is another limitation of this paper, which partly reflects broader challenges in the child protection research base regarding the involvement of men in perinatal research. Further, perceptions on whether this is a limitation may vary given the cultural context of Women's Business. Finally, data for this paper were analysed by non-Indigenous researchers. Oversight, supervision and support were provided by Aboriginal researchers to ensure the integrity of analysis, which is nonetheless influenced by researcher subjectivity.

6 | Future Research

Active resistance to statutory interventions has persisted for Aboriginal and Torres Strait Islander peoples, with alternatives to statutory intervention in child protection envisioned. The importance of Indigenous self-determination in research must be centred at this juncture, with future research privileging community control in line with the Australian Institute for Aboriginal and Torres Strait Islander Studies (AIATSIS) *Code of Ethics* (AIATSIS 2020). Future research must prioritise Aboriginal and Torres Strait Islander parent- and family-led approaches, ensuring their perspectives are central. Ideally, this should be led by Aboriginal and Torres Strait Islander researchers, with community control in line with best practice ethical research with Aboriginal and Torres Strait Islander peoples (AIATSIS 2020). Care must be taken with any future research in this field, since moving forward requires both acknowledging systemic harms and identifying immediate improvements, while also working towards structural transformation.

7 | Conclusion

Reducing the number of Aboriginal and Torres Strait Islander children in OOHC is a national priority. Comprehensive integrated and community-led perinatal care models may help to improve support for families and prevent child protection system involvement. However, there are significant issues with the way that child protection systems operate in Australia that pose challenges to developing effective prevention approaches in perinatal care. Part of the challenge is that Australian child protection systems have colonial origins, whereby risk-averse practices can present a major limitation to effective perinatal support and care, particularly for Aboriginal and Torres Strait Islander peoples. Transformative change requires genuine Aboriginal and Torres Strait Islander self-determination and integration of Indigenous ways of knowing, being and doing into practice.

Author Contributions

Neve Mucabel-Bue: formal analysis, investigation, visualisation, project administration, resources, writing – original draft, writing – review and editing. **Shakira Onwuka:** formal analysis, supervision, writing – original draft, writing – review and editing. **Paul Gray:** conceptualisation, investigation, writing – review and editing. **Kimberley A. Jones:** investigation, writing – review and editing. **Melissa O'Donnell:** writing – review and editing. **Helen Herrman:** writing – review and editing. **Renna Gayde:** investigation, writing – review and editing. **Skye Stewart:** investigation. **Kimberley A. Jones:** investigation, writing – review and editing. **Jane Fisher:** writing – review and editing. **Emma Stubbs:** investigation, writing – review and editing. **Cath Chamberlain:** conceptualisation, methodology, investigation, formal analysis, supervision, funding acquisition, project administration, resources, writing – original draft, writing – review and editing. **Jacynta Krakouer:** conceptualisation, investigation, formal analysis, supervision, project administration, resources, writing – original draft, writing – review and editing.

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Ethics Statement

The research was undertaken with the understanding and written consent of each participant and according to the above-mentioned principles. Ethics approval has been reviewed and granted from the St Vincent's Human Research Ethics Committee (HPNF project—St Vincent's HREC approval no. 239/22; RBT project—St Vincent's HREC 148/23).

Conflicts of Interest

Jacynta Krakouer is a co-editor of this journal. She was not involved in the peer-review process or editorial decision-making for this manuscript. No other co-authors have any competing interests to declare.

Data Availability Statement

Due to the sensitivity of the data collected and principles of Indigenous data sovereignty, the data are not available upon request.

Endnotes

[1] In this paper, allied systems refer to typically government-operated institutions (e.g., hospitals) where many workers are mandatory child protection reporters (e.g., doctors, nurses).

[2] This includes family support services, intensive family support services, protective intervention services, and care services (out-of-home-care and other supported placements).

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Appendix A

Parent Discussion Groups

- How acceptable *or appropriate* you feel this would be for Aboriginal and Torres Strait Islander parents experiencing trauma using the scale on your worksheet. We would also like to hear or read any other comments you have about the appropriateness of the wise counsel.
- Please also tell us about how useful you feel this would be for Aboriginal and Torres Strait Islander parents experiencing trauma? We are asking you to rank the usefulness as either not at all, a little bit, somewhat, a fair bit or very. Please don't forget how much we would like to have more feedback on your thoughts, so please use the comments section on your page or share your thoughts out loud with us.

Service Provider Discussion Groups

- How *feasible* do you feel it would be for service providers to *implement* and use the wise counsel model? We would also like to hear or read any other comments you have about the feasibility of the wise counsel.
- Please also tell us about how *useful* you feel it would be and please don't forget how much we would like to have more feedback on your thoughts. You can use the comments section on your page or share your thoughts out loud with us.

Workshop A

- What should the 'Wise Counsel' look like?
- Who should be on the Wise Counsel?
- Who should decide this?
- Do you have any suggestions, comments, or the process for developing or establishing the model (including who to speak to or challenges we should be aware of)?
- Are there any challenges or barriers to this being and useful for service providers?

Prompt Questions in Workshop B

The questions in this workshop were simply a guide/examples of what to ask. Facilitators were asked to lean into the flow of the group and their own facilitation techniques. Example prompt questions are below.

Day 1

Session 1: Principles session

- What stands out as essential?
- Are there any values you would add/remove from the list?

Session 2: Refining the core components

- Who are the key personnel who should be involved?
- Should there be set collaborators?
- Do we need a designated lead?
- How do we ensure that solutions are generated and owned by the family and/or community?

Session 3: Case study scenario

- How often is the Wise Counsel meeting?
- Who is facilitating the Wise Counsel? Is there a Wise Counsel worker/role?
- How does the Wise Counsel facilitate decision-making when it convenes?

Day 2

Session 4: Barriers and anticipated challenges. Review and add barriers from multiple perspectives (e.g., perspectives of parents, service providers, funders)

- Do you foresee any other challenges that were not identified? What's missing?

Session 5: Facilitators and enablers

- What has working in practice/in the field?
- What is working well for families and children in the community?

Session 6: Implementation questions

1. Are there key factors underpinning programme success?
2. What does and doesn't work when implementing a new model of care?
3. What are some of the things that are unspoken or ignored in design and delivery?
4. Where does implementation 'go wrong'?

Evaluation questions

1. What are the important outcomes we should evaluate?
2. Any suggestions about evaluating the model?
3. Any questions people are still unsure about that we should try to answer?