ORIGINAL ARTICLE

Community views on 'Can perinatal services safely identify Aboriginal and Torres Strait Islander parents experiencing complex trauma?'

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Abstract
Family and extended kinship systems which nurture healthy, happy children are central to Aboriginal and Torres Strait Islander cultures. Since colonisation, Aboriginal and Torres Strait Islander communities have been impacted by intergenerational cycles of trauma, stemming from colonial violence, genocidal policies and discrimination, including the forced removal of children from their families. Becoming a parent offers a unique life-course opportunity for trauma recovery and preventing intergenerational trauma. However, identifying or 'recognising' complex trauma carries significant risk of harm for Aboriginal and Torres Strait Islander parents due to reactive prenatal child protection involvement potentially compounding experiences of trauma, and limited benefits due to lack of culturally appropriate support. The Aboriginal-led participatory Healing the Past by Nurturing the Future project aims to co-design safe, accessible and feasible perinatal awareness, recognition, assessment and support strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma. This paper presents views of 38 workshop

participants to determine prerequisites for ensuring benefits outweigh risks of assessment to safely recognise parents experiencing complex trauma, consistent with screening criteria. Six essential elements were identified from thematic analysis: high-quality holistic care; cultural, social and emotional safety; empowerment, choice and control; flexible person-centred approaches; trusting relationships; and sensitive, skilled communication.

Key Practitioner Messages
- The impacts of colonisation and rates of Aboriginal and Torres Strait children in out-of-home care mean that there can be a myriad of issues facing Aboriginal and Torres Strait Islander parents with regard to perinatal child protection involvement.
- The benefits must outweigh the risks of identifying parents experiencing complex trauma.
- Assessment must be offered within foundations of supportive relationships and holistic care in culturally-safe, empowering settings, where choices are respected and skilled communication approaches are used.

KEYWORDS
Aboriginal and Torres Strait Islander, assessment risks, indigenous, perinatal, trauma

INTRODUCTION

Family and extended kinship systems have always been central to the functioning of Aboriginal and Torres Strait Islander societies as the social fabric and cultural attachment systems for nurturing healthy, happy children. These systems have been underpinned by cultural knowledge, governance structures and lore, supporting Aboriginal and Torres Strait Islander peoples to adapt and thrive for at least 2000 generations (Thomson, 1984). New parents are supported using principles of Grandmothers Law (Langton, 1997) – traditional knowledge, experience and practices of senior women in a community for supporting mothers before and after birth (Ramsamy, 2018). The wellbeing and safety of children was fostered within collectivist systems of kinship and community care (Lowell et al., 2018; McMahon, 2017).

Since colonisation, Aboriginal and Torres Strait Islander communities have been impacted by successive waves of violence and trauma (Atkinson, 2002), including introduced diseases, dispossession from land, laws to restrict movement and access to resources, and the forced removal of children from their families referred to as the 'Stolen Generations' (Wilson, 1997). The impacts of this collective trauma (Menzies, 2019) are cumulative and intergenerational, compounded by ongoing personal, lateral and structural violence and oppression, discrimination, and inadequate access to social, cultural and economic determinants of health (Clark et al., 2020). Perinatal and family services are significant sites of past and ongoing trauma, many infants were removed from their parents in hospitals or homes shortly after birth. The ongoing and escalating high rates of Aboriginal and Torres Strait Islander children in out of home care signify ongoing structural violence and a failure to address compounding intergenerational trauma (O'Donnell et al., 2019).

Clinical understandings of complex post-traumatic stress disorder (complex trauma) have evolved over the past three decades (Cloitre et al., 2014; Herman, 1992), formally recognised by the World Health Organisation in the Eleventh Edition of the International Classifications of Diseases (Maercker, 2021). This classification describes a symptom profile that typically follows traumatic interpersonal experiences of a prolonged nature or repeated adverse events, not restricted to but commonly associated with childhood maltreatment (Cloitre et al., 2014). Core symptom clusters include those of post-traumatic stress disorder (PTSD), namely re-experiencing the events (triggers), avoidance and a sense of threat, in addition to affect/emotion dysregulation, negative self-concept and relational disturbance (Cloitre et al., 2014). There is a strong evidence-base for long-term impact of childhood maltreatment on social, emotional and physical wellbeing (Felitti et al., 1998; Font & Maguire-Jack, 2016; Sara & Lappin, 2017). Critically, these effects can impede the capacity of parents to nurture their children, contributing to intergenerational cycles of trauma (Alexander, 2015).

The Power Threat Meaning Framework (Johnstone et al., 2018) provides a conceptual classification of mental health disorders related to emotional distress, describing the dynamics of power in people's lives, such as the threats that misuse of power can impose, as well as the learned responses to threats (Johnstone et al., 2018). Mental health professionals and support systems are offered an alternative way to conceptualise trauma (Johnstone et al., 2018) that seeks

to explain why people experience a range of forms of distress, reframing the question 'What is wrong with you?' to 'What has happened to you?' (Harper & Cromby, 2020). Evolving understandings of complex trauma that describe power, threat and distress, are more consistent with Aboriginal and Torres Strait Islander conceptualisations of trauma (Clark et al., 2020) and wellbeing models that recognise how social, historical and political determinants affect individuals, families and communities. (Butler et al., 2019; Gee et al., 2014).

The transition to parenting offers a unique life-course opportunity to recognise and support healing for parents impacted by complex trauma and prevent intergenerational trauma (Chamberlain et al., 2019a; Sperlich et al., 2017) for three main reasons. First, there is a convergence of potential risk factors for experiencing trauma-related distress, including the intimate nature of perinatal care and experiences, hormonal fluctuations, sleep deprivation, financial instability, and increased family stress and risk of family violence (Muzik & Rosenblum, 2018). Second, despite these risks, the parenting transition offers the best opportunity for recovery, being a period of rapid brain development, neuroplasticity and personal growth (Fava et al., 2016; Piccini, 2021). A positive strengths-based focus of optimism and hope can create a 'virtuous cycle' of positively reinforcing responses through nurturing children and the love they bring (Chamberlain et al., 2019b), promoting healing through a process of 'earned security' (Segal & Dalziel, 2011). That is, Healing the Past by Nurturing the Future (Chamberlain et al., 2019a). Thirdly, this is often the first time since childhood that parents have scheduled contacts and continuity with service providers – offering a unique 'window of opportunity' to build relationships and ensure health care contacts are safe and not re-traumatising, and to identify people at risk and enable support (Reid et al., 2021a).

Identifying parents who may experience complex trauma during pregnancy and the first 2000 days provides a key opportunity to promote healing and wellbeing through tailored support and trauma-informed care. However, the importance of ensuring that the benefits outweigh the risks of screening have been endorsed worldwide (Andermann et al., 2008; Dobrow et al., 2018). Within Australia, 21 essential criteria for population-based screening include the need for: informed choice, confidentiality and respect for autonomy, equity of access, and ensuring that the overall benefits of screening outweigh potential psychological, physical, social, cultural, ethical and legal harms (Department of Health, 2018). Within the context of perinatal care, risks related to identifying complex trauma include labelling individuals as 'at risk' which may undermine parents' resilience and coping skills, increase stigma and potentially trigger trauma-responses such as avoidance as a coping strategy. In turn decreasing engagement with important services and supports (e.g. routine antenatal services) can potentially trigger inappropriate notifications to child protection services (Chamberlain et al., 2020). Screening processes may be unsafe for parents despite 'safety' being a key aim of perinatal care for both mothers and infants. Many Aboriginal and Torres Strait Islander parents currently experience their care as 'unsafe' and experience poor health outcomes (Brown et al., 2019; Marriott et al., 2019).

Current screening recommendations in the national pregnancy guidelines (Department of Health, 2018), based on the Australian perinatal mental health guidelines (Austin et al., 2017), include using a range of clinical assessment measures (e.g. the Depression, Anxiety and Stress Scale) and structured psychosocial assessment tools (e.g. Antenatal Risk Questionnaire) with direct questions about childhood experiences of emotional, sexual or physical abuse (Austin et al., 2013). Given that perinatal and family services have been significant sites of infant removal and the escalating rates of Aboriginal and Torres Strait Islander children in out-of-home care – approximately 20 per cent enter in their first year (Australian Institute of Health and Welfare, 2021) – many parents are unlikely to feel sufficiently safe to engage with such direct questions and thus may not be offered appropriate support. Further, such items may raise areas of concern, but not be matched by skilled and culturally appropriate support. There are risks that these non-specific screening items (whose sensitivity for identifying complex trauma is unclear) will have limited benefits and might elicit inappropriate child protection service referrals. We argue that it is critical for psychosocial assessments to consider intersectional responses and support that address multilayered, potentially oppressive or inappropriate service practices (Leany, 2020).

The aim of this paper is to explore, from the perspectives of Aboriginal and Torres Strait Islander and non-Indigenous key stakeholders working with parents, how assessment processes (i.e. screening) might safely identify Aboriginal and Torres Strait Islander parents experiencing complex trauma.

METHOD

The Healing the Past by Nurturing the Future project is an Aboriginal-led community-based mixed methods participatory action research (action research) project which aims to iteratively co-design perinatal awareness, recognition, assessment and support strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma. Methods are described in detail elsewhere (Chamberlain et al., 2019a), and in Supplementary File 1. The sub-study described in this paper was conducted within the third co-design workshop (illustrated in Figure 1), held over two days
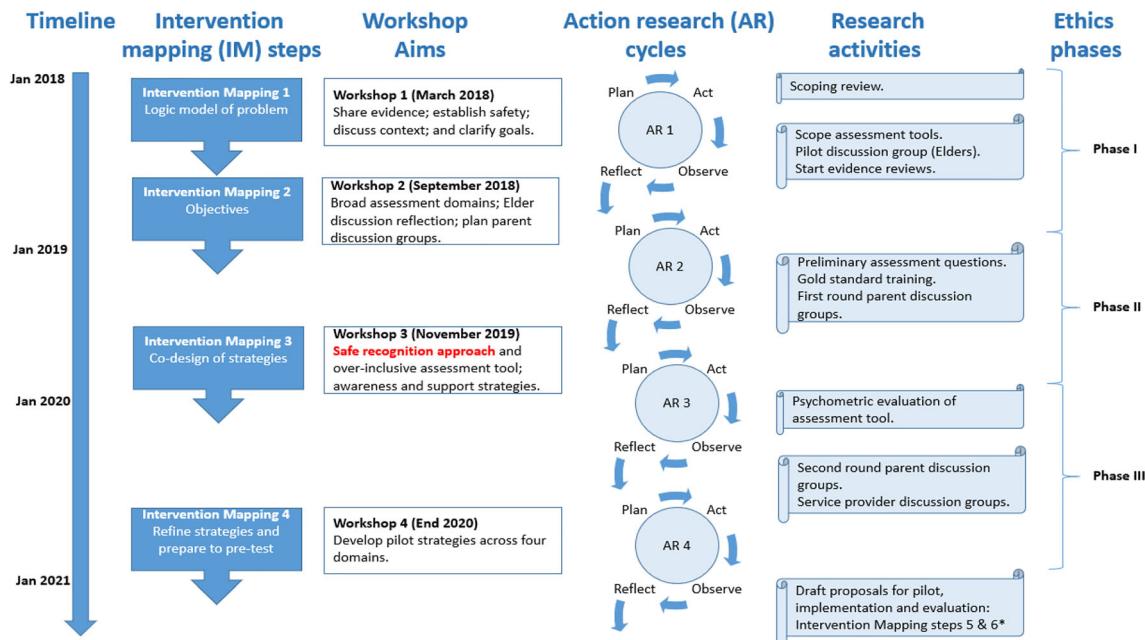
FIGURE 1 Context of study within the Healing the Past by Nurturing the Future project

in Melbourne, Victoria, Australia in November 2019. We have used recommended standards for reporting qualitative research (O'Brien et al., 2014). Ethical procedures for this workshop were approved by the St Vincent's Hospital Melbourne Human Research Ethics Committee (HREC, App. No. 50428, 023/19).

Co-design workshop and data collection

The workshop was designed to present data gathered through the HPNF project that would inform four three-hour semi-structured co-design discussions. These discussions were aligned with the four domains of the HPNF Conceptual Framework: Awareness, **Recognition** (the focus of this paper), Assessment and Support (Chamberlain et al., 2019a) (Figure 2).

Participants

Thirty-eight key stakeholders participated in the workshop, of whom 22 (58%) were Aboriginal and/or Torres Strait Islander, representing 24 distinct 'Country' or tribal groups. Two participants attended one day only, hence there were 37 participants attending each day. The majority of key stakeholders were female (95%) and aged 30–64 years (79%). Seventeen project team members also attended the workshop to present, take notes and assist with facilitation. See Table 1 for details of participant roles.

Data collection

A 20-minute presentation outlined current evidence related to 'safe recognition'. This included principles of screening, and summary of concerns raised about risks of perinatal assessment for complex trauma (Chamberlain et al., 2020). Yarning and story-telling was used to facilitate non-intrusive discussions about sensitive topics (Bessarab & Ng'andu, 2010). For this activity, between six to eight participants at each table were given a perinatal health service 'scenario' and fictional 'story' (see Supplementary File 2) of a parent attending for care, and were asked to discuss:

1. What would 'safe recognition' look like in this scenario? (goals)
2. What activities need to happen to achieve safe recognition in this setting?
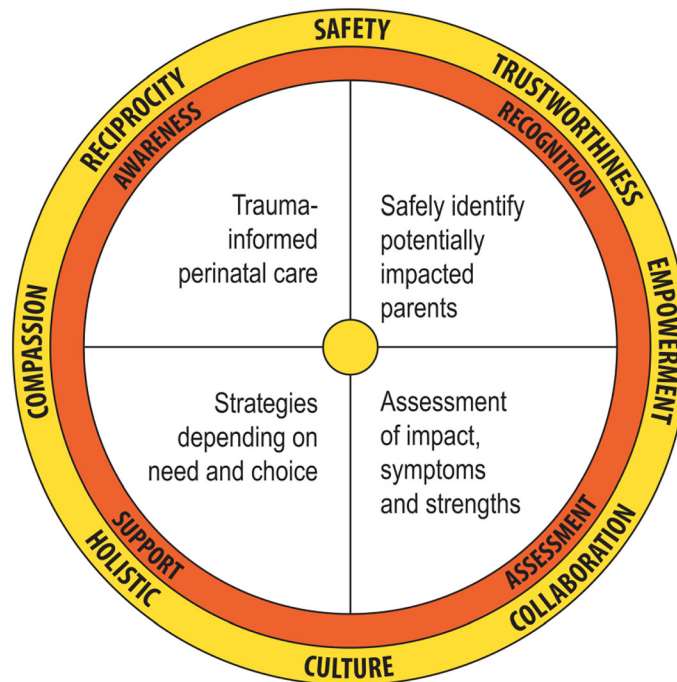
FIGURE 2 Healing the Past by Nurturing the Future conceptual framework for culturally safe, empowering perinatal care – four domains of care (inner circles) and eight supporting values (outer circle)

TABLE 1 Participant roles by Indigenous status

	Aboriginal and/or Torres Strait Islander number (%)	Non-Indigenous number (%)	Total (%)
Health and wellbeing professionals (e.g. Midwives, Maternal and Child Health Nurses, General Practitioners, Family Support Workers, Aboriginal Health Workers, Psychologists, Psychiatrists, Counsellors, Social Workers)	14 (37%)	12 (32%)	26 (68.4%)
Community members	5 (13%)	NA	5 (13.2%)
Researchers and students	3 (8%)	4 (11%)	7 (18.4%)
TOTAL included in analysis	**22 (58%)**	**16 (42%)**	**38 (100%)**
Project team members (not included in analysis)	6	11	

Data analysis

Thematic analysis was conducted in NVivo (QSR International Pty Ltd., 2018) using iterative steps as outlined by authors previously (Braun & Clarke, 2006; Green et al., 2007):

1. Immersion in data collection.
2. Line-by-line coding of free text data, creation of major analytic themes or 'goals', with related activities (Supplementary File 3). This inductive process used a constant comparison method to discuss and record notes regarding emergent themes and explore both associations and exceptions to these themes.
3. Preliminary analytic themes and supporting quotes were reviewed and refined with the authorship team to develop a conceptual diagram based on principles of program logic or logical framework (Mills et al., 2019).
4. Preliminary findings were circulated to workshop participants who were invited to comment on the accuracy of the analysis and invite further contribution to the manuscript.

Findings

Thematic analysis revealed that, in order to safely recognise Aboriginal and Torres Strait Islander parents' experiencing complex trauma, and to ensure that the benefits outweigh potential harms, any assessment needs to be offered within the context of six core elements (Figure 3) that need to be embedded within practice:

1. High-quality holistic care
2. Cultural, social and emotional safety
3. Parent empowerment, choice and control
4. Flexible, tailored, person-centred approaches
5. Foundation of trusting relationships
6. Wise, sensitive communication and enquiry skills.

Figure 3 situates Aboriginal and Torres Strait Islander families within the centre of the elements, using a Healing the Past by Nurturing the Future illustration (Andrews, 2018).

The image within Figure 3 illustrates a father, mother and child wearing possum skin cloaks looking to their ancestors and past generations. The parents are connected with a song line which gives them strength. The stones below represent a strong foundation and the stitching on the cloaks represent the relational connectedness of Aboriginal people and their worldviews. We draw on this image to illustrate the six elements (themes) identified for ensuring safe identification for Aboriginal and Torres Strait Islander parents experiencing complex trauma. The cloaks represent shelter and comfort, and the six panels represent essential elements for ensuring safety. The stitching binds the panels with the relational connectedness of Aboriginal people and worldviews and wrapping around families to provide comfort and safety that is attuned to their experience, perspective and identity.

FIGURE 3 Elements central to safe recognition of Aboriginal and Torres Strait Islander parents experiencing complex trauma

The essential elements to enable safe recognition of Aboriginal and Torres Strait Islander parents experiencing complex trauma are listed and discussed separately below. However, they are interconnected and integral to each other. The text in italics represents direct quotes from workshop participants.

Element 1: high-quality holistic care

Participants observed that safe recognition of complex trauma can only occur when assessments are embedded within high-quality holistic care. This includes several features. One is that parents should only be offered assessment for complex trauma if there are appropriate referrals and supports in place. As one participant noted, *'If you do ask, you need to know what to do with the answer'*. This involves being able to respond immediately and ensuring referral and support options are clear and available. Including a community focus was also seen as critical, for example bringing someone in from the community if appropriate, and the need for developing evidence-based community guidelines. Participants highlighted that workers need training to be equipped with skills that would enable them to feel confident in responding to assessments of complex trauma, ensuring the safety of families and for their own safety and ability to sustain the role. Worker supervision that involved self-reflection as a key component was also viewed as important.

Access to a range of resources is part of quality, holistic care. For example, non-threatening stories reflecting fears parents may have around parenting to help enable supportive conversations and disclosures. Access to group or peer support processes was seen as another potentially valuable resource. However, participants also recognised that group settings might be too overwhelming for some parents experiencing complex trauma, and support groups would need to carefully consider group dynamics, safety, and gender needs and diversity.

Service collaboration was identified as important, with an underlying sentiment being that perinatal care was about much *'more than just the birth'*. Services should let parents know about the types of supports available *'focusing on care goals rather than [just] direct questions'* (for example, building resilience, connections, parenting skills, life skills, self-care, recovery (Reid et al., 2021b)). Accordingly, service providers need to know what specific types of support are available for parents in their respective communities, including Midwifery Group Practice, Aboriginal Community Controlled Health Organisations and antenatal education. Services must communicate honestly and be clear and up front about their known limitations around service provision.

Another key aspect of high-quality holistic care that participants emphasised was the need for understanding and care. Parents experiencing trauma need more reassurance and services need to be informed about the nature of *'triggers'* or trauma responses. For families with multiple generations of child protection service involvement and children being removed, interactions with these services in and of itself can be stressful, triggering experiences. Service providers need to *'understand the cultural contexts of trauma'*. Participants also suggested that it's important early in care for providers to *'suspend judgement'* and try to avoid tackling things like smoking or other potential behavioural difficulties until they *'understand where the parent is at'*. If parents are reluctant go to hospital for birth or appointments, providers need to be non-judgemental and gently explore concerns with parents.

Element 2: ensuring cultural, social and emotional Safety

Closely linked to high-quality holistic care, the cultural, social and emotional safety needs of families must be prioritised within perinatal assessment and care. *'Cultural ways of doing'* were seen as key to fostering safety, including interacting in ways that involved *'acknowledging the cultural background'* of parents, working with Aboriginal staff to enact *'rituals that help celebrate and build connections'* and promoting Indigenous worldviews and *'both ways'* thinking. Having an Aboriginal and Torres Strait Islander presence and an option of Aboriginal and Torres Strait Islander workers involved in care was viewed as vital, including in providing advice and guidance for non-Indigenous team members. Offering choice and control for parents, including who they want to see where possible, was seen as a key to safety, the *'need to ask parents what makes them feel safe – how do they feel comfortable?'*

Self-awareness was viewed as an essential element of providing safety. Participants described the need *'to be a reflective worker [and understand] you may not be the person that this parent can open up to – [there may be a] need to connect them with someone who will allow the parent to open up'*. Self-reflective practice was emphasised to help providers understand how they might be perceived by the parent, for example with respect to their own physical presence in the room or space. Alternative spaces and contexts were also identified as elements of ensuring safety, *'creating inviting safe physical space'*, such as being *'out on Country'*, or in an *'Aboriginal birthing room'* or having access to outdoor spaces parents can step out to.

Participants highlighted the importance of demonstrating *'our way'* through cultural activities such as weaving, art, smudging, and smoking and cleansing ceremonies. These activities can be used to introduce the parent to new spaces and/or start a conversation. Children and extended kin need to be welcomed in an inviting space, including a place for children to play.

Element 3: parent empowerment, choice and control

Participants emphasised the importance of options and the need for '*giving choice – empowering, planning and pacing what happens*' in any assessment for complex trauma. Parents need to know that '*they don't have to talk, that they have a choice of who to talk to, a choice of who can be in the room*'. Participants were clear that it needs to be the parent's choice to participate in any assessment for complex trauma, and that they can choose not to continue participating at any time. Service providers need to approach parents with an understanding that traumatic events and impacts of complex trauma are not uncommon, and that this is not a deficit. Parents can be offered indirect support, including information packs about trauma, healing, resilience and recovery, so that awareness and potential self-identification may be possible, with a view to having more direct discussions when relationships have developed and it feels safer for the parent.

Element 4: flexible, tailored, person-centred approach

Aligning discussions about empowerment and control, participants emphasised the need for flexible, tailored, person-centred approaches to assessment for complex trauma. In some circumstances, offering assessment might not be appropriate. Participants highlighted the need for providers to first learn about the parent's unique circumstances. Depending on the type of relationship and level of trust established, examples of questions could include: '*Who's your mob/where are you from?', 'How are you feeling about this pregnancy?' and 'You're back, how are you feeling?*' Finding common ground from previous conversations and talking about things that are real for the parent in the here-and-now were seen as positive ways to establish connection. Participants thought that parents need to be recognised as leaders in their care, and service providers need to be '*flexible on clinical judgement*' and '*ask permission to talk about difficult stuff, giving [the parent] the power to say 'no', but also emphasizing why you feel they need to talk about it and encourage them*'.

Participants' ideas relating to flexibility focussed on issues around physical access to care, such as transport assistance, having 'open-door' policies (e.g. offering an option of being able to walk-in without an appointment even if parents may need to wait, and accessing some level of support without the need for formal referrals), and opportunities such as making '*connections [while driving] in the car*'. Participants discussed the potential different formats for assessment, asking whether assessments always needed to look like a document, and whether formats such as iPads or apps were accessible. They also identified that assessment specific to complex trauma could be dispersed through a framework of assessing parent support needs, general wellbeing and strengths. The need to recognise non-verbal communication and behaviours was also highlighted.

Timing was identified as a critical issue for assessment. Participants noted the challenges of standard GP 10-minute appointment times, and the impossibility of approaching complex trauma-related difficulties within such a time frame. Accordingly, participants emphasised that there is '*no need to know specifics immediately, and assessment should not be offered at the first visit, [rather] consider down the track*'. Assessment and discussions about complex trauma need to be gradual.

Element 5: conversations held from a foundation of trusting relationships

Participants emphasised the need for any assessment to come from a foundation of trusting relationships. As one participant noted, '*assessment cannot be safely conducted in a system where a parent sees a different person each week*'. Complex trauma assessment within perinatal care has to be based on building the relationship first and '*ensuring continuity of carer*' during pregnancy, birth and postnatally. This may also require involving carers who have developed a relationship over a longer time, such as GP shared care and Aboriginal Health workers. A good place to start is for health professionals to '*explain who they are to build a sense of relatedness*' and take time to '*hear parents stories*' to build rapport. Participants suggested that it is important to start with something that interested parents and make the time each week to build the relationship. Parents need to feel safe to attend and feel positively about themselves. A range of helpful communication strategies identified by participants included: having positive things to say (e.g. '*it's great to see you each week*' and '*we love having you and your little bub with us*'); using strategies such as reassuring and explaining what to expect or not to expect; connecting and building trust by sharing a little about one's self (reciprocity).

Element 6: wise, sensitive communication and enquiry skills

Participants highlighted the need for wise, sensitive communication skills for talking about complex trauma. Strategies include acknowledging trauma, *'as even acknowledgement is therapeutic'*. Participants recommended sensitive enquiry, which includes careful and reflective use of language, such as speaking on an appropriate level without jargon, being comfortable with waiting and silence, reading body language and responding appropriately, and giving the person a safe entry and exit.

Participants outlined a range of cultural forms of communication for talking with parents that were less direct, such as yarning, *dadirri* (deep listening) and story-telling. Creative strategies, including tying into local stories related to nature, use of analogies like rivers and rocks (for example) and use of narrative approaches rather than directly asking about trauma. Participants emphasised that competent clinical practice, training and experience was necessary to hear what is not explicitly said. As one participant noted, *'clients often don't have language around trauma and may be getting through day to day in survival mode'*. Another participant added that there is the need to *'be open about clues that have taken you around the story… Deep listening (dadirri)… observing what's not being said – body language. Tuning in, active listening. Be aware of triggering – [you] may recognise something they aren't aware of – try not to trigger this by saying the wrong thing. [They] might not be comfortable or have experienced a positive relationship before'*.

Participants outlined the need for clear communication and expectations including what the parent can expect, what the worker will and will not do, having boundaries and not breaking expectations. The need for honest conversation was emphasised, including having discussions about what will happen if complex trauma is recognised (or not recognised), and knowing when to have the difficult conversations, including fears parents may have about harming their child.

Participants observed that parents process and perceive trauma differently. Meaning-making was viewed as a good starting point of engagement, with initial discussions that focussed on the baby. One participant stated that *'birth stories are important and can reveal a lot and are not intrusive… Talk about the child, 'how's things going? How's the little fella', ask how they are travelling as a family. Let the conversation start and stop as they need'*.

Wise communication was viewed as being strengths-based and could be used to help normalise trauma responses rather than taking a pathologising perspective. Celebrating the positives was also seen to be important, for example *'celebrate him being there as a good Dad'* and talk about *'bringing up great kids'*. Participants emphasised the need to remember the men, and to make sure they were nurtured as well as the mothers. Finally, *'Educaring'* – the process of using conversations to help educate parents about trauma – was proposed as a helpful, indirect strategy for talking about trauma.

DISCUSSION

In this Healing the Past by Nurturing the Future project co-design workshop, 38 predominantly Aboriginal and Torres Strait Islander key stakeholders explored how parents experiencing complex trauma-related distress could be recognised safely during perinatal care. Thematic analysis revealed six interconnected and integral 'elements' or principals of practice deemed essential for this to occur: high-quality holistic care; cultural, social and emotional safety; empowerment, choice and control; flexible, tailored, person-centred approaches; foundations of trusting relationships; and using wise and sensitive communication and enquiry skills. Participants and scenarios discussed represented a range of health professions and settings, yet there was a consistent emphasis on the risks involved for Aboriginal and Torres Strait Islander parents within perinatal care systems. These concerns were similar to those reported in previous workshops (Chamberlain et al., 2020).

Strengths of this study include the Aboriginal and Torres Strait Islander leadership ensuring cultural integrity of the research and the authenticity and quality of data collection and analysis. There are also limitations to acknowledge. While the total of 38 participants was optimal to ensure group safety and reach saturation of the themes, we recognise findings cannot represent the diversity of perspectives among Aboriginal and Torres Strait Islander communities countrywide. The small number of men and non-binary gender parents who participated in these discussions is also a significant limitation. While we were committed to provide interpreters if required to enable participation for community members whose first language is not English, all participants spoke English as a first language.

Implications for practice, policy and research

There is an urgent need to scale-up implementation of culturally safe continuity of care for Aboriginal and Torres Strait Islander parents. Perinatal care services are uniquely positioned to safely offer support for Aboriginal and Torres Strait

Islander parents experiencing complex trauma, with potential to draw on culturally grounded, strengths-based relational principles that foster attachment and nurturing (Piccini, 2021). It is time for a renaissance within perinatal care that recognises Aboriginal and Torres Strait Islander wisdom generated in fostering social and emotional wellbeing for over 2000 generations (Marriott & Chamberlain, 2019). Birthing on Country and Continuity of Carer models for Aboriginal and Torres Strait Islander parents have provided the strongest evidence yet for improving health outcomes, including 38 per cent reductions in preterm births, increased breastfeeding, increased antenatal engagement and families staying together (Kildea et al., 2021).

Perinatal care services need to consider concepts of 'safety' and how services are experienced. The primary aim for trauma-informed care is to foster a sense of safety – that is, to help providers to think *'What can I do to help parents feel safe?'* However, many Aboriginal and Torres Strait Islander parents do not feel safe seeking care for pregnancy, birth and early parenting (Marriott et al., 2019). Concerns include experiencing racism and discrimination, and notably, the omnipresent threat of child protection notification and involvement and removal of infants after birth. Participants in this study were clear that the escalating rates of Aboriginal and Torres Strait Islander children in out-of-home care was never far from the minds of parents. Further, the 'language of trauma' itself can cause anxiety, and we need to positively reframe this negative language to foster the aspirations, hopes and dreams of parents for a 'fresh start' and new life with their baby (Chamberlain et al., 2019b; Chamberlain et al., 2021).

These findings raise important cautions with respect to national perinatal screening guidelines (Austin et al., 2017; Department of Health, 2020), which currently include direct questions about parents' experiences of childhood abuse or maltreatment. In settings that lack the key elements outlined in this paper (i.e. cultural safety and responsiveness, and established, trusting relationships), direct screening questions can potentially represent a danger or threat of child removal, rather than possibilities of support. Frequently there will be a reticence and caution to answer such questions. Furthermore, we are unaware of evidence that asking Aboriginal and Torres Strait Islander parents screening questions of this nature leads to effective responses, the pre-requisite for widespread, public health screening. Conversely, such experiences may lead to avoidance or disengagement from antenatal care or other important services by those most likely to benefit. Further work is required to develop and evaluate appropriate assessment and support strategies for parents experiencing complex trauma. Developing understandings of how to translate and implement the key elements of care identified in this paper, in perinatal and child protection settings, is one way forward to developing these safely.

One critical area for reform is that of 'mandatory reporting'. Perinatal care services need to be able to address the social and emotional needs of parents without 'referring out' to child protection services unless there is a legitimate concern about child safety. Perinatal care services include a network of highly skilled professionals that routinely address complex physical risks and healthcare needs and are more than capable of providing high-quality emotional support and addressing social issues such as housing. Involving child protection services can often be a barrier to enabling support (Langton et al., 2020) and is not 'risk free', despite 'risk' being a key factor in mandatory reporting policies. It can trigger fear and trauma responses, and subsequent behaviours that may be misunderstood, and assessments are often not culturally safe and responsive. In the absence of effective and timely child and family supports, prenatal reports can have the effect of transferring the risk from the system and provider to the family who may be subject to unwarranted and intrusive intervention. For example, Davis (2019) noted outdated and inadequate prenatal reporting policies, coupled with insufficient engagement with and support of families contributed to unwarranted removals, with growing recognition of the lifelong and intergenerational harms of such interventions (Davis, 2019). We propose an alternative 'wise counsel' model of care as one way forward for parents identified as 'at risk' – reframing support as a therapeutic model of care rather than 'risk management'. This approach is similar to a 'therapeutic justice model of care' (Marsh et al., 2019), and includes high-level expertise and cultural leadership, drawing on practices used in perinatal care for millennia (Chamberlain et al., 2015).

Decision-making processes need to be transparent and subject to review and evaluation to generate rigorous knowledge about the most effective strategies for supporting families with complex social and emotional needs. The key elements of care outlined in this paper help form the basis for re-thinking how those working in the perinatal and child protection space can meet families in ways more likely to nurture wellbeing. These findings and the proposals for reform are closely aligned with and support those advocated by the SNAICC Family Matters campaign, including the 'Building Blocks' (SNAICC, 2016) and the Aboriginal and Torres Strait Islander Child Placement Principles (SNAICC, 2017).

Finally, there is an urgent need for more community-based participatory action research to implement and evaluate the safety and effectiveness of perinatal approaches to support Aboriginal and Torres Strait Islander parents experiencing complex trauma. Once work has been done to establish the safety and the effectiveness and feasibility of recognition and support strategies, research to generate stronger health outcome measures may be feasible. Safe processes of recognition should be positioned within adequately resourced, self-determined Aboriginal and Torres Strait Islander holistic child and family service systems, as part of a long-term, generational strategy to reimagine and transform supports and services so that Aboriginal and Torres Strait Islander children and families can thrive.

CONCLUSION

The perinatal period presents unique opportunities to identify and offer support for Aboriginal and Torres Strait Islander parents experiencing complex trauma. Within the context of a culturally safe and responsive system, there are a range of important elements that could help to ensure benefits outweigh the risks of assessment for complex trauma among Aboriginal and Torres Strait Islander parents. These include high-quality holistic care; cultural, social and emotional safety; empowerment, choice and control; flexible, tailored, person-centred approaches; foundations of trusting relationships; and using wise, sensitive communication and enquiry skills. There is an urgent need for reform to ensure a safe and culturally responsive perinatal care system, based on innovative community-led solutions for Aboriginal and Torres Strait Islander parents that can be developed, implemented and evaluated.

ETHICS STATEMENT

Ethical procedures for this workshop were approved by the St Vincent's Hospital Melbourne Human Research Ethics Committee (HREC, App. No. 50428, 023/19).

CONFLICT OF INTEREST

The authors declare they have no conflicts of interest.

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