Healing the Past by Nurturing the Future: Perinatal support for Aboriginal and Torres Strait Islander* parents who have experienced complex childhood trauma

Workshop 1 Report

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[*] There are many diverse populations in Australia. The term 'Aboriginal and Torres Strait Islander' is used throughout this report to be respectful and inclusive of all Aboriginal and Torres Strait Islander peoples. The only exceptions to this are where an entity have specified the use of 'Aboriginal' in their context. The term 'Indigenous' is used to refer to Indigenous people globally. For ease of reading, the term 'non-Aboriginal' is used to refer to people that are not from an Aboriginal and Torres Strait Islander background.

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'We know we cannot live in the past but the past lives in us.'

(Dr. Charles Nelson Perrurle Perkins AO, 1967)

'The trauma experienced by Indigenous people as a result of colonisation and subsequent policies, such as the forced removal of children, has had devastating consequences. The disruption of our culture and the negative impacts on the cultural identity of Aboriginal and Torres Strait Islander peoples has had lasting negative effects, passed from generation to generation. The cumulative effect of historical and intergenerational trauma severely reduces the capacity of Aboriginal and Torres Strait Islander peoples to fully and positively participate in their lives and communities, thereby leading to widespread disadvantage.'

(Aboriginal Healing Foundation, 2013, p.3)

'Overlapping circles of extended family lie at the heart of the lives of most Aboriginal Australians. Networks of family relationships determine day-to-day activities and shape the course of destinies. From an early age Aboriginal Australians learn who belongs to whom, where they come from and how they should behave across a wide universe of kin. These are highly valued and integral components of Aboriginal cultural knowledge. And yet, these same familial systems have been the site of repeated attacks by successive waves of Australian Governments, tearing at the very heart of Aboriginal family life'

(Haebich, 2000, p. 13).

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Executive Summary

The first workshop for the Healing the Past by Nurturing the Future (HPNF) project marked the start of formal collaboration with key stakeholders working in the areas of Aboriginal perinatal care, trauma and recovery. This collaborative process sits at the heart of the HPNF project, which aims to;

- **Assess the acceptability, validity, safety and feasibility of assessment** processes for Aboriginal and Torres Strait Islander parents during the perinatal period (pregnancy to 24 months postpartum) to help identify those who experience complex trauma symptoms of distress;
- **Co-design acceptable, safe and feasible support strategies** that could be offered during the perinatal period for Aboriginal and Torres Strait Islander parents who are experiencing complex trauma symptoms, with the goal of promoting healing for the parent and preventing transmission of intergenerational trauma to the child.

Four workshops are being held over the course of the HPNF project, funded by the Lowitja Institute (2017-2019) and National Health and Medical Research Council (NHMRC) (2018-2021). These four workshops are aligned with four 'intervention mapping' steps enabling reflection and planning as part of the 'Plan, Act, Observe and Reflect' cycles that are central to the Community Based Participatory Action Research approach used in the HPNF project. The second workshop will be held on September 11 2018, the third in late 2019, and the fourth and final workshop in mid-2021.

The first workshop brought together key stakeholders from across Australia, that were all currently working with Aboriginal and Torres Strait Islander parents with complex trauma backgrounds over the perinatal period. Collectively, those in the room reflected years of research knowledge, and therapeutic, clinical and community practice from a wide range of fields related to perinatal, family and primary heath care (e.g., midwifery, nursing, social work, psychology, Aboriginal and Torres Strait Islander health)

There were three main goals of the first workshop:

1. To share evidence regarding complex trauma and parenting,
2. To develop cultural and emotional safety protocols for the HPNF project.
3. To document strategies currently being used across hospitals, health services and other organisations to identify and support Aboriginal and Torres Strait Islander parents with complex trauma.

Working from a strengths-based approach is essential. This was demonstrated in the structure of the workshop, where the focus was on creating opportunities for the sharing of knowledge and experience, as we begin this co-design process; and also in the way that we need to work with families and communities to co-design screening tool and support strategies. This report loosely follows the agenda for the first workshop.

Dr Chamberlain outlined the increasing understanding of the importance of childhood trauma, the unique risks and opportunities in the perinatal period, and the urgent need for strategies to identify Aboriginal and Torres Strait Islander parents who have experienced complex childhood

trauma. Workshop participants reflected that the most important aspects of the project included:

- Being involved with an Indigenous-led community based participatory action research project
- 'Making a difference', hope and opportunities for healing
- Creating clear evidence-based tools and resources
- Embedding culture in strategies and incorporating Aboriginal and Torres Strait Islander knowledge
- Better outcomes for kids

Participants raised concerns about some of the risks of screening, including applying negative diagnostic labels to parents and triggering punitive responses from the child protection system. The need to 'care for the carers' (ie staff), provide 'holistic' care for individuals and consider different needs of different age groups (e.g. teenagers and grandparents) were also emphasized.

Dr Yvonne Clark presented a session on working together in a cultural and emotionally safe manner. Fostering cultural safety and security within systems and projects, requires the creation of resilient environments by those within and engaged with Aboriginal and Torres Strait Islander communities. Assisted by Karen Glover, cultural safety and lateral violence within the Aboriginal and Torres Strait Islander communities was explored through a presentation and role play. The role play asked participants to take on the role of of children, mothers and women, fathers and men, grandparents and Elders and to stand in concentric circles. and to stand in concentric circles. The various stages of Australia's very recent history were then enacted, and participants asked to remove themselves, or move as the impact of past policies and practices were explored. The evaluation comments noted that the role play was sensitively executed and powerful. This was followed by small group work to brainstorm ways to work together safely in various contexts. This generated six main themes that were important to participants to ensure cultural and emotional safety for the HPNF project;

- **Appropriate and open communication**: to intently and deeply listen in various contexts; taking into account other people's views, how they want to participate in the project; and use various modes of communication to ensure visibility and transparency.
- **Reciprocity, collaboration and unity:** to give back to the community and ensure that reciprocal (two-way) relationships and respect occurs between all people involved in the project. When people reciprocate and share information, knowledge and respect, there is greater collegiality and collaboration which in turn can unite and strengthen a group.

- **Flexibility and open to change:** asking others how they want to be involved and participate in the project even if that means that we need to challenge ourselves and our current way of working to ensure we can be flexible in various contexts.
- **Participating, learning and recognising community expertise and needs:** learning from local Aboriginal and Torres Strait Islander communities and recognising their expertise, including; Aboriginal and Torres Strait Islander project staff, researchers, Elders, mothers, fathers, family, staff within Organisations and services, and other people aligned with the project.
- **Participants want to be heard and be valued:** Participants want to be heard and valued in the project, particularly if they are making a commitment toward valuable outcomes.
- **Guidelines, leadership and commitment to achieve goals and outcomes:** providing guidance and leadership in ensuring that timelines are adhered to, there is follow through, that there is a 'checking in' (with participant) processes, that strategies and protocols are in place, confidentiality is maintained and there is transparency.

Dr Graham Gee presented the rationale for co-designing assessment processes and strategies for healing complex trauma with Aboriginal and Torres Strait Islander parents. This was followed by group work to establish the current landscape, and what tools, programs and approaches are currently being used during the perinatal period in response to complex trauma. There was a lot of discussion regarding preferences for a screening tool, assessment strategies and support strategies. Participants felt that trauma informed care practices need to be universally applied. Further, that strategies need to prevent escalation with child protection. Lastly, that it was essential to build on existing work and knowledge within Aboriginal and Torres Strait Islander communities.

The evaluation feedback was positive, and participants found the workshop safe, enjoyable and relevant. The workshop provided an Aboriginal and Torres Strait Islander space within which to learn about and contextualise the HPNF project in relation to trauma and trauma care. Nearly all participants agreed or strongly agreed that the aims of the workshop had been met, that a strong foundation for working together had been achieved and that they had been able to contribute to the co-design aspects of the project.

Acknowledgements

We would first like to thank Kaurna Elder, Uncle Frank Wanganeen for welcoming us to Kaurna country, and for taking the time to spend the rest of the day with us. We thank all participants and the organisations they work with for taking the time to attend and contribute to the first workshop for the Healing the Past by Nurturing the Future (HPNF) project. Funding for this workshop was provided by the Lowitja Institute CRC as part of the funding received to conduct foundational work for the HPNF project (1st December 2017 – 31st March 2019). Further funding for subsequent stages of the HPNF project is provided by an NHMRC research grant (1st January 2018 – 31st December 2021).

We also thank the South Australian Health and Medical Research Institute (SAHMRI) for hosting the workshop and the Wardliparingga Aboriginal Research Unit (https://www.sahmriresearch.org/our-research/themes/aboriginal-health/theme-overview), who welcomed and met with HPNF investigators the day before the first workshop.

Photo: HPNF Investigators meet with Wardliparingga Aboriginal Research Unit

Participants

More than 40 people attended the workshop, from 20 organisations in Victoria, South Australia and the Northern Territory.

Partners

This collaborative research is led by investigators from 12 institutions, including La Trobe University, the Victorian Aboriginal Health Service, Murdoch Children's Research Institute, University of Melbourne, We-Ali Pty Ltd, Orygen-The National Centre of Excellence in Youth Mental Health, South Australian Health and Medical Research Institute, University of Adelaide, Flinders University, James Cook University and Monash University.

Collaborators

Peak bodies in South Australia (Aboriginal health council of South Australia) and the Northern Territory (Aboriginal Medical Service Alliance Northern Territory) have provided letters of support for funding this project. We are currently working to establish collaborative agreements with Community Controlled health organisations within each Jurisdiction and have received in principle support from the Central Australian Aboriginal Congress (Congress) (NT).

Creating our Safe Space

Dr Graham Gee facilitated the workshop. Graham, a Chief Investigator on the HPNF project, works as a Psychologist and Clinical Coordinator of the Mental Health Service at the Victorian Aboriginal Health Service (VAHS) in Melbourne.

Much attention was given to foster a culturally and emotionally safe space during the workshop. This included ensuring that there was an accessible, spacious and technologically sound room to conduct the workshop.

Photo: Welcome by Kaurna Elder, Uncle Frank Wanganeen

Welcome to Country

Kaurna Elder, Uncle Frank Wanganeen, warmly welcomed workshop participants to country and joined the workshop to actively contribute throughout the day.

Access to psychological support

Participants were provided with a *Thank You* card that listed relevant psychological support services that could be accessed in person, online or over the phone if the workshop triggered emotional responses during the day, or afterwards. Two registered psychologists, endorsed by the local Aboriginal Community Controlled Health Organisations were available to provide support during the workshop, Dr Rachel Reilly and Fiona Fallo. Other resources were placed on the tables for participants to peruse and take away for follow up if need be.

Creative activities

Small smooth rocks, paint pens, Aboriginal and Torres Strait Islander-themed 'mindfulness' coloring-in sheets and pencils were available on tables to offer diversionary therapeutic activities for participants during workshop discussions. Participants were invited to use these resources throughout the day, during discussion or breaks. With the rocks, participants were invited to draw inspirational or meaningful symbols on them throughout the day, and to share their inspirations at the end of the day.

Introductions and 'getting to know you' session

Participant introductions began in a circle where everyone had the opportunity to share their name and where they were from. Following this the chairs were arranged into triangles (3 chairs

in each) where several '*Talking Up Our Strengths*' cards were placed (SNAICC Resource Service and St Luke's Innovative Resources, http://www.snaicc.org.au/product/talking-up-our-strengths). These cards present themed photomontages that celebrate the strength and resilience of Aboriginal and Torres Strait Islander cultures, both urban and remote, past and present and are useful for promoting discussion, building self-esteem and connecting people in groups. Using a 'speed dating' format, participants were invited to randomly move to one of the triangles, sit down and select a card that resonated with them. Then, each person took it in turning sharing what inspires them through the strength cards.

After five to eight minutes of sharing and discussion, Graham asked people to change groups, and find a new triangle to sit and share with. Working from a strengths based position, this was a great way for many of the participants from different backgrounds and professional fields to get to know each other and share something significant about themselves




Photo: Morning activities

Sharing Research Knowledge

Dr Catherine Chamberlain, Senior Research Fellow, NHMRC Early Career Fellow, Judith Lumley Centre, La Trobe University

The first presentation for the day, *Sharing Research Knowledge: What the project is about*, was made by Dr Catherine Chamberlain, descendant of Trawlwoolway people (Tasmania) and a Chief Investigator on the HPNF project. In this presentation Cath's purpose was to present the evidence considered thus far in the project, including from a scoping review conducted by the project team. A copy of the slides can be downloaded from the HPNF website.

Photo: Dr Catherine Chamberlain

Scoping Review findings

We drafted a scoping review to map existing perinatal-specific evidence related to parents who had experienced any form of child maltreatment in their own childhoods. In this systematic review we looked for: theories to explain the effects of childhood trauma, intergenerational pathway mediators, experiences and views of parents, interventions and screening tools. We included 55 studies and extracted data from 74 articles. These were mostly in the US, involving mothers and there was one epidemiological study with a Native American community.

Theories

The most commonly reported theories to explain childhood trauma effects in the perinatal period included; attachment theory, 'ghosts/angels in the nursery', 'hidden trauma', and social learning theory. Belsky's socio-ecological model, relational developmental systems theory, and family systems theory were used to help explain interactions and why people have different reactions and resilience to maltreatment experiences (i.e. risk and protective factors). Resilience and post-traumatic growth constructs were used in two healing models, including a *Child Sexual Assault healing model* and *Construct of Anger* in healing model. While none of these studies with a specific perinatal focus involved Indigenous people, broader theories related to Aboriginal and Torres Strait Islander experiences of resilience, and healing and recovery from trauma were acknowledged (e.g. Atkinson, 2002; Milroy, 2008; Gee, 2016).

Intergenerational pathways

There were clear positive and negative intergenerational pathways between parental experiences of child maltreatment and a range of poor outcomes for the parent and/or child. Steps on the negative pathways (risk factors) from parental experiences of maltreatment included; a lack of parenting knowledge, poor mental health (including abnormal cortisol/stress hormone responses to babies crying etc) and substance use, poor sleep (a very common symptom of trauma and particular problem for new parents with trauma experiences) leading to poor parenting practices, poor attachment, infant maltreatment, poor infant development and health outcomes. These were mirrored by positive trajectories that included protective factors such as financial solvency and access to resources, social and family support, warm relationships, counselling and parenting

interventions, self-care activities, resilience, 'meaning making' and 'reorganising attachment', associated with less rigidity in parenting styles, more positive parent-child interactions and attachment, parental perceptions of healing and satisfaction and lower rates of child maltreatment and better infant outcomes. Only one study was conducted among Indigenous people, in the US, showing drug and alcohol use were strongly associated with poor child health outcomes.

Experiences and views of parents

Parents described experiences of post-traumatic growth and hope for healing, challenges with disclosure and stigma, a negative sense of self-worth, lack of trust impacting on ability to form relationships, and concerns about lack of control. Perinatal care could sometimes be re-traumatising, with intimate procedures not necessarily problematic in themselves, but how they were conducted was important. The many barriers to accessing mental health support were also noted. Strategies parents used to heal include; understanding and 'meaning making', conscious strategies to keep children safe and 'parent differently', increasing social support, spirituality and helping others. There were mixed reports about the value of therapy, with a number of barriers highlighted and a desire for more alternative therapies.

Support strategies

The scoping review found the following support strategies specifically for parents who are experiencing the effects of trauma or that are including a trauma informed focus within a broader program; nurse home-visiting, the 'Head Start' parenting program, brief infant-parent therapy and cognitive behaviour therapy. All suggested positive effects on parent wellbeing, but limited effects on other outcomes. Again, there were no evaluations of support strategies found that included Indigenous parents.

Experts such as Bessel Van de Kolk suggest we need to develop mental health programs that also focus on people feeling good about themselves, having fun, and being present and connected. Currently there is some debate about the role of 'talking therapies' such as trauma focussed cognitive behavioural therapy (TF-CBT) and ACT / mindfulness therapies for responding to trauma. Because trauma affected people commonly have difficulties with sleeping, diet and breathing / increased heart rate, there is the need for interventions to also to pay attention to basics of diet and exercise. Art therapy and drama are also gaining prominence as modalities that are helpful for healing trauma.

Assessment tools

The scoping review found 22 tools worldwide that have been used to identify parents with experiences of child maltreatment and/or trauma symptoms. However, this didn't include tools that have been developed or adapted for Indigenous peoples more generally (i.e., not parent focused), such as the Aboriginal Australian Version of the Harvard Trauma Questionnaire developed by Dr Carlie Atkinson.

Recent Australian perinatal mental health guidelines have recommended that perinatal care providers undertake psychosocial assessment (Austin M-P, Highet N, & and the Expert Working Group, 2017), and suggest that the most appropriate current tool available to use is the Antenatal

Risk Questionnaire (ANRQ) which generates a total psychosocial risk score (cumulative risk) as well as identifying specific risk factors that independently put the woman at greater psychosocial risk (e.g. past history of trauma or significant mental health condition). However there has been limited discussion about this generally, and whether this is appropriate for Aboriginal and Torres Strait Islander parents. There is also limited advice in the guidelines about what support to offer parents, which is a recommended pre-requisite to routine screening (Australian Health Ministers' Advisory Council, 2008).

What is this project about?

A positive thing emerging from the research is that the transition to parenthood offers a unique life-course opportunity for healing and emotional growth for the parent, even after severe trauma. Leonie Segal and colleagues argue that a positive strengths-based focus during this often optimistic period has the potential to disrupt the 'vicious cycle' of intergenerational trauma (with defense system triggering) into a 'virtuous cycle' that contains positively reinforcing elements through building loving relationships that promote healing through a process sometimes referred to as 'earned security' – where positive attachment relationships can be relearnt and fear responses managed (Segal & Dalziel, 2011).

There are few other healing opportunities for relational trauma as strong as the transition to parenting during a person's life course. A longitudinal study of youth after detention in the US (who experience high rates of complex trauma) found that parenthood was one of the few 'turning points' altering negative life-course trajectories for women (Teplin, Welty, Abram, Dulcan, & Washburn, 2012). So the perinatal period can offer rare opportunities for emotional healing – but it is also a period of high risk of triggering which can lead to a crisis. Overall, we think it's important that perinatal care providers develop awareness of this as an issue and we want to consider how we can maximise the opportunities to support families during this time.

As well as being one of the few opportunities in the life-course, for most healthy young people this is the first time since childhood that they have frequent scheduled contacts with service providers before and shortly after birth. This also offers a unique opportunity to ensure that health care contacts are safe and not re-traumatising, and to be able to identify people at risk and enable access to professional support if needed.

Shawana Andrews has put together the beautiful image and story to capture our approach over the next four years to co-design screening and support strategies with communities in Vic, SA and NT.

Cultures Child, Ink on paper, 2018 © Shawana Andrews
A father, mother and child wearing possum skin cloaks sitting by a myrnong daisy, the father holds the stem and looks to the daisy as it holds history and knowledge of the ancestors, this gives him strength. The mother holds a newborn and rests against the stem, it supports her. Mother and father are on different sides of the stem representing their different paths and roles in caring and nurturing for children. The daisy is in flower but also has a new bud and speaks of future generations and continuity. The stones below represent a strong foundation of many generations and the stitching on the cloaks represent the relational connectedness of Aboriginal people and worldview. The mother's hair blows in the wind, representing change.

Figure 3. Cultures Child

Summary

We are now starting to understand that '*complex relational trauma*' is a huge public health problem worldwide and a major risk factor with long term consequences for physical, social and emotional wellbeing. Indigenous communities are particularly affected due to the legacy of colonization, with its marginalisation, disruption of families and culture, and poverty. There are particular risks for during the transition to parenting as the parent enters an attachment relationship with their own child, and due to the intrusive nature of perinatal care. However – the parenting transition offers a unique life-course opportunity for healing and prevention of intergenerational transmission during frequent healthcare visits and to improve health equity for this and future generations…and we believe the wisdom of our Elders and within our communities can make really important contributions to the worldwide understandings of relational trauma and how to heal.

Photo: Tanja Hirvonen, Dr Graham Gee, Dr Yvonne Clark, Uncle Frank Wanganeen, Dr Catherine Chamberlain

Learning from the Sharing Research Knowledge

As part of the 'Why are we here' discussion that followed the presentation by Dr Catherine Chamberlain, participants at the workshop broke into small groups and were asked to discuss motivations and aspirations related to taking part.

Why are you here? What's brought you to this project?

The collaborative nature of the HPNF project, and the opportunity to contribute to an Aboriginal and Torres Strait Islander-led and designed project on this topic was a motivating factor for many. For some, it was also a much anticipated call to arms, which also reflects the frustration felt by people at the workshop with current practice, and lack of tools, training or funded programs to assist them in their work with Aboriginal and Torres Strait Islander parents struggling during the perinatal period due to complex trauma backgrounds. It was also the potential to work from a position of proactive prevention to address intergenerational trauma and keep children with their mothers, fathers and families.

Collaborative approach • *Opportunity to learn from expertise in the room. How to make a research difference'*; • *'Learning – collective wisdom'*; • *'Work out how to translate knowledge at service level.'*; • *'Connect up work across projects (e.g. nutrition project – HIP)'*	**Time for action** • *People have been talking for decades - We need to change [what's happening on] the ground not 4 years of talk'* **Proactive approach** • *Protect the children – be pro-active not re-active'*; • *'Take preventative actions before crisis occurs.'*

Table 1. Participant feedback to Why are you here? What's brought you to this project?

What are the most important things for you about this project?

There were several aspects of the HNPF project that appeared to draw participants to the first workshop, and were considered essential for conducting research in this area with implications for clinical practice. Firstly, the design of the research, as an Aboriginal and Torres Strait Islander led project using the community based participatory action research model was attractive. There was also a desire for there to be hope for change, with research that will make a difference. Service providers and academics discussed 'walking together' or 'walking alongside' community to stop the cycle of transgenerational trauma and begin a cycle of intergenerational healing.

Having access to a clear, evidence based tool and model of support for service providers to use in their work with Aboriginal and Torres Strait Islander parents with complex trauma backgrounds was considered important. In addition to this, the contribution the research would make to the evidence base was considered important as this provides the opportunity to use the findings to demonstrate areas of need and advocate for increased investment in this specific area, and access to training for service providers. Further developing midwives understanding of mental health issues and cultural competence was also actively discussed as important area for growth through the HPNF project, and is considered further, later in this report (see p.19).

Aboriginal and Torres Strait Islander Led • '*Indigenous research by & for indigenous people*'; • '*Connection to community*'; • '*Aboriginal and Torres Strait Islander led*'; • '*Good support from NHMRC – for co-designed & indigenous led CBPAR project*'.	**Walking together to heal** • '*This is research making a difference – implementation. For people we are walking alongside. Ourselves and our systems*'; • '*Hope – Recognition of trauma, opportunity for healing and walking with community*'; • '*…stopping the cycle of transgenerational trauma.*'; • '*Begin intergenerational healing cycle.*'; • '*Once identified (already good at this / resources not there for first line responses), what is the appropriate response (from services) to complex trauma. (What works for the community?)*'
Evidence based tools to use • '*To have a clear evidence based tool model to work with – Toolbox*' • '*Evidence based screening tool – Safety*'; • '*Tools for parents and organisations.*'	
Evidence base for advocacy • '*Advocacy for services - Better education; Better investment (evidence of need)*'; • *'This research will provide the evidence to advocate for change and interim practices and the chance for healing.'*	

Table 2. Participant feedback 'What are the most important things for you about this project?'

What do you want to get from being involved?

People were drawn to the first workshop, and to being involved in the HPNF project for reasons that were similar to those that they identified as been important about the project (as above), but in a more personal way and relating more directly to their clinical practise and their hopes for change. Some noted that they wanted to have a screening tool for complex trauma that was safe to use, to identify complex trauma with Aboriginal and Torres Strait Islander parents, and for this tool to be used broadly across organisations. The knowledge that the tool was been developed by Aboriginal and Torres Strait Islander people with Aboriginal and Torres Strait Islander people garnered confidence that there would be *'Better practical tools to work with community and family.'*.

Creating better perinatal services and outcomes for children and families • '*System change.*' • '*…develop culturally safe maternity services and healing for families around this.*' • '*Better outcomes for kids.*'	**Valuing Aboriginal and Torres Strait Islander Knowledge** • '*Breaking institutional racism, culture embedded in any change. Aboriginal knowledge held alongside western knowledge.*'; • *Cultural Competence – specific understanding Aboriginal context of trauma and trans generational trauma.*'

Table 3. Participant feedback 'What do you want to get from been involved?'

The valuing of Aboriginal and Torres Strait Islander knowledge and building this into the service system and clinician practice was also something participant's wanted to take part in. The potential to be part of '*System change.*' in the area of perinatal care for Aboriginal and Torres Strait Islander parents with complex trauma backgrounds and to '*…develop culturally safe*

maternity services and healing for families around this.' was with the desire to achieve '*Better outcomes for kids.'* and Aboriginal and Torres Strait Islander families in the longer term.

Other Major Themes Emerging During Discussions

Intersection of Perinatal Complex Trauma and Child Protection

The intersection between perinatal complex trauma and child protection became clear during the first session of Workshop 1. Concerns were raised regarding the potential for a complex trauma screening tool to have the unintended consequence of contributing to the removal of newborns from their parents care. It was noted that the Antenatal Risk Questionnaire (ANRQ; Austin et al., 2013) was currently routinely used by midwives at the first antenatal appointment to generate an antenatal psychosocial risk profile. If risk is identified, then the new mother is referred on to other services. For workshop participants the identification of complex trauma in the mother's history was viewed as the point at which child protection services may become involved. The extreme difficulty service providers have experienced, in working with new parents and seeing their progression through the child protection system, was acknowledged, and clinical experience had indicated that it was rare for a newborn to be returned to the care of their mother once removed.

Workshop participants expressed concern with the brevity of the ANRQ measure, and that the nature in which highly sensitive and potentially distressing information is gained seems quite abrupt. The skill of the midwife to use this tool well may vary by the individual, and needs to be supported by cultural awareness, mental health and trauma informed care training.

Child protection concerns	**Cultural competency training**
• '*Lots of Child Protection Inquiries have to be done – focus in CP system, lesson on interface CP- mental health/ MH=the other side of the story → Abuse.*'; • '*Child protection = trauma informed = risk reactive = fight/flight/freeze system. Not reflective, not long term. Child Prot. Does not let other parts of the 'brain' take* over.'; • '*How you teach the 'brain science' lessons to change how a whole system, reacts. Currently perpetuate trauma*' • '*40% babies removed from hospital were Aboriginal, and there are difficulties in getting them returned.*'; • '*Building trust with women, other CP services. Jumping in on these and … undermining relationships.*'	• '*Use ANRQ midwives – CSA, relationships with men, Issues with this process/inappropriateness.*'; • '*Need to have the right person asking these questions because they may seem simple, but will trigger.*' • '*Good timing – national midwifery stats now reflect better cultural training. Current lack of knowledge back to M/W training*'; • '*Lack of MH training/understanding in Mat/MW services.*'

Table 4. Theme: perinatal complex trauma and child protection

It was noted that some midwives (either Aboriginal and Torres Strait Islander or non-Aboriginal) are able to do this very well, having established sound relationships with the Aboriginal and Torres Strait Islander parents that permit disclosure. It was also noted that there is a clear need

for appropriate cultural, mental health, or trauma informed care training required to be able to provide safety for new parents answering these questions.

Trauma and culturally informed service systems

As noted above, the need for service systems to provide clinical care that is both culturally informed, trauma and healing informed was a strong message. Concerns were raised for frontline staff working in clinical (i.e. midwives, Aboriginal health workers, case workers) and non-clinical roles (i.e. reception, administration, management) and their exposure to the trauma of others, and the ongoing impact of this trauma.

Trauma and culture informed care • '*Cultural and clinical are just as important as each other and need to be equally recognised.*'; • '*Who holds the staff who are holding the community!!*'; • '*Build resilience & recognition in workforce.*'; '*Protection/safety front staff – are community and supports / hear the conversations. Agencies need guidelines on how to get trauma support.*'; • '*Frontline workers may not have access to training or support and their own trauma might be triggered too.*'; • '*A screening tool is a great start and to also have trauma informed care (TIC) support to wrap up around workers and support and intervention for parents.*'.	**Trauma and culture informed care** • *'How you teach the 'brain science' lessons to change how a whole system, reacts. Currently perpetuate trauma [in relation to child protection and perinatal].'* • *'Take preventative actions before crisis occurs.';* • *'Protect the children – be pro-active not re-active.'*
Funding models for trauma informed care • '*For frontline in trauma informed / culturally competent ways, but not funded / models of service delivery aren't set up in this way.*'; • *Ted talk. How specific, this is what we need in every capital.*'; • '*Centralised space, family space, allied health will use this for families*'.	**Gender and geography** • '*Unpack trauma – in a culturally appropriate ways & separate groups/activities for both men and women.';* • *'Safe space for men too.'; 'Culturally appropriate responses for men (and women) e.g. domestic/family violence discussions – for both men and women.*'; • *'Take account of cultural differences approaches in both remote and urban and rural cultural differences and therefore approaches in this project.'*
Research translation • *'Screening tool for – the next step → what is the service response. → engage knowledge translation and exchange.'*; • *'Work out how to translate knowledge at service level.'* • *'Connect up work across projects'*	**Grandparents and young parents** • '*Grandparent role, parents choosing this to bring in grandparent, need to acknowledge grandparents trauma at this time*' • '*What is the capacity for father/mother to be a mother/father under 18?';* • *'Teenagers – involve them – voices- Feel safe and connected – perspectives.'* • *'Who is questioning and responding to underage – what is happening? – Underage girls having babies – extended families taking care of babies.'*

Table 5. Theme: trauma and culturally informed service systems

An analogy was drawn between current service systems and neurobiological understandings of the impact of trauma on children, and the point made on how to change reactive systems. The disjunction between funding models and the provision of trauma and culturally informed services was also noted as an issue, impacting the capacity for services to operate successfully in this manner. There was a clear desire for child protection services to be effective, and to protect and prevent any harm to children, but that this needed to be made from a service system that was pro-active, and not re-active in it's approach. Gender was raised in relation to working with trauma in culturally informed services, with the need for access to care for both men and women, separately at times as appropriate. As was geographic region, with cultural differences between urban and regional and remote communities acknowledged, and the need to reflect this in the scope and translation of the HPNF project. Knowledge translation, and how to apply knowledge from this research and other to the service models currently in place was also an important area.

Transgenerational elements were also acknowledged, with participant's reflecting that the transition to parenting is often a time when new parents will reconnect with their parents, and the trauma of grandparental generations needs also to be considered, and safety provisions made. The experiences of young parents was also considered, with questions regarding how services and by extension the HPNF project could work with young parents and the families that are supporting them. These many concerns, brought people to reflect on the Nadine Burke Harris Ted Talk that was part of the pre-workshop package (see https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime), which was well received, and there was agreement that these type of specific services, developed out of need and experience to provide a centralised, family space for a range of service providers to use, are what is needed across Australia.

Trauma and culturally informed screening and assessments

Participant's at the workshop also expressed the need for screening and assessment approaches to be developed that are trauma and culturally informed. It was noted that discussing trauma can be difficult for Aboriginal and Torres Strait Islander parents. At the same time it was acknowledged the ability of non-Aboriginal service providers to be able to listen, and respond with empathy, can be compromised if they have not dealt with their own understandings and acceptance of the traumas Aboriginal and Torres Strait Islander people have experienced in Australia. The need for healthcare providers to have an understanding of trauma, and common trauma responses, including symptoms relating to complex trauma was noted As was developing a relationship with the Aboriginal and Torres Strait Islander parents and family, and working with this collaboratively with this understanding.

Cultural competence	
• *'Talking about trauma is difficult as people have to accept the truths of historical traumas.'*; • *'Don't use diagnostic labels – need to understand the personal experience. Better history taking to know the individual circumstance.'*	• *'Importance of pressing the family. Good intentions often sit underneath the behaviour – not intending harm. Need to start from assumption every parent has the best intentions?'*; • *'Culturally informed screening – overlap/confusion causes PTSD, borderline etc. Blame →individ./family.'*

Table 6. Theme: trauma and culturally informed screening and assessments

Working together safely

Dr Yvonne Clark, Research Fellow, HPNF, University of Adelaide, La Trobe University & SAHMRI

Introduction

Photo: Dr Yvonne Clark

The development of protocols to create a culturally and emotionally safe research environment for staff, investigators, stakeholders and in particular Aboriginal and Torres Strait Islander parents who have experienced complex trauma is an important part of the Healing the Past by Nurturing the Future (HPNF) project. A session on working together in a cultural and emotionally safe manner for the HPNF project was incorporated into the workshop and presented by Chief Investigator Dr Yvonne Clark (and assisted by Karen Glover). This session comprised of 3 parts, all with a different purpose: part 1 was a brief slide show to explain cultural safety and lateral violence within Aboriginal and Torres Strait Islander communities; part 2 a role play about lateral violence and trauma; and part 3 was small group work to brainstorm ideas about working together safely in various contexts. The information provided and shared during part 3 of the session will add to the working together safely protocol which will be used to guide the safety of the project. A copy of the slides can be downloaded from the HPNF website.

The importance of cultural safety and security within systems and projects require the creation of resilient environments by those within and engaged with Aboriginal and Torres Strait Islander communities. This is to feel safe and secure to be oneself, to build relationships, for group cohesion and to be able to work together productively. Another essential component of cultural safety is cultural competence which enables non-Indigenous people to have increased skills, knowledge and competency to work effectively and build positive relationships with communities.

The previous Social Justice Commissioner, Mick Gooda (Human Rights and Equal Opportunity Commissioner) indicated that "*cultural safety* can bullet proof our communities, so that they are protected from the weaponry of *lateral violence* within our communities" (p123, AHRC, 2011). Providing people with an awareness of the effects of lateral violence and its traumatic and triggering effects can assist in change, coping and provide motivation to build protective communities. This can include collaborative projects where people are able to build and maintain positive relationships and work together in a safe way (Clark, Augoustinos and Malin, 2017).

Part 1: The slide show

To articulate lateral violence the slide below (figure 4) was used in the presentation. It recognises that various forms of racism (i.e. personal, scientific, political, institutional, internal, etc) have been used to oppress Aboriginal and Torres Strait Islander people in Australia. These have incorporated practices of control, exclusion, tokenism, segregation, as well as continuous child removals. Racism contributes to collective experiences of trauma that can have intergenerational effects and render those most vulnerable to further experiences of either victimization or re-entactment of trauma (Clark, Augoustinos and Malin, 2016).

Aboriginal and Torres Strait Islander people are not passive recipients to the history of colonisation. They've fought oppressive systems of structural violence through political resistance and maintaining connection to land, cultural heritage, community and cultural identity. However, sometimes people can also internalise oppression and integrate these experiences as part of their self-image or identity.

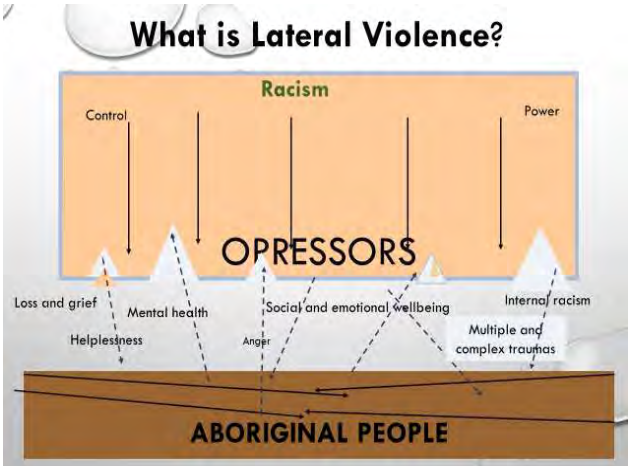

Figure 4: The oppressive and divisive nature on lateral violence

Moreover, people can feel bad about themselves and then behave in ways that hurt others. Internalisation can also mean that these processes operate at an unconscious or automatic level,whereby dysfunctional and harmful behaviours can appear normal and people are unaware of these behaviors.

People can give up hope, become burnt out, feel helpless (learned helplessness) and disempowered. A means to re-gain some power is to repeat the oppression, and cause hurt within one's self or within one's own family and community. Lateral violence is often portrayed as covert violence which is subtle and insidious. This can be in the form of bullying, gossiping, attacking each other's Indigenous identities, sabotage of projects and jobs, etc.

Part 2: Community role play

The work shop participants were invited to participate in group role play to explore how lateral violence has developed over time and continues within some Aboriginal and Torres Strait Islander communities today. Figure 5 represents the circular and cohesive nature of Aboriginal and Torres Strait Islander communities prior to colonisation.

In the role play the audience was invited to become part of the pre-colonised community and were given meaningful roles and asked to reflect on them. A narration through successive periods of pre- and post-colonial history enabled participants to explore and reflect on the protective effects of culture, and the impacts of clonisation. Many participants felt comfortable enough to share their own family stories and the effects of history, and there was a valuable group discussion about the divisive nature of lateral violence and it's role as a deterrent to community cohesion. Safety for the exercise was crucial and the facilitators regularly checked in with participants to ensure they felt culturally and emotional safe.

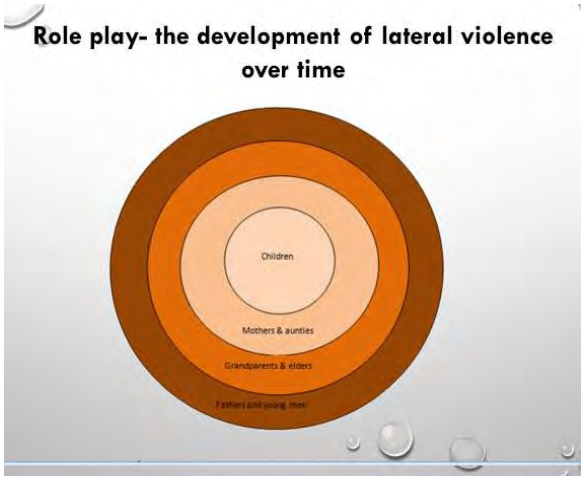

Figure 5: The circular nature of communities prior to colonization

Photo: The community role play in action

Part 3: Brainstorming ideas to work together safely and collaboratively.

This part of the session participants were divided into 4 groups, and each group was asked to work collaboratively and identify different ways that the project could provode cultural and emotional safety for all those working on and recruited in the project" (from slide).

Each group was also asked to draw on values (respect, commitment, participation, be honest, maintain confidentiality, fairness) and brainstorm ideas about how to work together and support each other across the various members of the project (e.g., team members and stakeholders, service providers, families, and the broader community).

The findings and themes from the worksheets are below. These themes will be synthesised with other information from the workshop to develop a draft 'working together safely' protocol. This draft will then be forwarded to investigators and everyone involved in the co-design process for further discussion and refinement.

Learning from the Working Together Safely

Appropriate communication and engagement

Appropriate and open communication was a key component to the working together worksheets. That is to: intently and deeply listen in various contexts; taking into account other people's views, how they want to participate in the project; and use various modes to ensure there is appropriate communication when necessary (i.e. reference groups, visual-aides, interpreters, individual and group consultations, etc.). Visibility and transparency of documents (i.e. strategy and vision statement documents) was also important. A website is in the process of development and can serve many functions related to transparency.

Group 1 Response	Group 3 Response
• Listening • Consulting cross-culturally • Community consultation and involvement • Partnership • Real engagement	• Deep listening- authentic • Different engagement processes- that reflect the local cultural needs
Group 2 Response	**Group 4 Response**
• Open communication • Listening • Attempt to understand a different viewpoint • Asking people how they like to participate	• Interpreter • Visual communication • Consultative (with Aboriginal and Torres Strait Islander staff) and have Community reference group • Co-visits • Two-way learning • Resarch aims and strategies clearly visible and promoted • Ensuring appropriate communication

Table 7. Working together safely theme 1 - Appropriate communication and engagement

Reciprocity, collaboration and unity

Reciprocity was included by participants as a primary value on some of the tables. This is to ensure that one gives back to the community and that reciprocal (two-way) relationships and respect occurs between all cohorts involved in the project. Although collaboration and unity are different concepts to reciprocity, they are relative and inter-twined. When people reciprocate and share information, knowledge and respect etc, there is greater collegiality and collaboration which in turn can unite and strengthen a group.

Group 1 Response	Group 3 Response
• Relevant knowledge exchange • Both ways • Two-way communication • Finding common ground	• Respect back • Collaboration - genuine

Group 2 Response	Group 4 Response
• Relational participation rather than an inflexible approach	• Shared understanding and genuine connection with community • Mutual respect • Knowledge sharing • Reciprocity- two-way knowledge • Two-way learning • Presenting a united front and coherence as a team

Table 8. Working together safely theme 2 – Reciprocity, collaboration and unity

Flexibility and open to change

Flexibility and openness was central across most cohorts. This can be achieved by asking others how they want to be involved and participate in the project rather than imposing expectations. Even if that means that we need to challenge ourselves and our current way of working to ensure we can be flexible in various contexts. Rigid and imposed structures may hamper progress and therefore overcoming barriers are an important aspect of this project.

Group 1 Response	Group 3 Response
	• Flexibility
Group 2 Response	**Group 4 Response**
• Asking people how they like to participate • Removing barriers • Being open to change • Flexibility • Challenging ourselves to work differently	• Being aware and open to knowing • Overcoming barriers

Table 9. Working together safely theme 3 – Flexibility and open to change

Participating, learning and recognising community expertise and needs

Learning from the respective Aboriginal and Torres Strait Islander communities involved in the project with regards to their needs and the crucial matters affecting them is vital for the outcome of the project. Local community members are the experts on community, family and individual matters and their expertise needs to be recognised and is equally, if not more, important than other forms of expertise or evidence. In this project local community could be Aboriginal and or Torres Strait Islander project staff, researchers, Elders, mothers, fathers, family, staff within Organisations/ services, and other people aligned with the project.

Group 1 Response	Group 3 Response
• Community ownership of information	• Different engagement processes- that reflect the local cultural needs
Group 2 Response	**Group 4 Response**
• Treating families as experts • Asking people how they like to participate	• Understanding Aboriginal and Torres Strait Islander child rearing practices • Understanding disparities in healing and other (e.g. housing, income etc) impacting on decision making (and therefore engagement) • Shared understanding and genuine connection with community • Cultural learning and participation (in relation to sorry business)

Table 10. Working together safely theme 4 – Participating, learning and recognising community expertise and needs

Participants want to be heard and be valued

Participants want to be heard and valued in the project, particularly if they are making a commitment toward valuable outcomes. Participants from various cohorts and backgrounds come with a variety of valuable skills, experiences and expertise and are committed to these contributions being acknowledged and taken seriously. This view is held from the birthing mothers to clinicians and researchers who hold doctorates and professorships.

Group 1 Response	Group 3 Response
• Feeling genuine and able to contribute	• Collaboration -genuine • Feel heard and acknowledged
Group 2 Response	**Group 4 Response**
• Treating families as experts • Asking people how they like to participate	• Shared understanding and genuine • Safe work environment, trust • Safe to ask questions and learn from each other. • Participation • Commitment- Valued

Table 11. Working together safely theme 5 – To be heard and valued

Guidelines, leadership and commitment to achieve goals and outcomes

Although inclusion and acknowledgement are fundamental to project commitment so too is guidance and leadership to achieving the project goals. Thus, the investigator team and project staff are accountable to take the lead and progress the project. That is in ensuring that timelines are adhered to, there is follow through, that there is a 'checking in' (with participant) processes, that strategies and protocols are in place, confidentiality is maintained and there is a process of transparency. These processes can guide and ensure that outcomes will be achieved.

Group 1 Response	Group 3 Response
• Timeline • Checking in at points • Building capacity (workforce, resources, knowledge) • Guarding information- protocols i.e. research • Commitment to follow through	• Defined roles and responsibilities • Involved at the start • Confidentiality • Clear outcomes • Tangible outcomes
Group 2 Response	**Group 4 Response**
	• Strategies and vision statement being visible and promotion • Presenting a united front and coherence as a team • Achieving goals

Table 12. Working together safely theme 6 – Guidelines, leadership and commitment to achieve goals and outcomes

Summary

There was great participant engagement and commitment to develop protocols to work together in a culturally and emotionally safe manner. For the project and protocols related to safety there needs to be: appropriate and varied forms of communication; flexible and open approaches that consider and are accountable to local community needs and expectations; and good guidance and governance by those leading the HPNF project. Transparency and inclusiveness will be maintained to develop such protocols.

Photos: Co-design discussions

Sharing community and service knowledge

Dr Graham Gee, Chief Investigator HPNF, Psychologist and Clinical Coordinator Victorian Aboriginal Health Service.

Current understanding and context

Photo: Dr Graham Gee

In this part of the workshop, Dr Graham Gee gave a short presentation on the rationale for co-designing a screening tool, assessment processes and strategies for healing complex trauma with Aboriginal and Torres Strait Islander parents. It was noted that studies among Aboriginal and Torres Strait Islander people reveal high levels of trauma exposure and symptoms of posttraumatic distress, including Posttraumatic Stress Disorder (PTSD), Complex trauma, and cultural idioms of distress;

- As high as 10 -12 different traumatic events experienced in a life time (Atkinson, 2008; Gee, 2016)
- Elevated rates of PTSD: 14-16% (Ralph, 2010), 20% (Holmes and McRae-Williams, 2008), 55% (Nadew, 2012), 58% (Atkinson, 2008), 40% (Gee, 2016)
- PTSD, Complex trauma symptoms and cultural idioms of distress have all been documented
- Intrusive memories (flashbacks), emotional numbing, avoidance, high anxiety, hyper arousal
- shame, guilt, low self-worth, difficulty managing emotions, difficulty maintaining relationships
- fragmented identity, disconnection from community

However, no studies worldwide have specifically examined the impacts of trauma for young Indigenous parents during the neo-natal to 24 month period. It is highly likely that a significant proportion of young Indigenous people entering parenthood are suffering from the impacts of historical trauma and adverse childhood events (e.g., PTSD, Complex trauma). There is a large body of non-Aboriginal research demonstrating that harsh parenting practices among parents suffering from trauma, mental health and SEWB difficulties are transmitted across up to three generations (Kerr et al., 2009). However, safe, secure and stable parenting practices have recently been found to mitigate harsh parenting practices across generations (Schoefield, Lee & Merrick, 2013). There is also qualitative research in Aboriginal context that supports theories of parenting that can break cycles of intergenerational trauma transmission (Gee, Lesniowska, Santhanam & Chamberlain, in submission, see Figure 6). Hence, the primary question is how can we work

Figure 6. VAHS Parenting Resources

together to co-design safe, acceptable assessment processes and screening tools that will help identify young Indigenous parents who experience complex trauma -in ways that are sensitive to our cultural needs? And how can we work together to develop culturally grounded therapeutic strategies? There are some considerations; including investigating whether Aboriginal organisations and practitioners currently screen and asses for complex trauma among young parents, and do they have strategies to support healing? Is so, then what is needed to build capacity. Further, in this development of a screening tool, assessment and support strategies - what types of processes and domains of trauma, mental health and Social and Emotional Wellbeing need to be considered (see Figure 7)?

Through the systematic review, 22 screening tools have been located that have been used with young parents that assess (1) trauma exposure (2) trauma symptoms, (3) or both. None of these tools were developed with Aboriginal and Torres Strait Islander people, although some have been used in Aboriginal and Torres Strait Islander populations. There is one adapted Aboriginal designed trauma measure; the Aboriginal Australian Version of the Harvard Trauma Questionnaire (AAVHTQ; Atkinson, 2008) which assesses trauma exposure, PTSD, Complex Trauma symptoms and cultural idioms of distress. Recently Complex trauma has been included in the ICD-11 mental health diagnostic system and research demonstrates clear differences from PTSD.

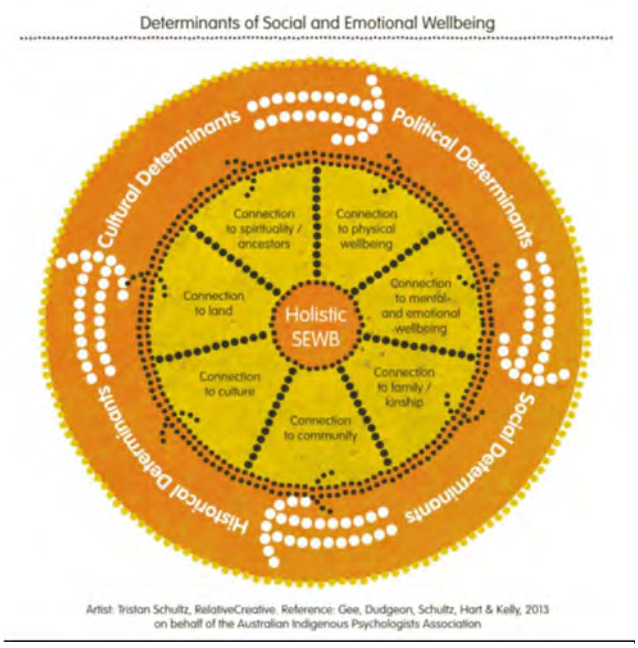

Figure 7. Determinants of Social and Emotional Wellbeing

There are a few possible approaches, to adapt a world-wide non-Indigenous measure; further develop the AAVHTQ or to build our own measure. There is also the need to consider what is missing from nearly all of these tools (except the AAVHTQ), and cultural determinants. It is stressed that this knowledge exists with us, it does not exist outside our communities.

Following the presentation was group work, with participants asked to join one of three groups to discuss screening, assessment and strategies for support and healing. Findings from the group discussions are presented below.

Learning from Sharing Community and Service Knowledge

Currently used assessment tools

Participants noted that the following tools are currently been used in their clinical practices with Aboriginal and Torres Strait Islander parents, children and families.

'**Strong Souls**' has been developed as a social and emotional wellbeing (SEWB) tool for Aboriginal and Torres Strait Islander youth (aged 12-25 years). Strong Souls screens for symptoms of anxiety, depression, suicide risk, and also includes some indicators of resilience across a checklist of 25 items scored on a four-point Likert scale. The items were developed with Aboriginal and Torres Strait Islander youth in the Northern Territory (NT), and thus showed excellent cultural and face validity. During wave 2 of the Aboriginal Birth Cohort (ABC) longitudinal study, Strong Souls was validated with a sample of Aboriginal and Torres Strait Islander youth in the NT (n=361) (Thomas, Cairney, Gunthorpe, Paradies & Sayers, 2010). Strong Souls was also administered in Wave 3 of the ABC longitudinal study, with SEWB and resilience markers reported in relation to oral health (Jamieson, Cairney, Gunthorpe, Paradies & Sayers, 2011).

The **ASQ-TRAK** has been developed specifically for use with Aboriginal children as a structured developmental screening tool (Simpson, D'Aprano, Tayler, Khoo & Highfold, 2016). The ASQ-TRAK was adapted from the Ages and Stages questionnaire (ASQ-3, Squires, Twombly, Bricker & Potter, 2009), which is commonly used across Australia and internationally. The ASQ-TRAK is family centred and focusses on the child's strengths, and identifying any early signs of development delay. The tool is administered by interview by the Maternal Child Health Nurse (MCHN) with the caregivers and their child at each scheduled MCHN visits (2 months, 6 months, 12 months, 18 months, 24 months, 36 months and 48 months of age). Caregivers are invited to be co-observers in the interview to provide the opportunity for learning about child development, and reflection on their own child's skills. The ASQ-TRAK is available in three languages (modified English, Western Arrarnta and Yolngu Matha (Dhuwaya or Djambarrpuyngu).

The **ANRQ** is a brief, 12 item measure assessing six psychosocial risk domains: emotional support from subject's own mother in childhood; past history of depressed mood or mental illness and treatment received; perceived level of support available following the birth of the baby; partner emotional support; life stresses in previous 12 months; personality style (anxious or perfectionistic traits); and history of abuse (emotional, physical and sexual) (Austin et al., 2013). It is important to note that the ANRQ was validated with a general community sample of women at 32 weeks gestation (n=276), of whom 14% reported a past psychiatric history. Ethnic identity was not presented, and the sample were in their early thirties (m=31 years) and the majority were well educated (53% 11-15 years education, 37% 15 years – postgraduate). Of this sample, 91% reported that they were not distressed by the measure, and of the midwives surveyed (n=44), 70% were very comfortable using the ANQR, and 70 were very comfortable identifying risk using the ANQR. Conversely, this also finds that 9% of participants were distressed by the measure and 30% of midwives were uncomfortable with it's use which is a considerable limitation. Concerns

with the use of this measure in Aboriginal and Torres Strait Islander populations with complex trauma backgrounds was raised earlier in W1, and again in the afternoon session. These concerns are presented in the next theme below (see p.).

The Edinburgh Postnatal Depression Scale (**EPDS**; Cox, Holden & Sagovsky, 1987) is a 10 item self-report measure that screens for symptoms of emotional distress (depression and anxiety) over the perinatal period. The items relate to symptoms experienced by the mother over the last 7 days. Validation studies have found the EPDS to be have satisfactory sensitivity and specificity, and to be sensitive to change in severity of symptoms over time (Cox, Holden & Sagovsky, 1987) – hence, the EPDS can be administered at indicated time points across the perinatal period (COPE, 2014). An item screening for suicidal risk is included, and clinicians are asked to check this item and explore the nature of any thoughts of self-harm to determine level of risk to mother and baby and make appropriate referrals before the mother leaves the appointment.

The **Kimberley Mum's Mood Scale** is a recently developed screening tool comprising two parts; an adaptation of the EPDS with Aboriginal women in the Kimberley region of Western Australia, and a psychosocial tool that enables contextualisation of scores from part one (KMMS; Marley, Kotz, Engelke, Williams, Stephen, Coutinho & Trust, 2017). The KMMS has been validated for use with women in the Kimberley and found to present high internal consistency, and moderate risk equivalence for screening for symptoms of anxiety and depression (sensitivity 83%, specificity 87% and positive predictive value 68%; Marley et. al., 2017). Issues with the use of EPDS with Aboriginal women as noted elsewhere (Marley et. al., 2017; Campbell, Hayes & Buckby, 2008), were also noted at W1 and are presented below (see p.). Qualitative research assessing the acceptability of the KMMS to the women and health providers who took part in the validation study found that the process was easy and useful for both groups, and that part two in particular increased rapport and a deeper level of understanding (Marley et. al., 2017).

'**Wondering From the Womb**' is a program currently running in Mildura, which was mentioned earlier in W1 and was also discussed at length in relation to therapeutic support strategies. Although not developed or used as an assessment tool, the approach was viewed favourably by participants in the workshop to have potential use as an assessment approach. Wondering From the Womb uses a series of 9 stories written from the perspective of the unborn child to promote parent reflection and discussion over the perinatal period. The facilitators of the Wondering From the Womb program have found that for the Aboriginal and Torres Strait Islander parents taking part, this approach is a gentle way to give permission to speak of the past; and that answering questions from the baby's perspective opens up the conversation around trauma backgrounds. The focus on the baby, which naturally flows from the stories presented from the baby's perspective encourages a child centred approach, and is in tune with the parents own transition to becoming a parent, and the excitement and concerns that they may have regarding this.

Concerns regarding currently used assessment tools and approaches

Validation and acceptability concerns

There were concerns regarding the use of tools considered to be gold standards and commonly used across the perinatal period in public health care systems in Australia that have not been not been validated for use with Aboriginal and Torres Strait Islander women. Issues relating to construct validity, in particular the accuracy of the EPDS to measures anxiety and depression

when the items have not been considered through the framework of social and emotional wellbeing and the influence this has on mental health. The language used in the EPDS was also thought to be negative and inappropriate, and to assume certain levels of literacy and health literacy that were potentially out of step with the diversity of Aboriginal and Torres Strait Islander communities nationally. It was noted that in Victoria, the EPDS is not advised for use with Aboriginal communities as it is not validated with Aboriginal women, and is not a strength based measure. In comparison, those who were familiar with the recently developed KMMS mentioned this as a preferred tool for screening for perinatal depression and anxiety due to the validation and acceptability concerns participant's had with the use of the EPDS.

Similar validation and acceptability concerns were raised in relation to the use of the ANRQ with Aboriginal and Torres Strait Islander women, however the emphasis was more on the manner in which trauma exposure is screened for, which was thought to be abrupt, and potentially without adequate support for appropriate referral and follow-up. It was thought that the ANRQ, by focussing on exposure to childhood adversity was not taking into account the persons current functioning and symptoms. The acceptability of the ANRQ was considered to be low by some participants who described tailoring the administration to be more sensitive, for example by advising women that they don't need to answer all the questions or readministering at later appointments to allow rapport to develop to be able to discuss high initial scores.

Validation and acceptability concerns	
• '*Concerns whether [ANQR, EPDS] appropriate for Aboriginal women (not used for men) & whether capturing right information among Aboriginal Staff*'; • '*Some staff opposed/concerned that [EPDS] not appropriate and whether will collect the right information – mixture aboriginal and non-aboriginal staff.*'; • '*Language concerns – negative & inappropriate language – assumes literacy & health literacy [EPNS]*'; • '*Making the wording appropriate for different women – high level of language and more urban setting – meaning of questions – literacy and health literacy – very correct language.*'	• '*In Vic EPNS considered not validated for aboriginal women (depression & anxiety).*'; • '*EPDS not advised for aboriginal community as not strengths based (Victoria).*' • '*Women's and children – midwifery Antenatal Risk Questionnaire (ANRQ) exposure rather than functioning/symptoms. – May have experienced but not dealt with.*'; • '*Discussion in aboriginal birthing team about whether appropriate (ANRQ) – just for women – very personal so advise don't need to answer – no obvious resistance…If high score at triage redone at 28 weeks*'.

Table 13. Theme – Screening tool validation and acceptability concerns

Concerns about how the information is used post screening

The steps following administration of the ANRQ were of concern to participant's, with an emphasis on needing more information to know how to support women with high scores. Support was generally provided through referral pathways, and it was noted that this kept the frontline healthcare provider (i.e. midwife) at arm's length, rather than enabling the establishment of a deeper relationship and capacity to respond. The referral pathway was generally for continued assessment and support from mental health, community health and child protection services. There was clearly an unease with this process in relation to using screening tools like the ANRQ, particularly in relation to child protection services involvement at this step.

'*Screening and assessment is being used as a weapon – used as evidence to remove child.*' As well as the knowledge that '*Many families won't access mental health*' mainstream services.

Overall, the discussion suggested that enabling frontline healthcare providers such as midwives, G.P.s and family workers to be able to respond in a more therapeutic way was supported. As was reducing stigma and finding ways to encourage Aboriginal and Torres Strait Islander families to access mental health support.

Referral pathways	**Enabling frontline healthcare staff to build relationships and respond therapeutically**
• '*ANRQ – just assesses exposure not effects – not helpful for understanding what support women need.*'; • '*Most women will complete and not difficult to identify issues but the next step is the most important to women.*'; • '*A lot of screening at 'arm's length (referral pathways unclear)';* • *'How do we help women once risk has been highlighted?*' • '*Referral for continued assessment and stream to social work and mental health – psychiatric registrar – mental health nurses - direct therapeutic services for a few people through the hospital – referral to community based services depending on need.*'.	• '*A lot at arm's length – expectation of first line response to pass on rather than establishing capacity to respond*'; • '*Clinician concern about 'what to do' with disclosure at non psych level → Able to frame therapeutic activity*'; • '*Non stigmatising approaches needed*'; • '*Need to de-mystify mental health*'; • '*Needs to not be stigmatising – many people would not see a mental health professional – many concerns could be dealt with a frontline emotional support – GP's and midwives and family worker with enough knowledge to go a certain distance then can go to a specialist.*'.

Table 14. Theme – Screening tool post testing concerns

Trauma informed care: from waiting room - to delivery suite - to MCHN visits

The need for trauma informed care principles to be applied across the perinatal period – in particular the points of contact parents have with healthcare providers and administration staff when attending antenatal appointments, the delivery suite, and subsequent Maternal Child Health appointments was often referred to, and highly supported by participants. It was thought that there was an overlap between trauma informed care - and healing informed approaches. Further, that providing staff with a greater awareness of the impact of trauma on people, and thus enabling staff to respond therapeutically was appropriate. This would consequently improve the service systems response to the needs of Aboriginal and Torres Strait Islander women and parents over the perinatal period, possibly even promoting de-escalation in some situations. A key component to this was the inclusion of culturally therapeutic practises in the workplace, such as smoking ceremonies for babies, and that having a strong cultural base embedded in healthcare systems had the added benefit of providing cultural safety for non-Aboriginal health professionals as well.

Trauma + healing + culturally informed care • '*Trauma informed care – embedding in system from reception – safe care*'; • '*Trauma informed care – whole of organisation approach – with specialists*.' • '*Systems needs to be trauma informed as well as healing informed.*'	• '*Therapy vs therapeutic response – all staff should be aware of the family.*'; • '*Awareness and de-escalation.*' • '*Cultural therapeutic practices accepted in workplaces (ie smoking ceremony for babies)*'; • '*Cultural safety for non-indigenous health professional*'.

Table 15. Theme – trauma informed care

Keeping baby in mind during the screening process

The need for a child centred approach was raised in relation to screening tools, with an emphasis on keeping the baby in mind during the screening process. '*A lot of tools don't have thought about baby.*'; '*Support for midwife – more information for the speech bubble of the baby.*'.

Multidisciplinary teams

There was a preference for teams be multidisciplinary, and inclusive of mental health and social workers, key family members and other lay people that are important to the presenting parents. However this was met with some concern, if working in a multidisciplinary team resulted in the undue involvement of child protection services. The strengths of multidisciplinary practise was acknowledged in the potential to provide the right type of responsive care to those that need it most.

Advantages of multidisciplinary teams • *'Multi-disciplinary approach would be powerful – expansion with CTG program – inclusion of social worker.'*; • *'Marvellous work in groups e.g. Rwanda – friendship bonds – task sharing, inclusion of lay and community workers – training to demystify and use emotional skills of midwives.'*	**Concerns for multidisciplinay teams** • '*Having another support person to engage mums and dads – aboriginal midwife / social worker – can be problematic as often directly linked with child protection.';* • *'Unbooking and reporting to child protection if appointments are missed.'*.
Improved outcomes for women and families • '*Many damaged women who aren't really being helped.*'; • '*Influence on service delivery environment – therapeutic intervention needs to hit what is needed.*'; • '*Team organisation so specialists are used where really needed.*'	

Table 16. Theme – multidisciplinary teams

Preferences for approaches to be used by midwives with the perinatal screening tool

In terms of the preferences participants had for the approaches to be used by midwives using the screening tool, the following was noted;

- Having some flexibility with appointments would allow for more responsive screening approaches to be used by midwives, and this includes extended time for appointments.
- Having greater access to a 'backup team' of mental health and social workers in the referral pathways would reduce the midwives anxiety to have more in depth

discussions with Aboriginal and Torres Strait Islander parents when using screening tools, and improve referral processes.

- Having a yarn, as the first step in the midwifery consult as part of a screening process where certain key words or issues are looked for.
- This complemented the idea to better integrate screening processes into caring practices and interventions.
- An overall increased awareness of perinatal mental health care, and practical ways to integrate therapeutic responses into a midwives clinical practice.

Flexibility in practise	**Relatedness and caring practise**
• '*Flexibility of scheduling – fixed appointment windows.*'; • '*Extension of consult to allow more time to listen and have a backup team to link up with.*'; '*Responding to clinician's anxiety*'	'*1st Process may be a yarn – looking for key words – during midwifery consult.*' '*Integration of screening into interventions and caring – making embedded.*' '*Busy and understanding for perinatal mental health care.*'; '*Energy for screening versus intervention*'

Table 17. Theme – Screening tool midwife preferences

Preferences for perinatal screening tool itself

The preferences participants had for types of screening approaches are listed below;

- Relationship aspects need to be considered in the screening tool, to adequately assess complex trauma symptoms. The MacLean Screening Instrument for BPD was mentioned in relation to this construct.
- Tiered screening items that if answered positively, lead to further questions in relation to the symptom or experience. This could be presented digitally as a drop down list of further questions.
- Ensuring that the screening tool was a strengths based measure.
- It was acknowledged that there needed to be further discussion on whether or not the screening tool examined both trauma exposure and symptoms. The need to account for the cumulative and compounding nature of traumas experienced by Aboriginal and Torres Strait Islander people in Australia was also acknowledged.
- Using a conversational approach, with screening embedded as part of a yarn, or as the first part of the assessment process, looking for certain key words that could perhaps lead to the tiered screening items.
- Comprising a short form, that is able to be easily used in clinical practice in busy healthcare settings.
- Using appropriate wording in the screening tool, to ensure acceptability.
- Having the screening tool accompanied by a clear flow chart of appropriate referral pathways.
- Screening tool items that draw on the parenting transition been made by the parents, and the opportunity to frame items from the baby's perspective and aspirations they have for the future.

Screening for relationship difficulties • *Complex trauma – relationship aspects should be considered in screen.*'; • '*MacLean's for borderline – women with trauma may have parallel's – disruptions of relationships – maybe the presentations common to trauma.*'	**Appropriate wording** • '*Language modified in Kimberley mood scale.*'; • '*Making the wording appropriate for different women – high level of language and more urban setting – meaning of questions – literacy and health literacy – very correct language – Aboriginal version – Kimberley mood scale.*'.
Tiered response items & short form • '*Drop down questions to expand if positive responses to initial questions.*' • '*Need something realistic that can be used by busy hospital workers. – Tiered questions? – Exposure risk?*' • '*Short form for busy hospitals – elements of trauma.*'	**Screening tool + referral pathway presented** • '*Flow chart referral pathway*' (group 9). **Screening for trauma exposure** • '*Exposure vs symptoms – to discuss*'; '*Traumatic events – cumulative effect and compounding.*'.
Strengths based • '*Try to make more strengths based approach*'; • '*Screening approaches to understand impacts of trauma, but what is also keeping the person well – What is functionality.*'	**Thinking of baby** • '*Thoughts about the future – how do they think about the baby – what they see for the baby going forward?*'; • '*Reflective capacity to visualise themselves as a parent*'; • '*Different responses – some women may respond differently.*'; • '*Transition to parenting – how women are able to think about the baby and think outside themselves.*'; • '*Mindful of partners/families as well as mum*'
Conversational approach • '*McLean's – BPD screening questions & how asked yarn ship.*'; • '*Screening can be embedded as a "yarn" – Key words?*'; • '*1st Process may be a yarn – looking for key words – during midwifery consult.*'.	

Table 17. Theme – perinatal screening tool preferences

Currently used assessment tools and referral pathways

Assessment tools were not listed, with the focus on the processes used for mental health assessment and referral pathways. Following on from the frontline healthcare providers use of a screening tool, such as the EPDS or the ANRQ, it was discussed that referrals for assessment and ongoing support would be made, and might involve social workers and mental health workers initially; then psychiatric registrars, psychiatrists, clinical psychologists or consultant psychologist who perform the formal assessment; and then mental health nurses and social workers and mental health workers who continue to provide support. It was noted that specific therapeutic services are only accessed by a few people through the mainstream healthcare system. It was noted that Child Protection may initiate the process, setting up a mental health assessment with a mainstream provider. While some Aboriginal and Torres Strait Islander parents may prefer to seek help from an Aboriginal Community Controlled Health Organisation, who may organise for an appointment with a consultant psychologist, and then ongoing support from a therapist or counsellor, support person, or advocate.

Concerns regarding assessments

Participants felt it was important to acknowledge the limitations of mainstream assessments to account for the experiences of the Aboriginal and Torres Strait Islander people, and that this needs to be supported by guidelines relating to Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and trauma, and cultural variation in the interpretation of phenomenology. It was also considered important to name differences between Aboriginal and Torres Strait Islander and non-Aboriginal practitioners in relation to the Aboriginal and Torres Strait Islander client, and to actively consider who was best placed to make the formal assessment. This reflection also needed to consider gender. In terms of reporting, the potential for outcomes of the assessment to be reported to cultural groups, or in court was noted. Support by the NDIS scheme for the cost of clinical assessments was also noted.

Preferences for assessments

Participant's noted several preferences for certain approaches to be used in the mental health clinical assessment process. Namely, this was that the assessments are also tailored to be strengths based, with an emphasis on current areas of function; to be informal and relational in style, and to include an engagement with the family of the Aboriginal and Torres Strait Islander parents.

Currently used therapeutic approaches that are positive

Participants noted that the following therapeutic approaches were currently been used in their experience with Aboriginal and Torres Strait Islander parents, children and families;

- Parents under pressure
- Circle of Security
- Abecedarian approaches in child care centre
- Wondering From the Womb
- Alice Springs families project
- *Ngangkari* and *Akeyulerre*

Participants acknowledged that Circle of Security was used fairly universally across services, and that the Parents Under Pressure program and the Abecedarian approaches were fairly common. Wondering From the Womb, as presented earlier, is unique to Mildura District Aboriginal Health Service (MDAHS), and was discussed favourably during W1. The Alice Springs Families project was also described, and uses a bi-cultural model, with an Aboriginal and non-Aboriginal pair working with a case load of families. The Families project uses a strengths based approach, and although focussed on the first two years, has a whole of lifecycle care model. Therapeutic approaches that were described that worked best with Aboriginal and Torres Strait Islander children, parents and families included living in the moment with families, and using curiosity, play and spending time without planned activities to create a safe space for reflection. It was noted that the necessary documentation and data collection can be done separately, while at the backline. '*Using curiosity, play, in the moment, spend time not purposefully / service provider was to create a space and*

then reflect, use photos, implicit practice.'; '*Living in the moment with families on frontline and while at backline you can do evidence/data.*'. This program was also considered to present good value for money. It was meaningful for both the Aboriginal and non-Aboriginal staff who continued to learn from each other, could share carrying the workload, ensure cultural safety and as a result – be effective. The benefits of involving and working with *Ngangkari* and *Akeyulerre* (traditional Aboriginal healers in Central Australia) in the course of therapeutic work with individuals and families worried about something effecting a member of their family was also noted. A couple of further suggestions were made, and included ensuring that where relevant, people were linked up with Stolen Generation services. Also, that the healing benefits of Aboriginal and Torres Strait Islander women birthing on country were explored, as this has the potential to mitigate trauma when compared to hospital based deliveries, and could provide support through strengths of country and identity. Wondering From the Womb was discussed further during this session, noting that the program provides an education basis, with information on development across the perinatal period that helps the parent to respond, and that through thinking about what the baby might be feeling – that this enables the parent to reflect on what they missed out on, in their own childhoods. It was considered to be a therapeutic program as much as it is a screening process, gently probing early childhood experiences, and that an intervention can just be listening, at the right moment.

Barriers to currently used therapeutic approaches

It was noted that perinatal mental health services were often working with those in crisis, and were under resourced. '*MH services for postnatal, often in crisis, very stretched*' (Group 12). And that psychiatry services were often limited to focussing on psychopharmaceutic interventions. '*Psychiatry services for medications*' (Group 12). Traditional mainstream therapies, such as Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy(CBT), Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) and Dialectical Behavioural Therapy (DBT) were also recognised to be expensive and difficult to access for many Aboriginal and Torres Strait Islander parents. Further, it was noted that working therapeutically with complex trauma does not fit within the current Government funded mental health plans that are limited to 10 sessions. '*Complex trauma not a 10 session healing program – longevity in sessions/healing needed.*' (Group 13).

Reflections

At the end of the day participants circled up to reflect on their day being part of the workshop. Participants were also invited to discuss the meaning behind the images that they painted on their rock and then place it in the tarnuk that was placed in the centre of the circle. People that had not had the opportunity to paint a rock were also invited to talk about their aspirations for the project and their thoughts about the day. This was a voluntary process and participants could choose not to talk without judgement.

Workshop 1 Evaluation

Feedback forms were sent to participants via email immediately after the workshop in late March 2018 and again in early June 2018 via email and survey monkey. In all 17 feedback forms were received which is approximately 49% response rate.

The first two feedback questions enquired about the enjoyable or concerning aspects of the workshop.

Valuable aspects

The qualitative feedback was predominantly positive. Most participants found the workshop safe, enjoyable and relevant. The workshop provided the opportunity to learn about and contextualise the project in relation to trauma and trauma care.

Many participants liked the embedding of Aboriginal and Torres Strait Islander knowledge and space throughout the workshop - beginning with a welcome to country by a local Aboriginal Elder, having Aboriginal and Torres Strait Islander facilitators and utilising a local Aboriginal catering business. Other enjoyable aspects included building relationships with others and sharing information about themselves and their services.

There appeared to be a good balance between the informative/theoretical aspects and the interactive/practical aspects to the workshop. The interactive sessions were well received and engaging. For example, the ice-breaking exercise assisted the bonding process for participants. The lateral violence exercise within the working together safely section, was generally seen as powerful and helped contextualise trauma in the community. The Brainstorming exercise also assisted to draw out participants ideas on assessment tools and processes at the end of the day. See comments below.

Table 18. Enjoyable aspects of the workshop

Interacting with the other participants was rewarding
It was a good mix of hearing information and also activities. Whilst information was being gathered there was a healing and connecting aspect weaved throughout the day
It was all very interesting and informative. The exercise we did as a group with Yvonne was very powerful. Group discussions about our own experiences from different services was fantastic too, as I learnt so much from sharing how we do things.
The facilitators handled a very difficult topic with sensitivity, humour and respect for all participants, so it was a bonding, healing experience.
Lateral violence exercise Mapping exercise in small groups around what services are currently doing in this space
Really appreciated the balance of presentations, workshops and discussion. Valuable to learn more about the context and share participants' knowledge

I found the presentations excellent, and appreciated everything I heard today. The exercise with the circles (tracking effect of colonisation etc) was excellent, and very powerful and would be useful in many healthcare settings, I wondered as its purpose in today's session, it seemed to be preaching to the converted?
I really enjoyed the day, especially getting to know more about the proposed research and meeting lots of new people. The opening and use of the cards to start sharing was great
Good information about trauma and trauma care -Great opportunity to meet with the study investigators and the community -All sessions were important and facilitators were mindful of time and how the participants were travelling throughout the day. -Food and venue good -Aboriginal people running it was excellent -Good to have Frank Wanganeen there all day
Collegial relationship building Realistic discussion about helpful ways of dealing with past hurts and damage
Safety plan and different activities
morning session, breaking the ice was a nice way to start a session which potentially has a personal impact
Local respected person performed the welcome - interactive activities - well timed breaks - not too information heavy
Experiential exercises
It was great to meet others working in the area, and to hear perspectives from frontline staff working in perinatal, in particular in relation to child protection issues. The role play was also very powerful, and I reflected back on this over the following weeks.
I found the whole workshop beneficial to understanding the project. I liked meeting all the stakeholders- start of building relationships
Good discussion with relevant Aboriginal and non-Aboriginal health professionals about the topics of the study. Also was very good to brainstorm people's ideas for screening and assessment
It was all great. Really enjoyed the food, and that catering went to a local Indigenous business
Freedom to speak freely

Concerning aspects

The day was managed safely but concerning comments about the workshop was that advantage was not taken of the expertise about trauma in the room. Aspects of the workshop may have been preaching to the converted- given that there was already considerable knowledge in the room about trauma and trauma informed care. Therefore, it might have been useful to gauge people, their service and resources to determine what people think, want and might do.

Although the workshop attempted to provide an inclusive environment for participants, that is to get to know each other and bond within an Aboriginal and Torres Strait Islander space, perhaps clarity of the role of non-Aboriginal participants might have been useful.

Lastly time management was an issue- although the facilitators attempted to manage this, some sessions were rushed and not given the time needed to get the most out of the sessions.

Table 19. The concerning aspects of the workshop

Given the depth and breadth of experience of the investigator team - presumably why they were successful in securing funding and the large amount of research in the space, it felt like starting from square 1, as if nothing was known about the topic. It is hard to see how progress can be made if every research exercise starts from a bottom-up approach - i.e. let's find out what people think and lets find put what people want and then we will think about what we might do. It doesn't seem to allow for building on what is known.
None. The caring of people and inclusiveness was excellent - a model for all workshops
As a non-Aboriginal person, I wondered if I should have been there
No concerns
The workshop considered some very challenging concerns for Communities and the health system. I felt reassured that this was all managed very safely and respectfully.
Nothing that I was concerned about. Although the subject matter was confronting I felt very safe and cared for.
Lots to discuss, would have liked more time with the rock process at the end, but don't know what could have been deleted to make more time.

Feedback about the Aims of the workshop

A number of questions were posed to clarify whether the aims of the workshop were met. These questions utilised a 5-point likert scale, ranging from 1 (Disagree very much) to 5 (Agree very much). Sixteen participants filled out the scales and descriptive results were provided by survey monkey. Table provides the questions, the weighted averages and any qualitative responses from participants.

Table 20. How well the aims of the workshop are met (n=16)

	Questions and qualitative responses	**Weighted average**
1.	Established strong foundations for working together with Aboriginal and Torres Strait Islander communities in this project	4.56
	• *I think the bringing together of Aboriginal and non-Aboriginal staff from a variety of organisations and backgrounds is a great place to start*	
2.	Shared current research knowledge about complex trauma in the perinatal period	4.38
	• *The literature review emailed around was very helpful* • *I gained much from the presentations and opportunity to reflect on my own work and workplace*	
3.	Clarified goals, hopes and aspirations for the project.	4.31
	• *In relation to the psychological assessment, I thought the goals were clear* • *Really excellent progress in beginning to clarify goals, hopes and aspirations which will be a foundation to continue to build on in our continued work. This will be an important area to keep investing in as we continue with the workshops* • *Certainly did! Am very excited to see how these develop/ unfold over the 4 years* • *This was very clearly overviewed and structured*	

4.	Establish protocols for ensuring cultural and emotional safety for team members, collaborators, service providers and community members involved in the project.	4.31
	• *Was caring, nurturing space with lots of positive sharing* • *We started this process but unfinished and to be continued*	
5.	Did you find the workshop to be a safe space?	4.69
6.	Discuss community needs and how services and communities are currently identifying and addressing complex trauma.	4.13
	• *This felt like rushed at the end and would have liked more time for this* • *From my memory there were aspects of this but could be wrong given it was a while ago now*	

Nearly all participants agreed or strongly agreed that the aims of the workshop had been met (the average is between 4 and 5). As can be seen from the results in Table 10, participants believed that a strong foundation for working together had been achieved.

Most participants (87.5% either agreed or agreed very much) were satisfied with the knowledge output about complex trauma in the perinatal period. Access to this was via the literature (scoping) review that was emailed to participants prior to the workshop and from the session on trauma at the workshop.

The majority of participants (93.75% agreed or agreed very much) that the goals, hopes and aspirations of the project were clarified. The clarity helped refine and structure the workshop with a continued focus throughout the day. Further opportunities to discuss goals, hopes and aspirations was also present at the end of the day to ensure participants left feeling inspired.

Most participants (93.75% agreed or agreed very much) felt that protocols for ensuring cultural and emotional safety for team members were established and participants had participated in this process. Whilst this session may have been unfinished the safety activities and protocols were inclusive throughout the day and workshop process. In fact, 100% of participants either agreed or strongly agreed that the workshop was a safe space.

Many in the workshop (87.50% agreed or agreed very much) agreed that there was discussion on community needs and how services and communities are currently identifying and addressing complex trauma. Some dissent was that this session of the workshop was at the end of the day and rushed and therefore may not have had the benefit of a broader discussion.

Recommendation for future HPNF workshops

Recommendations for the next or future workshops include: that there is an action process and discussions about the way forward for trauma and trauma care; discuss and get more feedback on safety, and assessment processes; that that are more of the experiential and practical exercises and that time is allowed to reflect on them appropriately; that there is consistency with facilitators and the format (as it appeared to work well for workshop 1); and that there is local cultural input where ever the workshops are held.

Table 21. Recommendations for future HPNF workshops

Bring more knowledge to the table and ideas about possible ways forward
Reflection in the ideas from the first workshop. Continuing to progress the discussions that participants contributed in the first workshop. Updates with progress from the team.
I would like to see a little more time for reflection and feedback during Yvonne's lateral violence exercise. I have done this before and I think opportunities for people to share how they are feeling at every step of the exercise make for great insight and learnings
Absolutely
That many of the same facilitators attend the next one - for consistency.
To seek local cultural advice as to the format of the workshop to ensure it is suitable for diverse Aboriginal groups, particularly if Alice is your next stop.
More experiential activities
Looking forward to the workshop in Alice!
I loved the practical hands on approach to sessions- I would like to see that continue in the next workshop in Alice Springs. Some cultural aspects would be great- i.e. painting, rocks etc.
Pretty much the same format as I thought it worked. Next workshop important to discuss safety processes around screening and assessment and get feedback on screening items

Next Steps

The second HPNF workshop will be held at the Mercure Resort in Alice Springs on September 11th 2018 (9 to 4.30pm). Stakeholders from across Australia have been invited to attend Workshop 2. This will include Aboriginal and Torres Strait Islander service providers, organisational representative and academics, as well as Aboriginal and Torres Strait Islander community leaders that have expressed an interest in the HPNF project or contributed directly to the pilot research to be conducted in South Australia during 2018. All of these stakeholders will have experiences of working with vulnerable families.

The purpose of workshop will be to reflect on findings from phase 1 and refine protocols for working with Aboriginal and Torres Strait Islander parents in phase 2. After this workshop, and agreement on the protocols for Phase 2, another ethics application will be submitted to The Central Australian Human Research Ethics Committee (CAHREC) to consider conducting the next phases of the research with Aboriginal and Torres Strait Islander parents and service providers in central Australia. Please send queries or rsvp to hpnf@latrobe.edu.au by 17th August if you would like to join this workshop.

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