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Infant removals: The need to address the over-representation of Aboriginal infants and community concerns of another 'stolen generation'

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ABSTRACT

Objectives: The removal of a child from their parents is traumatising, particularly in Aboriginal communities where a history of child removals has led to intergenerational trauma. This study will determine where disparities in child protection involvement exist among Aboriginal and non-Aboriginal children and characteristics associated with infant removals. Challenges faced by child protection and other agencies, and opportunities for overcoming these, are discussed.

Methods: Data from both the Australian Institute of Health and Welfare and linked Western Australian government data was used to examine disparities between Aboriginal and non-Aboriginal children in the child protection and out-of-home care system.

Results: Nationally, Aboriginal children are ten times more likely to be placed in out-of-home care than non-Aboriginal children and this disparity starts in infancy. Infants were removed from parents with high levels of risk. Aboriginal infants were at increased risk of being removed from women with substance-use problems and had greater proportions removed from remote, disadvantaged communities than were non-Aboriginal infants.

Conclusions: Aboriginal infants have a high rate of removal. Although there are many complexities to be understood and challenges to overcome, there are also potential strategies. The disparity between Aboriginal and non-Aboriginal infant removals needs to be seen as a priority requiring urgent action to prevent further intergenerational trauma.

1. Introduction

The right of infants to be raised by their parents, except in the most exceptional circumstances, is recognised around the world. The 1989 United Nations Convention on the Rights of the Child states that family is fundamental for the growth and wellbeing of children, and that children should not be separated from their parents, except when authorities determine it is necessary for their best interests (United Nations, 1989). This issue is of particular relevance to the Aboriginal and Torres Islander people (hereafter respectfully referred to as Aboriginal) of Australia.

In March 2013, the former Prime Minister Julia Gillard apologised on behalf of the Australian Government to people affected by

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previous forced adoption or removal policies and practices. In point 18 she stated: *'We resolve, as a nation to do all in our power to make sure these practices are never repeated. In facing future challenges, we will remember the lessons of family separation. Our focus will be on protecting the fundamental rights of children and the importance of the child's rights to know and be cared for by his or her parents.'*(Gillard, 2013).

For many Aboriginal families the history of forced removals from their families continues to impact on their health and wellbeing, and on that of their communities. *Bringing them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Bringing them Home Report) details how the past policies of Aboriginal child welfare have impacted on Aboriginal communities (Human Rights & Equal Opportunity Commission, 1997). The history of white occupation and the forced removal of Aboriginal children has left a legacy of intergenerational trauma, contributing to high levels of substance use, parenting skills deficits, and mental health issues (Human Rights & Equal Opportunity Commission, 1997; Zubrick et al., 2005). Aboriginal academic Judy Atkinson (2002) has written of the trauma trails which carry 'fragmented, fractured people and their families', and are a 'record of the distress that occurred when relationships between people and their land, and between people and people, were wilfully destroyed' (Atkinson, 2002, p88).

This shameful history, for which the former Australian Prime Minster Kevin Rudd apologised in 2008, on behalf of the government, led him to state that: 'a new beginning, a new partnership, on closing the gap, with sufficient flexibility not to insist on a one-size-fits-all approach for each of the hundreds of remote and regional Indigenous communities across the country, but instead allowing flexible, tailored, local approaches to achieve commonly agreed national objectives'(Rudd, 2008). *The Closing the Gap* Strategy was developed in 2008 by the Australian government in consultation with Aboriginal groups, as a health-based blue-print to achieve greater equality in outcomes between Aboriginal and non-Aboriginal people. Although there has been some success, such as a recent decline in Aboriginal child mortality rates and an increasing proportion of Aboriginal young people completing Year 12, there are some areas which have seen little progress. One of the areas is safe, healthy communities which the government, in recent Closing the Gap reports, recognises as an ongoing priority area (2016, Department of the Prime Minister & Cabinet, 2015).

Aboriginal community members have expressed concern that Aboriginal children are still being removed in high numbers by the government, with some referring to this removal as 'another stolen generation' (Turner, 2017). Aboriginal children are ten times more likely to be in out-of-home care, compared to non-Aboriginal children. Australia's Aboriginal and Torres Strait Islander Social Justice Commissioner in 2015 stated that the over-representation of Aboriginal children and young people in the child protection system is one of the most pressing human rights challenges facing Australia today, and it is therefore 'incumbent on all of us to explore what more can be done and to actually do it'(Aboriginal & Torres Strait Islander Social Justice Commissioner, 2015).

Recent anecdotal reports from Aboriginal communities and an increased focus on earlier intervention (Australian Institute of Health & Welfare, 2017a), including reporting at-risk pregnant women to child protection services, suggests that an increasing number of Aboriginal newborns and infants (< 1 year of age) are entering out-of-home care. Few data are published which allows these trends to be examined and the child and family factors associated with these removals. This paper therefore attempts to examine the available data to determine the veracity of these reports and identify the risk factors for removal.

This aim of this paper is to:

1 outline the points in the child protection system in which there are disparities between Aboriginal and non-Aboriginal children;
2 examine the disparity in infant removal rates between Aboriginal and non-Aboriginal infants in Australia;
3 determine characteristics of Aboriginal infants and parents who have had an infant removed;
4 examine the challenges facing the child protection system and the potential opportunities to reduce the number of infants being removed.

2. Methods

To address these aims, two sources of data have been used: national and Western Australian, where an existing data linkage project allows for more detailed analysis of child protection and associated data.

1 National administrative data

This research utilises the national child protection data collated from the Australian Institute of Health and Welfare's (AIHW) Child Protection Australia Reports (AIHW 2014, 2015, 2016, 2017a) to determine the rates of Aboriginal and non-Aboriginal involvement in the child protection system. This includes receiving child protection services, notifications, substantiations of notifications and entries into out-of-home care over time. This data includes all Australian state/territory child protection data. Since 2012–13, the AIHW has reported in their Child Protection Australia reports, unit record data which allows for more detailed analyses. Additional data broken down by age group was requested and provided by AIHW. Rates were calculated using denominator data from the Australian Bureau of Statistics reported by AIHW in the Child Protection Australia reports (Australian Institute of Health & Welfare, 2016).

2 Western Australian linked datasets

The second data source is the linked Western Australian (WA) data from the Department of Communities - Child Protection and Family Support Division and the Department of Health. These data were utilised to investigate the characteristics of Aboriginal

parents and non-Aboriginal parents whose infants entered out-of-home care within their first year in this jurisdiction.The WA Data Linkage Branch linked the data using common identifiers such as name, address and birthdate (Holman, Bass, Rouse, & Hobbs, 1999). The identifiers were separated from health and child protection information to maximise privacy during the linkage process, with only de-identified information provided to researchers.

2.1. Study population

This retrospective population cohort included all children born in WA from 1990 to 2010 (n = 524,534). During this time, there were 2334 infants who entered out-of-home care (aged less than one year) and their parents.

2.2. Variables

Children's gender, parental age, and marital status (at time of child's birth) were identified from Midwives and Birth Registration, and these databases were also used to identify children who were Aboriginal (this is recorded through self-report and/or midwives' notifications). Neighbourhood level socioeconomic status was determined by the Index of Relative Social Disadvantage from the Australian Bureau of Statistics using the Birth and Midwives data as well as the Accessibility/Remoteness Index of Australia (2008, Australian Bureau of Statistics, 2001).

The mother's mental health and substance-related contacts were determined from two sources: (i) the Hospital Morbidity Data System which records all in-patient hospitalisations of parents from 1970 onwards; and (ii) the Mental Health Information System containing information on public and private mental health inpatient hospitalisations and public outpatient contacts from 1980 onwards. Data from both of these datasets were included in the study up until 2010. Maternal mental health contacts were included if they had any of the International Classification of Diseases (ICD) Version 10 Codes (F00-F99-Mental and behavioural disorders, X60-X84- Intentional self-harm) and substance related-codes (ICD-10: F10-F19) (World Health Organisation, 2016) and their equivalent ICD Version 9 codes.

The Western Australian Register for Developmental Anomalies and the Intellectual Disability Exploring Answers Database were both used to identify children with disabilities (i.e. birth defects, cerebral palsy and intellectual disability) (Bower et al., 2015; Petterson et al., 2005). The Department of Communities datasets provided child maltreatment information, including whether the child entered out-of-home care and the reason for entry.

2.3. Analysis

For both Aboriginal and non-Aboriginal infant removals descriptive statistics are utilised to indicate the characteristics of families. Logistic regression is utilised to determine the factors associated with an increased risk of infant removal. There are three models utilised: 1) a model which combines both the Aboriginal and Non-Aboriginal population (n = 524,534); 2) the Aboriginal population only (n = 31,612); and 3) the non-Aboriginal population only (n = 492,740). Models 2 and 3 were included to determine if there were any specific factors that varied by Aboriginality.

2.4. Ethics

Ethics approval for the use of linked data was granted by the University of WA's Human Research Ethics Committee, the Department of Health Human Research Ethics Committee, and the WA Aboriginal Health Ethics Committee.

3. Results

Data from the AIHW show an increasing involvement of Aboriginal children in the child protection system and evidence of the disproportionality between Aboriginal and non-Aboriginal children. These increases are evident in the receipt of child protection services, notifications to child protection, substantiated notifications, and infants admitted to out-of-home care.

3.1. Receipt of child protection services: National data

Across Australia, in both Aboriginal and non-Aboriginal families, there have been recent increases in the overall number of children receiving child protection services. Receiving child protection services was defined by the AIHW as children who, in the reporting period, were the subject of an investigation of a notification, and/or on a care and protection order, and/or in out-of-home care (Australian Institute of Health & Welfare, 2017a). In 2015-16, infants (aged under 1 year) were the most likely to be receiving child protection services, at a rate of 37.6 per 1000 children, with those aged 15–17 years the least likely (20.7 per 1000 children) (Australian Institute of Health & Welfare, 2017a).

When the receipt of child protection services is broken down by Aboriginality there is a large disparity, with Aboriginal children receiving services at a rate of 157.6 per 1000 children compared to non-Aboriginal children at a rate of 22.0 per 1000 (Australian Institute of Health & Welfare, 2017a). Aboriginal children were seven times more likely than non-Aboriginal children to be receiving child protection services during 2015–16.

In the under 1 year age group, there was a decrease in child protection system involvement between 2012–13 and 2013–14,

Table 1
Number of Aboriginal and non-Aboriginal children receiving Child Protection Services, Australia.

		2012–13	2013–14	2014–15	2015–16
Aboriginal	All age groups	36656	39716	42913	46632
	< 1 year	4252	2909	3074	3368
non-Aboriginal	All age groups	90957	94439	103052	111509
	< 1 year	8501	6334	6766	7458

however involvement has risen each year since then (the only years for which data are available) (see Table 1).

3.1.1. Substantiated notifications: national data

In the AIHW data (Australian Institute of Health & Welfare, 2016), notifications to child protection departments include allegations of child abuse or neglect, child maltreatment, or harm to a child. These notifications are substantiated when, following an investigation it is concluded that there was reasonable cause to believe that the child has been, was being, or was likely to be, abused, neglected or otherwise harmed.

The rate of substantiated notifications in Australia has increased for non-Aboriginal children, rising slightly from 4.6 per 1000 in 2009–10 to 6.4 per 1000 in 2015–16 (Australian Institute of Health & Welfare, 2017a) (see Fig. 1). For Aboriginal children, however, the rates of substantiations are almost seven times higher than for non-Aboriginal children and have also substantially increased from 35.3 per 1000 in 2009–10 to 43.6 per 1000 children in 2015–16 (Australian Institute of Health & Welfare, 2017a) (see Fig. 1).

In examining substantiated notifications for children less than 1 year of age, the trends vary over time but have shown increases in recent years (Fig. 1). There is a large disparity in the rate of substantiated notifications for children aged less than one year by Aboriginality with 80 per 1000 Aboriginal children having a substantiated notification in 2015-16 compared with 11 per 1000 for non-Aboriginal children. Aboriginal infants were substantiated at eight times the rate of non-Aboriginal children.

According to the AIHW (Australian Institute of Health & Welfare, 2016) data, the primary type of maltreatment which is most commonly substantiated varies by Aboriginality. Aboriginal children are most likely to have substantiated neglect (36%) and emotional abuse (39%) (Australian Institute of Health & Welfare, 2017a). Non-Aboriginal children have a higher proportion of other abuse types such as physical and sexual abuse, as well as emotional abuse which is the highest abuse type for all children. Emotional abuse covers acts that result in a child suffering significant emotional deprivation or trauma and also includes exposure to family violence (Australian Institute of Health & Welfare, 2017a).

3.1.2. Out-of-home care: national data

The greatest disparity between Aboriginal and non-Aboriginal children is in the rate of children in out-of-home care. While the rate for non-Aboriginal children has remained relatively stable (at 5.8 per 1000 children in 2016, with a slight increase since 2012 from 5.4 per 1000), the rate for Aboriginal children in care has remained high and increased by 21%, from 46.6 per 1000 in 2012 to 56.6 per 1000 Aboriginal children in 2016 (Australian Institute of Health & Welfare, 2017a). Therefore, the rate of Aboriginal children in out-of-home care is 10 times the rate of non-Aboriginal children.

Nationally, 66% of Aboriginal children were placed with relatives/kin, other Aboriginal caregivers or in Aboriginal residential care in 2014–15, in accordance with the Aboriginal Placement Principle (Australian Institute of Health & Welfare, 2017a). This Principle aims to enhance and preserve Aboriginal children's connection to family, community and culture by having placement priority in the following order: i) placement with family and kinship; ii) with non-related carers in the child's community; and iii) with carers in another Aboriginal community. However, the rates vary substantially by Australian jurisdiction, from 36% in the Northern Territory to 81% in New South Wales.

Since 2013–14, when the AIHW commenced collating the numbers of children in out-of-home care aged under 1 year, there has been a rise in the rate of non-Aboriginal infants in out-of home care from 2.6 in 2014 to 3.0 per 1000 children in 2016, and a rise for Aboriginal infants from 24.8 to 29.1 per 1000 children (Australian Institute of Health & Welfare, 2015, 2016, 2017a). Therefore the

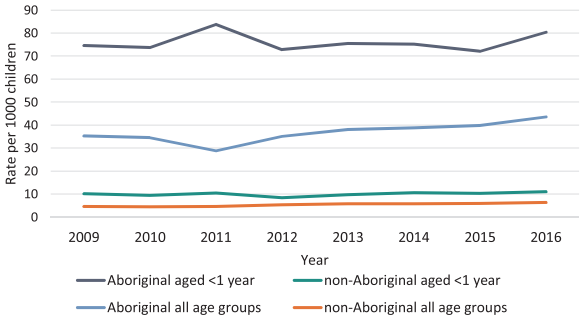

Fig. 1. Rate of substantiated notifications by Aboriginality: all ages and infants, Australia.
*ABS population estimates used to determine Aboriginal and non-Aboriginal population denominator for rates[1,2].

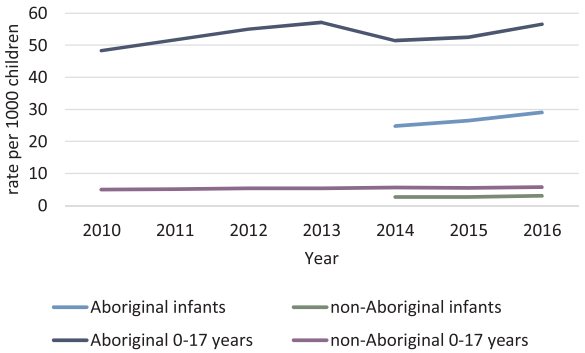

Fig. 2. Rate per 1000 children in out-of-home care by Aboriginality: all ages and infants, Australia.

disparity in Aboriginal infants in out-of-home care is almost ten times the rate of non-Aboriginal infants (see Fig. 2).

There is also evidence of increasing early removal with Fig. 3 showing a rise in the number of infants being removed in the first 7 and 31 days of life nationally (data requested and provided by theAIHW). No information is available on the proportion of Aboriginal and non-Aboriginal children for these data.

3.2. Infants in out-of-home care: characteristics of parents and infants using Western Australian linked data

There is limited information available regarding the characteristics of parents who have had an infant placed in out-of-home care, but this information is essential for determining those families most at-risk, and targeting prevention and early intervention services accordingly. The information provided in Table 2 is from WA linked data and identifies the characteristics of parents and infants in which an infant has entered care by Aboriginality for children born 1990 to 2010 (which is a different period of time compared to the National data).

As can be seen in Table 2, there are high levels of risk factors across both Aboriginal and non-Aboriginal families in which infants have entered out-of-home care in WA. This is consistent with data on the families of children of other ages who are notified to child protection (O'Donnell et al., 2010). These risk factors include a high proportion of: teenage mothers and to a lesser extent teenage fathers; mothers who have had a mental health-related contact; mothers who have had a substance-related contact; and children with disability. Amongst all these families there were high proportions living in the most disadvantaged communities, although it was higher for Aboriginal families. Aboriginal parents whose infant entered out-of-home care were more likely to be living in remote to highly remote areas compared to non-Aboriginal families, amongst whom the majority lived in urban areas. As can be seen for all infants who entered out-of-home care there is a high level of missing data for fathers as captured on the birth registration forms which is consistent with previous research (Sims & O'Donnell, 2015). Data on infants who commenced a period in care in WA between 1990–2010 indicates that while a large proportion of the mothers have only one infant entering out-of-home care during the period 1990–2010, there were at least 18% of mothers who had more than one infant entering care, slightly higher for mothers of Aboriginal infants at 23%.

A logistic regression analysis of factors involved in risk of infant removal was performed utilising three models as displayed in Table 3. Model 1 is the univariate results for all children which showed that Aboriginal infants had almost 9 times the risk of infant removal compared to non-Aboriginal children. However, the multivariate results indicate that this risk is attenuated to double the risk once other infant and parent factors are taken into account. The multivariate results indicate that the factor with the largest risk for infant removal is maternal substance-related contact (OR = 5.73), followed by maternal mental health contact (OR = 2.74), being born in the most disadvantaged community (OR = 2.44) and being single (2.32). The Model 2 multivariate results, which only

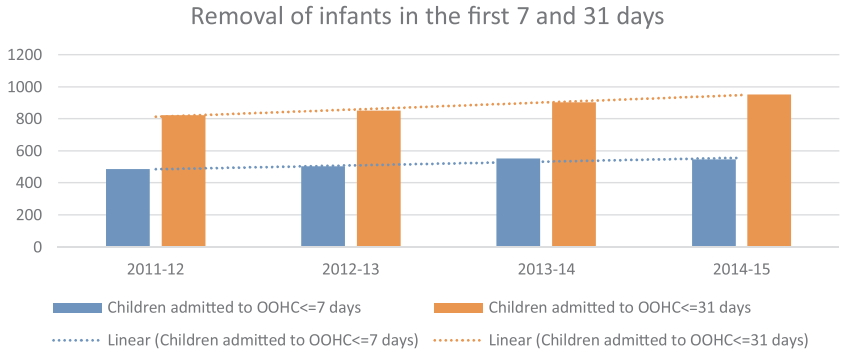

Fig. 3. Removal of infants in the first 7and 31 days (number), Australia.

Table 2
Aboriginal and non-Aboriginal parent and infant characteristics for infants entry into out-of-home care < 1 year of age, Western Australia data for children born 1990–2010.

Infant entry to care	Both Aboriginal and non-Aboriginal	Aboriginal	Non-Aboriginal
N	2334	831	1503
Parental Aboriginality*			
non-Aboriginal mother	1284 (55.0%)	0 (0%)	1284 (85.4%)
Aboriginal mother	704 (30.2%)	668 (80.4%)	36 (2.4%)*
Mother Aboriginality unknown	346 (14.8%)	163 (19.6%)	183 (12.2%)
non-Aboriginal father	940 (40.3%)	91 (11.0%)	849 (56.5%)
Aboriginal father	410 (17.6%)	339 (40.8%)	71 (4.7%)*
Father Aboriginality unknown	984 (42.2%)	401 (48.3%)	583 (38.8%)
Maternal age			
1 (< 19 years)	460 (19.7%)	140 (16.9%)	320 (21.3%)
2 (20–29 years)	1240 (53.1%)	460 (55.3%)	780 (51.9%)
3 (30–39 years)	595 (24.5%)	219 (26.3%)	376 (25.0%)
4 (40 + years)	39 (1.7%)	12 (1.4%)	27 (1.8%)
Mother Mental health contact			
0 – No	917 (39.3%)	408 (49.1%)	509 (33.9%)
1 – Yes **	1417 (60.7%)	423 (50.9%)	994 (66.1%)
Mother Substance-related contact			
0 – No	895 (38.3%)	158 (19.0%)	737 (49%)
1 – Yes	1439 (61.6%)	673 (81%)	766 (51%)
Marital Status			
1 (Single)	1129 (49.2%)	371 (45.7%)	758 (51.2%)
2 (Married/Defacto)	1164 (50.8%)	441 (54.3%)	723 (48.8%)
Father age			
1 (< 19 years)	140 (6.0%)	44 (5.3%)	96 (6.4%)
2 (20-29 years)	650 (27.8%)	195 (23.5%)	455 (30.3%)
3 (30-39 years)	456 (19.5%)	151 (18.2%)	305 (20.3%)
4 (40 + years)	174 (7.5%)	50 (6.0%)	124 (8.3%)
Missing	914 (39.2%)	391 (47.1%)	523 (34.8%)
Child Disability			
0 - No	1661 (71.2%)	585 (70.4%)	1076 (71.6%)
1 - Yes	673 (28.8%)	246 (29.6%)	427 (28.4%)
SEIFA			
1 (Most disadv)	1150 (49.8%)	524 (63.1%)	626 (41.7%)
2	523 (22.6%)	156 (18.8%)	367 (24.4%)
3	321 (13.9%)	73 (8.8%)	248 (16.5%)
4	203 (8.8%)	54 (6.5%)	149 (9.9%)
5 (Least disadv)	113 (4.9%)	13 (1.6%)	100 (6.7%)
Missing	24 (1.0%)	11 (1.3%)	13 (0.9%)
Remoteness			
1 (Urban)	1411 (60.5%)	337 (40.6%)	1074 (71.5%)
2	251 (10.8%)	48 (5.8%)	203 (13.5%)
3	189 (8.1%)	83 (10.0%)	106 (7.1%)
4	139 (6.0%)	100 (12.0%)	39 (2.6%)
5 (Highly remote)	196 (8.4%)	187 (22.5%)	9 (0.6%)
Missing	148 (6.3%)	76 (17.8%)	72 (4.8%)
Reason for entry			
Caregiver can't care adequately	814 (34.9%)	359 (43.2%)	455 (30.3%)
Caregiver in Custody	49 (2.1%)	26 (3.1%)	23 (1.5%)
Caregiver physical illness	47 (2.0%)	14 (1.7%)	33 (2.2%)
Caregiver psychiatric illness	123 (5.3%)	17 (2.0%)	106 (7.1%)
Homelessness	13 (0.6%)	7 (0.8%)	6 (0.4%)
No Guardian	11 (0.5%)	9 (1.1%)	2 (0.1%)
Other	85 (3.6%)	27 (3.2%)	58 (3.9%)
Prospective Adoption	236 (10.1%)	10 (1.2%)	226 (15%)
Result of Investigation	763 (32.7%)	265 (31.9%)	498 (33.1%)
Respite for Caregiver	93 (4.0%)	30 (3.6%)	63 (4.2%)
Unable to locate caregiver	52 (2.2%)	43 (5.2%)	9 (0.6%)
Missing	48 (2.1%)	24 (2.9%)	22 (1.5%)
Number of Infant removals from mother* **			
1	1527 (81.6%)	480 (76.9%)	1047 (83.9%)
2	256 (13.7%)	96 (15.4%)	160 (12.8%)
3	67 (3.6%)	37 (5.9%)	30 (2.4%)
4-6	22 (1.2%)	11 (1.8%)	11 (0.9%)

* Parental Aboriginality was determined from the Birth Registrations and Midwives Notification however the parent may decide to not identify their child as Aboriginal or this was not recorded by the Midwife.

** Mental health contact occurs on average 5 years prior to birth.

*** Does not include removals of children aged > 1 year or removals prior to 1990 or after 2010.

Table 3
Logistic regression of risk of infant entry into out-of-home care (univariate and multivariate estimates), Western Australia data for children born 1990–2010.

Infant entry to care	Model 1 : All children		Model 2: Aboriginal children	Model 3: Non-Aboriginal children
	Risk of infant entry into out-of-home care UNIVARIATE	Risk of infant entry into out-of-home care MULTIVARIATE	Risk of infant entry into out-of-home care MULTIVARIATE	Risk of infant entry into out-of-home care MULTIVARIATE
Number of births	524,534	524534	31,612	492,740
Aboriginality				
No	Reference	Reference	–	–
Yes	8.82 (8.10-9.16)*	1.86 (1.65-2.09)*	–	–
Maternal age				
1 (< 19 years)	4.97 (3.58-6.89)*	0.96 (0.67-1.38)	0.30 (0.15-0.59)*	1.68 (1.09-2.59)*
2 (20-29 years)	1.57 (1.14-2.16)*	1.00 (0.71-1.42)	0.48 (0.25-0.93)*	1.23 (0.81-1.86)
3 (30-39 years)	0.83 (0.60-1.15)	0.99 (0.70-1.39)	0.68 (0.36-1.32)	1.05 (0.70-1.58)
4 (40+ years)	Reference	Reference	Reference	Reference
Mother Mental health contact				
0 – No	Reference	Reference	Reference	Reference
1 – Yes **	7.89 (7.25-8.57)*	2.74 (2.48-3.02)*	1.38 (1.18-1.61)*	3.79 (3.34-4.30)*
Mother Substance-related contact				
0 – No	Reference	Reference	Reference	Reference
1 – Yes	19.53 (17.96-21.25)*	5.73 (5.16-6.37)*	7.01 (5.75-8.54)*	4.48 (3.97-5.06)*
Marital Status				
1 (Single)	9.01 (8.29-9.78)*	2.32 (2.09-2.57)*	1.44 (1.22-1.70)*	2.58 (2.26-2.95)*
2 (Married/Defacto)	Reference	Reference	Reference	Reference
Father age				
1 (< 19 years)	4.49 (3.59-5.62)*	1.31 (1.00-1.71)*	0.77 (0.48-1.24)	1.30 (0.94-1.79)
2 (20-29 years)	1.12 (0.95-1.33)	0.69 (0.57-0.84)*	0.51 (0.36-0.74)*	0.66 (0.52-0.83)*
3 (30-39 years)	0.53 (0.44-0.63)*	0.55 (0.46-0.67)*	0.71 (0.50-1.01)	0.51 (0.41-064)*
4 (40+ years)	Reference	Reference	Reference	Reference
Child Disability				
0 - No	Reference	Reference	Reference	Reference
1 – Yes	2.40 (2.19-2.62)*	1.49 (1.35-1.64)*	1.52 (1.29-1.79)*	1.42 (1.25-1.60)*
SEIFA				
1 (Most disadv)	7.43 (6.13-9.02)*	2.44 (1.96-3.03)*	0.78 (0.43-1.42)	2.56 (2.02-3.23)*
2	3.38 (2.75-4.14)*	1.99 (1.59-2.48)*	0.91 (0.49-1.68)	1.79 (1.41-2.28)*
3	2.49 (2.01-3.09)*	1.79 (1.42-2.26)*	0.97 (0.51-1.84)	1.68 (1.30-2.16)*
4	1.67 (1.33-2.10)*	1.37 (1.07-1.76)*	1.47 (0.75-2.86)	1.19 (0.90-1.56)
5 (Least disadv)	Reference	Reference	Reference	Reference
Remoteness				
1 (Urban)	0.38 (0.33-0.44)*	1.56 (1.31-1.86)*	1.33 (1.08-1.62)*	3.05 (1.57-5.90)*
2	0.42 (0.35-0.50)*	1.55 (1.25-1.91)*	0.99 (0.70-2.40)	3.17 (1.62-6.23)*
3	0.35 (0.29-0.43)*	0.93 (0.75-1.16)	0.85 (0.64-3.11)	1.78 (0.90-3.54)
4	0.48 (0.39-0.60)*	1.03 (0.82-1.30)	0.92 (0.71-4.19)	1.70 (0.82-3.53)
5 (Highly remote)	Reference	Reference	Reference	Reference

* Statistically significant as confidence interval does not include 1.

compare Aboriginal infants who entered out-of-home care compared to Aboriginal infants who did not, indicate that the highest risk factor is maternal substance use contact which has seven times the risk. The Model 3 multivariate results, comparing non-Aboriginal infants who have and haven't entered out-of-home care, indicate that maternal substance-related contacts (OR = 4.48), followed by maternal mental-health contact (OR = 3.79), and being born in urban and rural area compared to very remote areas (OR = 3.05 and OR = 3.17 respectively) increased the risk for infant removal.

Case Example – Provided by Department of Communities to illustrate an infant removal case and complexity of factors. (Details have been deidentified). Stacy* (32 yrs old) a Noongar** woman with 3 children, Dwayne (16 years), Jacinta (13 years) and Tyreece (12 mths). Dwayne and Jacinta's father was incarcerated due to violent crimes. Daniel (Tyreece's father) and Stacy are currently in a relationship, and the 3 children were removed from their care earlier this year and placed with extended family, due to ongoing domestic violence. Prior to removal the Department had received information from the police that Daniel was severely beating Stacy and held her at knife point while Tyreece was in her arms being fed. On another occasion Jacinta was punched in the head by Daniel when she stepped in to defend her mother, requiring hospitalisation but no long-term injuries. After the children were removed, Daniel was again physically violent with Stacy and this time was arrested by police and remains in detention. Workers have met with Stacy to discuss her children and her safety while living with Daniel, however Stacy said she wanted to remain with Daniel, as when she was without a partner unsafe men would be around making her and her children more unsafe; Daniel protects them from these men. Stacy advised the worker that she was pregnant with Daniel's baby.

Stacy has a Community Mental Health worker as she has been previously diagnosed with Schizoaffective Disorder and has had psychotic episodes. Her Mental Health workers advise that her relapses are usually precipitated by substance use or by psychosocial stressors however her psychosis can be controlled by medication. Prior to the birth, workers assessed that Stacy's home is not appropriate for a new baby as there is no gas connected, it is rat infested and needs significant repairs due to the damage caused by Daniel. Workers from the Department of Communities, King Edward Memorial Hospital, Community Mental Health, and the local Aboriginal Medical Service were involved in pre-birth planning with Stacy and her sister Mary who cares for Stacy's older children. It was difficult to progress towards safety planning in these meetings due to Stacy's deteriorating mental health. When the new baby was born Stacy's mental health continued to decline; due to this and ongoing concerns regarding domestic violence and neglect, the department decided the new baby was in need of protection and was removed from Stacy's care to live with Mary and his siblings.

*This is a case study that has been created by the Department for Communities to illustrate risks involved in infant removal cases.
**Noongar – Aboriginal people who live in the south-west of Western Australia.

4. Discussion

The data presented in this paper raise important issues in relation to the involvement of Aboriginal infants and their families in the child protection system in Australia.

4.1. Trends and disparities in removal rates between Aboriginal and non-Aboriginal infants in Australia

Previous research has identified an over-representation of Aboriginal infants in the child protection system in Australia (Zhou & Chilvers, 2010; Harrison, Harries, & Liddiard, 2015), but has been more limited in its examination of the points in which the disparities between Aboriginal and non-Aboriginal children occur. The national AIHW data provided in this paper show the high and increasingly disproportionate involvement of Aboriginal children and families in the child protection system in Australia. There are indications that this disproportionate involvement of Aboriginal children and families has increased over recent years, and more Aboriginal infants are entering out-of-home care than previously. The rate ratios indicate that Aboriginal infants are receiving substantiated notifications at seven times the rate of non-Aboriginal infants, and this increases to 10 times the rate for non-Aboriginal infants in out-of-home care. Recent AIHW data looking at admissions into care show that Aboriginal children < 1 year of age are 9 times more likely than non-Aboriginal children to be admitted into care which has reduced from 10 times, however Aboriginal children are slightly more likely to remain in care than to have been discharged (Australian Institute of Health & Welfare, 2017b).

4.2. Characteristics of infants and parents who have had an infant removed

In addition to identifying higher rates of removals amongst Aboriginal families, the risk factors associated with these higher removal rates have been identified using linked data available from WA. These data highlight the high levels of risk factors in both Aboriginal and non-Aboriginal families who have had an infant enter out-of-home care. However, there were particular characteristics with a higher proportion in the Aboriginal families, including living in the most disadvantaged communities, and in remote to highly remote areas of Australia. Nearly one quarter of the Aboriginal mothers (23%) had experienced more than one infant entering out-of-home care, higher than for the non-Aboriginal population (18%). In the multivariate analysis Aboriginality was associated with almost double the risk of infant removal. Maternal substance-related contacts were a particularly high risk for Aboriginal infant removals at seven times increased risk and was slightly lower for non-Aboriginal infants at four and half times the risk. This is the first time that the characteristics of Aboriginal families in which one or more infants have entered out-of-home care have been identified.

4.3. Challenges facing the child protection system

Previous Australian research investigating mothers who were prenatally reported to child protection (Taplin, 2017) has found that they are largely disadvantaged women who present with a number of risk factors. These risk factors represent enormous challenges to child protection agencies who are faced with complex decisions regarding whether to leave a child with parents where there is likely a high level of risk and concerns about the capacity of families to protect the child from future harm, or to remove the child and place them in out-of-home care. However, there are additional challenges for the child protection system when there is a lack of available placements for Aboriginal children and the need to ensure that the Aboriginal Child Placement Principle can be met.

This is clearly a broader issue than the child protection system alone. The public health approach adopted by the *National Framework for Protecting Australia's Children* (COAG, 2009) signifies that the removal of children cannot be divorced from addressing underlying structural inequalities, poverty, access to culturally appropriate services including maternal and child health services, and the need for targeted services to support families who are facing the challenges of mental health, substance use, and family violence. Having access to culturally secure universal and early intervention services is a necessity for vulnerable families who do not often access specialised services, and are wary of child protection-initiated referrals to agencies.

4.4. Strategies to reduce removals in Aboriginal communities

4.4.1. Impacts of inter-generational trauma

The 2008 National Apology to the Stolen Generations (Rudd, 2008), highlighted the impact of intergenerational trauma on

Aboriginal communities, families and children. Research has shown how past policies and practices of forced removals have impacted on the current circumstances of Aboriginal children, families and communities. The Western Australian Aboriginal Child Health Survey (Zubrick et al., 2005) has revealed that Aboriginal parents/carers who had been forcibly separated from their families were more likely as adults to live in households where there were problems caused by excessive drinking or gambling, were twice as likely to have been arrested or charged with an offence, half as likely to have someone with whom to discuss problems, and one and a half times more likely to have had contact with Mental Health Services. They also investigated the effect on children of Aboriginal carers who had been forcibly separated from their families. They found that these children were twice as likely to have clinically significant emotional or behavioural difficulties, more likely to be at high risk of clinically significant emotional symptoms, conduct problems and hyperactivity, and their use of alcohol and other drugs were twice as high compared to children whose Aboriginal carer had not been forcibly separated(Zubrick et al., 2005).

In recognition of the significant impact of the stolen generation, the *Healing Foundation* was established in 2010 to address the past injustices and trauma experienced by Aboriginal communities. However, Mick Gooda, the Aboriginal Social Justice Commissioner, has stated that despite the initiatives funded by the *Healing Foundation* there is no coherent national strategy to address inter-generational trauma (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2015). The need to ensure supported long-term investment in healing initiatives including services, research and evaluation has the potential to benefit a range of outcomes across health, education, mental health and justice involvement, as well as the prevention of child maltreatment.

4.4.2. Aboriginal community involvement in strategies and design of services

It is recognised that Aboriginal involvement in service development is essential to meet the needs of the local community and provide family support. Futhermore, although there are challenges in modifying the way government departments develop and fund services, there are current opportunities and existing strategies. One example is Aboriginal and Torres Strait Islander Child and Family Centres which provide an integrated early years' service delivered in a holistic, culturally rich way within communities (Brennan, 2013). In WA the Department of Communities is implementing an Earlier Intervention and Family Support Strategy which includes the co-design of services with Aboriginal community organisations, to be delivered by these organisations to ensure that they are culturally safe and meet community needs (Department for Child Protection & Family Support, 2016). Services will include Aboriginal in-home support services and a parent-baby service. The state of Victoria in Australia has also implemented an innovative approach by transferring powers for Aboriginal children on protection orders to the Victorian Aboriginal Child Care Agency who will be responsible for decision making and case planning for these children.

4.4.3. Place-based responses

As stated by former Prime Minister Kevin Rudd it is essential that local community-based approaches are implemented to achieve shared objectives. This has been reiterated by the Secretariat of National Aboriginal and Islander Child Care (SNAICC) that place-based responses will result in more effective and culturally appropriate services, and there is the potential to have collaborative approaches between mainstream and Aboriginal services in rural and remote communities to reduce duplication of services, resource efficiency and promotion of shared goals (Secretariat of National Aboriginal & Islander Child Care, 2013).

At a local level there are leading examples of Aboriginal communities who are creating strategies for the reduction of Aboriginal children in care. An example is the Kimberley Aboriginal Children in Care Committee (KACCC) which is a community in the north of WA. In 2015 the KACCC produced a report (Kimberley Aboriginal Children in Care Committee, 2015) which identified gaps in the WA child protection system and provided recommendations to reduce the number of Kimberley Aboriginal children entering out-of-home care and ensuring those who do so, maintain their connection with culture. Potential solutions included: (i) a regional Aboriginal body/organisation with whom the statutory child protection system could consult at all stages of a child's case; and (ii) establishing a trial site to implement empowerment and preventative measures to ensure vulnerable families have access to prevention and early intervention service. In metropolitan WA a Noongar Child Protection Council has been established to support ongoing consultation with the Noongar community and Department of Communities to address the over-representation of Noongar children in care.

4.4.4. Fear of engaging with child protection services

Nationally child protection agencies try to increase their recruitment of Aboriginal child protection workers and carers to ensure adequate representation and improve their cultural knowledge and practices. However there is a reluctance by Aboriginal community members to work with child protection agencies due to the history of child removals (Bromfield, Higgins, Higgins, & Richardson, 2007).

The history of past removals also leads to the avoidance of and mistrust of these same agencies. This will be an ongoing challenge for child protection agencies and the need to ensure adequate and ongoing community consultation regarding services, and for partnerships with Aboriginal support organisations in communities who have the trust of local Aboriginal families. Grandmothers have been identified as taking on the responsibility of caring for grandchildren when their parents are unable to do so, but often without the involvement of the child protection system. However, there are few safeguards for those involved in informal care arrangements in terms of resources, respite care, child care and financial support. In a report on Aboriginal grandparents, non-Government Organisations identified shame and fear of intervention as barriers to payments and services for some grandparents, and a reluctance to claim family payments (Brennan et al., 2013). Issues around support for grandparent carers were raised by the Australian Human Rights Commission in 2014 and the need to determine what supports can be offered to not overburden them (Australian Human Rights Commission, 2014).

4.4.5. Other potential contributors to Aboriginal over-representation

Tilbury and Thoburn (2009)) have discussed micro factors such as the discriminatory practices of some reporters to child protection services, institutional racism and system biases, plus differences in child-rearing practices that may contribute to disproportionality in Aboriginal family involvement with the child protection system. They also discuss the difficulty in disentangling the effects of poverty in cases, and the additional service needs required to address poverty and disadvantage. The *Aboriginal Families Study* also identified the gaps in service provision in regards to access to postpartum primary care for Aboriginal women and children (Yelland et al., 2016). They found that there was a high prevalence of maternal morbidity and a need for holistic primary health care that is 'respectful and responsive to social health issues experienced by Aboriginal families.'

4.5. Opportunities to reduce the number of Aboriginal infants being removed

The intergenerational trauma that has resulted from past removal practices creates an imperative to ensure that current child protection practices do not repeat past practices and cause additional trauma and distress, likened to another "stolen generation". Further removal of children within Aboriginal communities are traumatic and are likely to compound the grief with which many are already struggling. However child protection agencies and communities face the dilemma that children cannot be left in situations in which there is a threat to their safety. There is no simple solution to this complex issue. It requires adopting practices that support family empowerment and preventative measures, including ensuring healing and early intervention services are in place, to address the trauma, mental health and substance use issues that families and individuals are dealing with. It is also essential to have culturally appropriate reunification services to support families in reducing the amount of time children are in care by facilitating the successful reunification of children back to family. To prevent the removal of another generation of Aboriginal children a collaborative effort between government, non-government agencies and Aboriginal local communities needs to be implemented to tackle this issue. What is required are 'sustainable solutions … to deal with the broader health and social issues that underpin child abuse, and it is important that these articulate with the longer-term aspirations of Aboriginal and Torres Strait Islander communities' (Ring & Wenitong, 2007, p204).

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