Developing a culturally responsive trauma-informed public health emergency response framework for First Nations families and communities during COVID-19: Workshop Report

Key stakeholder co-design online workshop

14th and 15th October 2021

* There are many diverse populations in Australia. The term 'First Nations' is used throughout this report to be respectful and inclusive of all Aboriginal and Torres Strait Islander peoples. We have chosen to use the term First Nations as this was proffered by the Aboriginal and Torres Strait Islander led committee which has funded this research. The only exceptions to this are where an entity have specified the use of 'Aboriginal' or 'Aboriginal and Torres Strait Islander' 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 do not identify as Aboriginal and/or Torres Strait Islander.

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Executive Summary

Background

This workshop was conducted under the auspices of the Healing the Past by Nurturing the Future (HPNF) project, which aims to develop and implement culturally responsive, trauma-integrated perinatal care for First Nations parents experiencing complex trauma. The impact of the Coronavirus Disease 2019 (COVID-19) pandemic on families and communities has highlighted the need to develop trauma-informed public health approaches for use in public health emergency settings. Thus, the HPNF project extended its focus to support the development of a culturally-responsive trauma-informed public health emergency framework for First Nations communities.

Aim

The aim of this two-day workshop was to share findings from a rapid review of trauma-informed public health emergency approaches and findings regarding First Nations experiences during COVID-19 from HPNF and other studies to develop a culturally responsive trauma-informed public health emergency framework for First Nations communities.

Participants

Due to the COVID-19 pandemic and associated government restrictions in Australia, the workshop was held virtually via the videoconferencing program, Zoom. Thirty-six service providers, academics and community members from 18 institutions across Australia attended Day One of the workshop, with 83% returning for Day Two.

Workshop overview

Dr Michelle Kennedy (Wiradjuri) facilitated the workshop. Four guiding principles were adopted to foster a safe space for engagement (confidentiality, being respectful, being brave, and being kind). Dr Kennedy shared these principles with participants at the start of the workshop. While participants engaged in discussions throughout the workshop, they were reminded that they would not be asked to share personal experiences. Day 1 also commenced with a Dadirri meditation facilitated by Dr Carlie Atkinson. Graphic facilitator Rhys Paddick captured key points raised throughout the workshop in visual format (Figures 1 and 2).

Day One

- Short summary of the HPNF project and background to this workshop provided by Professor (Prof) Cath Chamberlain.
- Dadirri meditation facilitated by Dr Carlie Atkinson.

- Findings from current research on First Nations communities' experiences of COVID-19 presented:
    - Key components of a trauma response framework for First Nations communities, and experiences of responding to COVID-19 in remote communities.
    - The impact of COVID-19 on Stolen Generation survivors.
    - Experiences of First Nations people during COVID-19 in relation to: COVID-19 prevention, access to health and other care support, impact on family and community relationships, and vaccines.
    - The health and wellbeing experiences of First Nations people living in Victoria during the COVID-19 pandemic response.
    - Qualitative and quantitative data reporting on First Nations parents' experiences of the COVID-19 pandemic.
- Breakout room discussions reflected on the content of the presentations and discussed key components of a culturally responsive trauma-informed public health emergency framework.
- Participants' ideas were shared on the online platform "Poll Everywhere" and reflected in real time using a word cloud.
- Participants voted on relative importance of framework components from the presented research and subsequent breakout room discussions, and were also given the opportunity to add additional components.
- Components were ranked in order of importance. Connections between components and relevant considerations were discussed.
- Current challenges facing First Nations communities were discussed, including vaccine hesitancy, lack of trust in governments and medical institutions, and the related spread of misinformation.
- Summary of lessons learned and the key components of a culturally responsive trauma-informed response were reflected on at the end of the day.

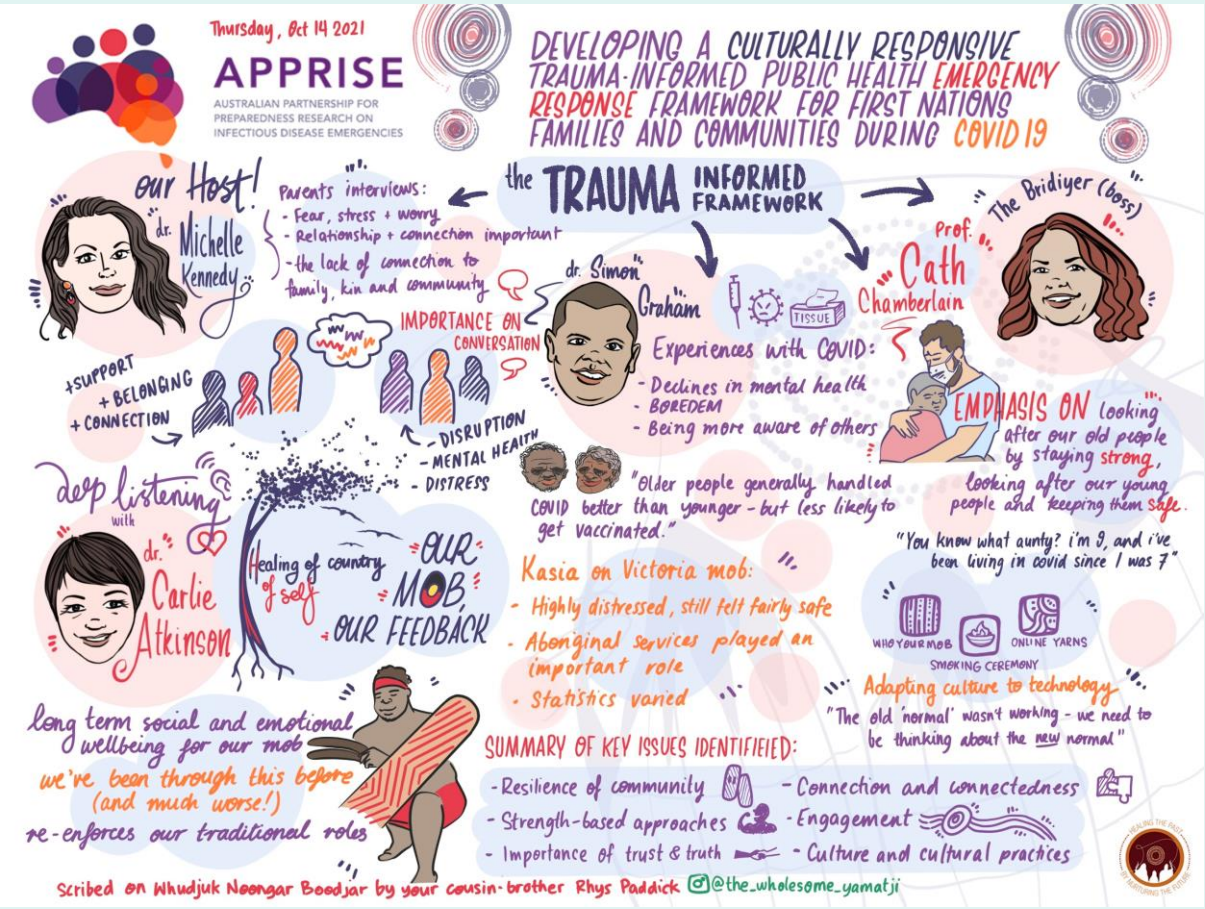

Figure 1. Key messages of Day One presented in graphic form

Day Two

- Summary of key themes that emerged from discussions on Day One.
- Dr Christina Heris presented the results of a systematic review of studies identifying key features for a trauma-informed public health emergency framework. Components identified in the literature as necessary in the establishment of a culturally responsive, trauma-informed public health emergency response included: *safety, trustworthiness and transparency, connectedness and collaboration, empowerment, cultural safety and responsiveness, holistic support, compassion and caring, leadership* and *communication.*
- Breakout room discussions reflected on review findings and previous days' discussions to identify additional framework components.
- Framework components identified in the review were collated along with the additional components identified by participants on Day One and presented for further discussion and suggestions.

- The main components considered by participants to be important for a culturally responsive trauma-informed emergency response framework for First Nations people were:
    - *strength-based approaches*
    - *enabling communities*
    - *leadership*
    - *empowerment*
    - *trust*
    - *engagement*
    - *connectedness*
    - *trauma-informed approaches*
    - *culture and cultural practices*
    - *grief and funeral practices*
    - *physical approaches*
    - *Aboriginal context*
    - *access to services/support*
    - *social support*
    - *equity/systemic biases*
    - *social and emotional wellbeing*
    - *safety and security*
    - *messages and information*
    - *diversity of sub-group needs*

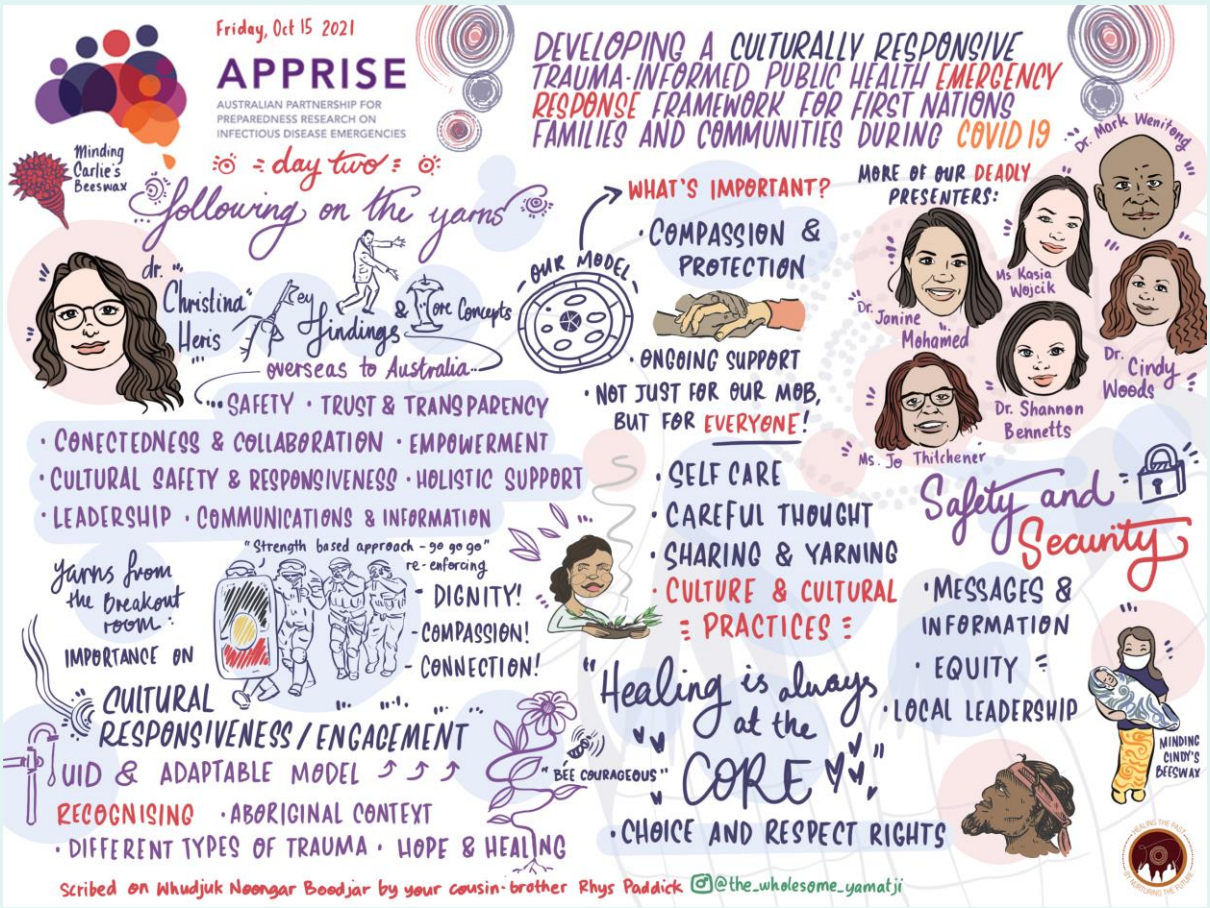

Figure 2. Key messages of Day Two presented in graphic form

Evaluation

Twenty-two of the 36 workshop participants responded to the online evaluation forms, giving a response rate of 61.1%.

Positive feedback about the workshop

- The large majority (91%) of respondents reported that the workshop was useful and informative, and that knowledge generated in the workshop will help First Nations communities. Many respondents also mentioned that they felt safe participating in the workshop.

Areas of improvement

- Two respondents (9%) felt that the discussions were not accessible for everyone, particularly large group discussions.
- Five respondents (23%) thought that the workshop would have been better in person.

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Day One

1. Acknowledgement to Country

To open the workshop, Dr Michelle Kennedy acknowledged all the Lands from which people were connecting. Participants were encouraged to use the chat function to acknowledge the Lands they were on. Dr Kennedy welcomed two of her jarjums (children) who have connections to both Wiradjuri country in New South Wales and Wurundjeri in Victoria to offer the group an acknowledgement of country in their local Awabakal language.

Dr Kennedy then acknowledged the First Nations communities who have been (and continue to be) impacted by COVID-19, including those people who have lost their lives due to this pandemic. The group held a moment's silence to acknowledge those people who have lost their lives.

2. Creating a Safe Space

Prior to the workshop, participants were emailed a workshop program (Appendix 1) trauma response factsheet (developed by WeAl-li) and information for psychological support, including the mobile number of a psychologist . Participants were informed that they could contact the psychologist at any time during the workshop for immediate support, particularly if any discussions raised issues for them. Additionally, participants were sent a pack with some diversionary activities, including mindfulness colouring/drawing and modelling beeswax. They were encouraged to use these throughout the workshop to help self-regulation.

Dr Michelle Kennedy shared with participants the guiding principles outlined below, to foster a safe space for engagement.

- Confidentiality – to ensure that participants felt comfortable to speak freely, and that content discussed was not to be shared outside the workshop.
- Be respectful – recognition and acknowledgement that there are different ways of doing things and that everyone is learning from each other. Participants were asked to avoid interrupting and encouraged to speak briefly.
- Be brave – participants were encouraged to share their thoughts and feelings to facilitate learning.

- Be kind – it was acknowledged that within the context of the pandemic, people are working harder than ever, under difficult circumstances, and are experiencing personal impacts. The importance of care for each other at times like this was highlighted.

Participants were encouraged to keep their Zoom cameras on as much as possible and to use reactions and the chat function. It was reiterated that people will not be asked or expected to share personal experiences (this was not the purpose of the workshop). Participants were also informed that they could leave at any time if they felt uncomfortable.

3. Introduction and Aims of the Project

Prof. Chamberlain provided a summary of the HPNF project and outlined the aims of the APPRISE CRE project:

- This project is being conducted under the auspices of the HPNF project which aims to co-design and implement perinatal awareness, recognition, assessment, and support strategies for First Nations parents experiencing complex trauma. The principle underpinning the project recognises that whilst pregnancy and birth can be a challenging time for parents who have experienced complex trauma, it also provides an opportunity for healing. HPNF is thus focused on culturally responsive, trauma-integrated perinatal care.
- Complex trauma is most commonly associated with a history of adverse childhood experiences/childhood traumas, and has been found to contribute to health inequities (Font & Maguire-Jack, 2016). Complex trauma is distinct from post-traumatic stress disorder (PTSD). PTSD is characterised by avoidance, sense of threat and re-experiencing traumatic events. Complex trauma or complex PTSD encompasses these characteristics in addition to interpersonal disturbances, negative self-concept and affect dysregulation. First Nations communities are particularly impacted by complex trauma following a legacy of historical trauma (Atkinson, 2002), which includes state-sanctioned removal of First Nations children from their families.
- An increasingly strong evidence base suggests that childhood trauma represents an important public health challenge (Sara & Lappin, 2017). However, there is limited research exploring the implications of complex trauma on public health initiatives targeting First Nations communities. Furthermore, the recent impact of COVID-19 on families and communities has highlighted the need to develop trauma-informed approaches for use in public health emergency situations.

The aims of this APPRISE CRE project were to develop a culturally-responsive trauma-informed public health emergency framework for First Nations communities. The objectives were to:

1) Conduct a systematic review of trauma-informed public health emergency responses. Prior to the workshop, participants were emailed a draft of this review and a summary article of the review published in The Conversation *10 Ways We Can Better Respond to the Pandemic in a Trauma-Informed Way*. https://theconversation.com/10-ways-we-can-better-respond-to-the-pandemic-in-a-trauma-informed-way-168486

2) Investigate COVID-19 experiences and complex trauma-related distress among First Nations parents in Victoria, South Australia and the Northern Territory.

3) Convene a key stakeholder workshop to consider the outcomes from (1) and (2) (and other relevant research) and develop a culturally-responsive trauma-informed public health emergency response framework for First Nations communities.

4. 'Connecting to Country' Grounding Exercise

Dr Carlie Atkinson led the group through a cultural grounding exercise. Initially the group watched a video of Dadirri, or deep inner listening, produced by Aunty Miriam-Rose Ungunmerr. Dr Atkinson then guided the group through a short connecting to country meditation.

5. Developing a Framework

Overview

Dr Michelle Kennedy provided an overview of the content for Day One of the workshop. Six presenters then shared the findings from current research on First Nations communities' experiences of COVID-19 (subsection 5.1). Upon completion of these presentations, participants were allocated to breakout rooms where they reflected on what components should be included in a culturally responsive trauma-informed public health emergency framework (subsection 5.2).

The online platform Poll Everywhere was used to capture participants' thoughts about the key features of the framework. Throughout the presentations and breakout room discussions, participants were asked to contribute single word or short text responses that were collated in real time to a word cloud.

5.1. Understanding First Nations Communities' Experiences of COVID-19

5.1.1 Community experiences of COVID-19

Dr Mark Wenitong from the Lowitja Institute described key components of a trauma response framework for First Nations communities, and shared experiences of responding to COVID-19 in remote communities.

Key Reflections

- Identify local First Nations leaders early and support them to lead throughout the response.
- Understand the context. There is often long-term poor infrastructure investment in most aspects of First Nations communities, which undermines any acute and any long-term responses needed.
- Understand that there are multiple complex layers of both personal and historical trauma underlying any acute needs.
- Ensure health and disaster expertise is supported by community experience and knowledge and practically apply this.
- Ensure that long term as well as acute gaps are documented.
- Ensure a social and emotional wellbeing approach is developed and applied, as well as acute mental health approaches.
- Use strength-based approaches.
- Utilise cultural processes to inform approaches, for example, including traditional healers, and smoking ceremonies.
- Empower First Nations staff to practice the right way, culturally.
- Identify and utilise grassroots community members such as youth leaders and Elders.
- Understand that while mental health services and everyone else will be focused on high priority targets, individuals in the broader community may be isolated and in need of support. An understanding of how to stratify risk is needed.
- Develop a whole-population, social and emotional wellbeing, mental health and psycho-educational approach, which includes everything (multimedia, radio, social media, etc) and ensure continuity of these services.
- Continue supporting a long-term strategic approach with the local Mob.
- Ensure staff have trauma counselling available for the duration of the response.

Experiences of Responding to COVID-19 in Remote Communities

- There was a lot of fear and anxiety among staff and community members. This was particularly the case in remote communities where individuals felt extremely isolated. People thought that they weren't going to get any support, and that the government was going to 'leave them to die'.
- Effort was made early to understand the cultural context. One approach involved utilising examples of past trauma and highlighting strengths and resilience of First Nations communities: 'hey look, our Mob survived smallpox epidemics, at the same time we were being shot and poisoned, we're going to survive this as well.' These kinds of approaches received strong positive feedback.
- It was important to try and incorporate cultural approaches into the responses. This involved reminding people of their cultural roles. For example, younger people taking initiative and shopping for Elders who might be concerned about getting infected with COVID-19.
- It was important to understand how people actually live and work on Country, particularly in remote communities.
- Recognising that First Nations people have experienced layers of trauma is critical to any response.
- It is important to find ways of helping people reduce their stress levels to prevent the development of trauma-induced stress.
- There are often fewer social and emotional well-being services available and/or accessible during emergency periods. It is thus important to ensure that people have someone to talk to.
- Women may potentially experience domestic violence. Requirements to isolate at home, and difficulty for those with substance use issues to access usual supplies and the associated frustration and irritability, are important contributing factors.
- Many First Nations community members wanted the Biosecurity Act enacted to protect their own communities. However, other community members felt as though this was like being back 'under the Act' where their rights were denied. How those issues are addressed is important as additional layers of trauma can be added. Mostly this was done in small communities by going door-to-door are asking whether individuals wished to vote to close the community through the Biosecurity Act. Mayors followed through with this.
- There are special contexts that need to be considered, such as prisons. People in prisons experience isolation, high levels of stress, and are exposed to violence.

- Some work has been done comparing peak cortisol samples of Indigenous tertiary students with non-Indigenous students (mean age 24yrs) (Berger et al., 2017). Findings demonstrated a flattened cortisol awakening response of Indigenous students when compared to non-Indigenous. Evidence suggests that cortisol dysregulation is associated with adverse health outcomes (Berger et al., 2017)
- The role of Elders is extremely important, especially during major events. For example, during one event that involved the death of children, Elders just came and sat in the community hub. This was very effective at making adults and children feel reassured. Elders are often undervalued in those kinds of situations.

5.1.2 Impacts on Stolen Generations Survivors

Jo Thitchener from The Healing Foundation presented findings from research exploring the impact of COVID-19 on Stolen Generation survivors.

This research was part of The Healing Foundation's COVID-19 Resilience project, funded by the National Indigenous Australians Agency which provided funding for 19 Stolen Generations organisations across Australia to deliver projects aimed at supporting survivors during the pandemic.

Data was collected via an online survey completed by Stolen Generation survivors and from seven virtual yarning circles hosted by The Healing Foundation, that included survivors from across Australia.

Key findings

- Many survivors reported that they experienced a retriggering of trauma responses.

> *"This feels like being back in Kinchela, except it's worse this time, without our brothers."* (Stolen Generations survivor).

- More than 90% of survivors experienced stress in important relationships (Figure 3).
- It was difficult for many people, in particular, those living in regional locations, to access practical supports offered by Stolen Generations organisations.
- Seventy five percent of survivors reported a decline in their mental health and wellbeing, 60% experienced a decline in their physical health, 66% reported a decline in their ability to cope with stress, and 50% were worried about access to hospital and medical services.

- More than 70% of survivors reported feeling ‘trapped in their own thoughts’, while over 90% reported an increased sense of isolation.
- Over 90% of survivors reported feeling disconnected from their family, community, and culture.

Figure 3. Stolen Generations survivors’ experiences of the impact of COVID-19

- Grief and Sorry business were key themes that emerged from the yarning circles. Border closures prevented people from going back to country and being there in-person to support family and community. Restrictions on the number of people permitted to attend funerals was reported to have been very challenging for families and caused sadness. Survivors spoke of the surreal nature of virtual funerals, and of a need to develop more culturally appropriate ways of grieving virtually.
- It was challenging for some Stolen Generations survivors to understand why they had to stay at home, particularly in the early stages. Mixed messaging regarding restrictions was (and continues to be) confusing for many.
- There were some examples of how “Zoom rooms” were done well, including the incorporation of Smoking Ceremonies that were being shared across

screens, accessing bush medicine, meditation in language, and sharing visuals such as backdrops from Country.

- Stolen Generations organisations spoke about vulnerable individuals becoming even more vulnerable. Survivors expressed concerns of Elder abuse and financial abuse. There were concerns expressed about the economic disadvantage that was prevalent before COVID-19, and the implications when financial support and funding stops. Cultural safety and supporting the social and emotional wellbeing needs of community members were also considered to be of significant importance.
- Elders and communities acknowledged of the strength and resilience of First Nations people. Connection to Country, land, family, kinship, spirit, and lore were recognised as protective factors.
- COVID-19 was described to have negatively impacted, delayed, or stalled the healing journey for 87% of survivors and descendants.
- All the survivors reported that care packages provided by organisations were helpful, and 62% said they were “massively helpful”.
- Suggested improvements included more arts supplies and more "culture stuff" for example, opportunities to connect with language, music, native food recipes, Dreamtime story books and activities.
- The concept of a ‘new normal’ emerged from the yarning circles – with members expressing that the ‘old normal’ wasn’t working, a ‘new normal’ needs to be considered. There were also reflections on reframing the narrative from a deficit to a strengths-based perspective and celebrating culture at the heart of everything.

5.1.3 Perspectives of First Nations People Living in Western Sydney

Dr Simon Graham from the Peter Doherty Institute presented findings from an Australian Research Council (ARC) Linkage grant funded project; ‘*Rapid qualitative assessment of COVID-19 health needs in urban Aboriginal communities in NSW*’. The project aimed to provide evidence to support community and other responses to COVID-19, using strengths-based research approaches.

Key findings

Interviews with 35 participants were undertaken on Dharug Country (Greater Western Sydney) in February and March 2021. Interviews explored First Nations peoples experiences of COVID-19 in relation to: COVID-19 prevention, restrictions, access to health and other care support, impact on family and community relationships, and vaccines.

At the time of the interviews, an outbreak in western Sydney was ongoing and stories of blood clots from the Astra Zeneca vaccine had not been reported yet.

1. Experiences of COVID-19

- Participants reported that COVID-19 restrictions, especially staying home and physical distancing, were negatively affecting their relationships with family, friends, and communities.
- Some participants described 'COVID-19 fatigue' or being tired of keeping up with information about COVID-19 and related restrictions.
- Participants mentioned that the COVID-19 prevention measures of staying home and physical distancing, as well as the impact of an economic downturn, had taken a toll on the mental health of some in the community. This was most often raised by young people.
- A few participants said that staying home more often had improved relationships within families, and that they had made additional efforts to stay in touch with other people through telephone and online communication.

2. Views about COVID-19 vaccines

- People were trying to work their way through the information about vaccines at the time. People were cautious about vaccines due to negative reactions. There was some negative information coming from social media (e.g., stories on Facebook about vaccine side-effects).

3. Expectations to return to 'normal'

- There was a real need to 'go back to normal', in particular with employment.

> *"Yeah, I'm willing to be vaccinated. I think it's important that a lot of people are vaccinated so we can get back to the normality of things. Yeah. So I'm willing to sort of speed that up and do my part". (Male, 30-49yrs)*

4. Distrust in governments and medical institutions

- The theme of distrust in government and medical institutions came up in approximately half of the interviews.

I have heard from a lot of other Aboriginal people though that are a bit wary of the vaccination. And I guess, you know, it's something coming from the government and we're just naturally wary of the government...For myself, like, like I'm gonna get it. I'm not too worried about it. I've had, you know, every other type of vaccination growing up…. but I do know there's a, it's a trust issue. A lot of people don't trust the hospitals or they don't trust the government". (Male, 30-49yrs).

5.1.4 Experiences of the Victorian Aboriginal community

Kasia Wojcik presented findings from research exploring the health and wellbeing experiences of First Nations people living in Victoria during the COVID-19 pandemic.

Participants completed the Measuring Indigenous Communities' Response, Resilience and Recovery to COVID-19 (MICRRR) survey. Data was collected between 8 November 2020 and 14 January 2021. Sixty-seven responses were included for analysis.

Key findings

- Almost half of the participants (48%) were characterised as having high/very high distress (Figure 4).
- While most of the participants (89%) did everything they could to stop the spread of COVID-19, almost half (48%) were worried about themselves or their family members contracting COVID-19.
- Many participants (71%) were unable to attend a funeral in person.

Figure 4. Experiences of the Victorian Aboriginal community as reported on the MICRRR survey.

- Almost half of the participants (48%) reported difficulties in accessing important services.

> *"There have been some positives come out of the COVID-19 pandemic and that's given us time to reflect about what's really important and identifying things that are not so important. Reflecting on our quality of lives and family life-work balance. Caring for our rivers, our Country and the environments and communities we live in. For me Aboriginality, cultural knowledge and Ancestral connections to Country are at the heart of all these things. This is what COVID-19 has reinforced for me more than ever. It's time for our Country and people to heal!"* (Female, 67yrs).

- On average, participants reported feeling at least somewhat socially supported, safe and connected to community.
- Changes in smoking, drinking and exercise varied, with slightly greater increases (35%) than decreases (27%) in smoking frequency and conversely more reductions (40) than increases (32) in alcohol consumption. The most common change in exercise was a reduction (32%).
- Consumption of take away foods (50), sweets and snacks (55%) increased, however home cooked meal consumption (50) also increased.
- First Nations organisations (40%) and family members (18%) were the most frequently reported sources of additional support.
- Community connection was maintained through increased use of digital technology (66%).

5.1.5 Parents' Experiences of COVID-19 – The HPNF APPRISE Project

As part of the HPNF project, parents were asked about their experiences of COVID-19 in the form of open-ended questions and a survey. Interim findings (data collected up until the time of this workshop) are presented below in subsections 5.1.5.1 and 5.1.5.2. Data collection is ongoing.

5.1.5.1 Responses to Open-ended Questions (Qualitative Data)

Dr Michelle Kennedy shared findings from research exploring First Nations parents' experiences of COVID-19.

Qualitative interviews were conducted between **August 2020 and July 2021** with 74 First Nations families in Victoria, South Australia, and Northern Territory. Participants were asked a series of **open-ended questions** exploring their experiences with

COVID-19, in particular, the impact on their social and emotional wellbeing, relationships, and community connection.

Themes

Four key themes emerged from the qualitative data: disruptions due to COVID-19 restrictions, social and emotional wellbeing, relationships and connection, and no effect.

1. Disruptions due to COVID-19 restrictions

- The most commonly reported area of disruption experienced due to COVID-19 was the transition to remote working and learning.
- Working from home was reported to impact parenting capacity due to the need to juggle multiple demands. However, some parents reported benefits of working from home.
- Difficulty in accessing regular medical appointments impacted parent's capacity to care for their children.
- COVID-19 restrictions also impacted women's experiences of accessing antenatal care, planning for pregnancy, and having their partners and families support them during childbirth.

> *"Having a baby during this time was very scary. Having a C-section in hospital without my family, just my partner was hard".* (Participant)

- The most commonly reported impacts of COVID-19 on children reported by parents were on school, sporting and social life.
- With regard to coping with the stress of the pandemic, financial support through the COVID-19 supplement was reported to be helpful by many families. The flexibility of being able to work from home was also valuable.

2. Social and emotional wellbeing

- Social and emotional wellbeing was reported by many participants as having been greatly impacted. The pressures of the uncertainty of the pandemic, in addition to fear, stress and worry, made life difficult for parents.
- The lack of school attendance, working from home and teaching children remotely was reported as having been difficult for many parents. Not having family and kin to help provide care was also reported as difficult.

> *Going from having a shared a collective responsibility to raising our son (aunties and grandparents) to being the only people raising him has been the biggest shift".* (Participant)

- Anxiety, fear and concerns regarding attachment were frequently reported by parents when reflecting on how the pandemic impacted their children.
- Parents reported a range of strategies to support their own social and emotional wellbeing including, artistic outlets, "cultural stuff" and going for walks.

3. Relationships and connection

- While parents reported conflicts with partners, the time at home together as a family was reported as a positive outcome of the pandemic.

> *"To just have my kids at home and realise what's important".* (Participant)

- Overwhelmingly, parents reported challenges with the lack of connection experienced due to COVID-19.
- Parents and grandparents reported challenges in not being present and able to support family, which is in opposition to cultural norms.
- The lack of connection to family, kin and community was a major area of impact on children during COVID-19. Mothers who had babies during COVID-19 reported the lack of connection impacting their children's knowledge and recognition of who their family are.
- A third of parents reported family, parents and community support as being helpful.

4. No effect

- Approximately 19% of parents reported that they weren't affected during the COVID-19 pandemic. Some mothers reported no effect due to being on maternity leave, and families in the Northern Territory reflected on the lack of restrictions and impacts experienced there.
- Thirty nine percent of parents reported no impact on parenting capacity, while 43% indicated that their children experienced no effect from COVID-19, however this was predominately due to the very young age of the children.

Participants were also asked whether there were any specific supports that were or would be helpful for them and their family during the COVID-19 pandemic.

- Participants reported that access to more financial supports would be useful.
- Parents suggested ways to connect with community virtually (e.g. online art classes and cultural courses).
- Several parents reported that the high level of support offered by First Nations Health and community services had been useful.
- While accessing telehealth was challenging, parents were grateful to keep up health care appointments for pregnancy.

5.1.5.2 Responses to Specific Survey Questions (Quantitative Data)

Dr Shannon Bennetts presented quantitative data on First Nations parents' (n = 74) experiences during the COVID-19 pandemic. Data were collected as part of the HPNF project between August 2020 and July 2021 and obtained from the same group of parents that Dr Michelle Kennedy reported on in the previous presentation.

Key findings

<u>Disruptions to parents and families</u>

- At this early stage of the pandemic, few participants or their family members had tested positive for COVID-19 (4%; Figure 5).
- Eight percent of participants and 19% of participants' family members were required to quarantine, due to being a close contact of a person with COVID-19. More than half decided to self-isolate without the direction instruction from authorities.
- Over 70% were unable to attend a funeral of a family member.
- Approximately 50% of participants or their family members had lost their job or had their paid employment hours reduced.

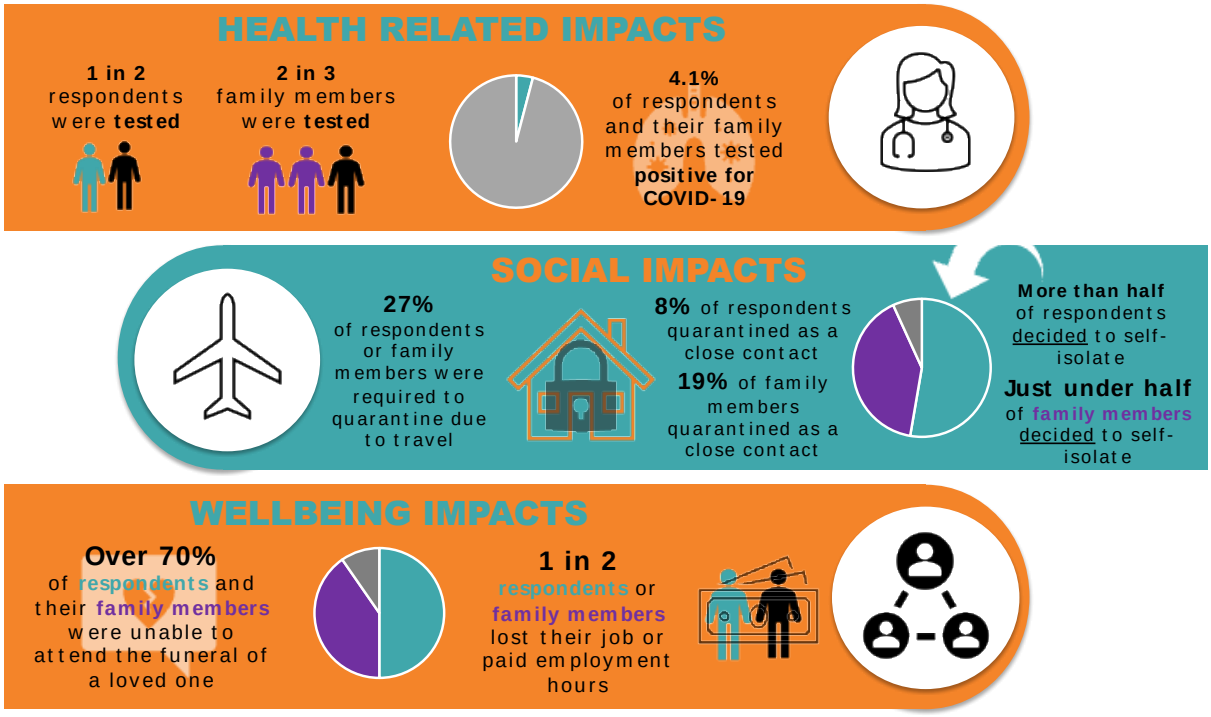

Figure 5. Impact of COVID-19 on First Nations parents

Social and emotional wellbeing

- Participants were asked to reflect on any differences in their social and emotional wellbeing *before* COVID-19, compared to *during* COVID-19.

  - Wellbeing was about the same during COVID-19.

  - Approximately one-third were finding it harder to access support, experienced more racism / inequality, or were concerned about their child's wellbeing.

- Approximately 40% were able to participate in cultural practices, however another 40% were less able to do those things (Figure 6).
- More than 80% felt as though they had a say about important decisions in their lives.
- More than 80% said that they could manage their emotions well at least some of the time.
- Nearly 40% of participants felt as though they were on guard (or on alert) a lot or a fair bit of the time.
- Over 30% reported feeling edgy, jumpy, frightened or nervous.

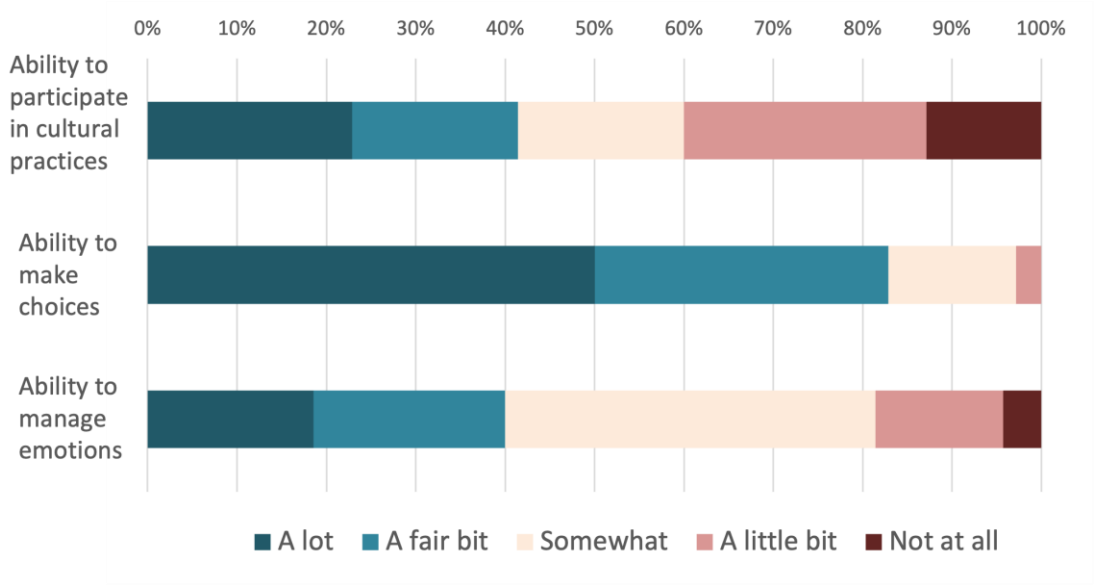

Figure 6. First Nations parents' views on social and emotional wellbeing

Relationships

- Compared to before COVID-19, participants identified some changes in relationships.
    - Maintaining relationships was **harder** during COVID-19 (around 50%)
    - Some had **less trust** in authorities, such as the government (around 40%)
    - Some had **greater trust** in their own communities (around 25%)
    - Some found it harder to care for their child (around 25%)
- Many participants reported that they felt like they belonged to their community (over 50%), supported by friends/mob (over 70%), have family/mob who can assist with their child (over 60%), and their home is a safe place (over 80%).
- Approximately 16% of participants were not feeling connected to their community, and for about 10% relationship difficulties were impacting their ability to function in life.

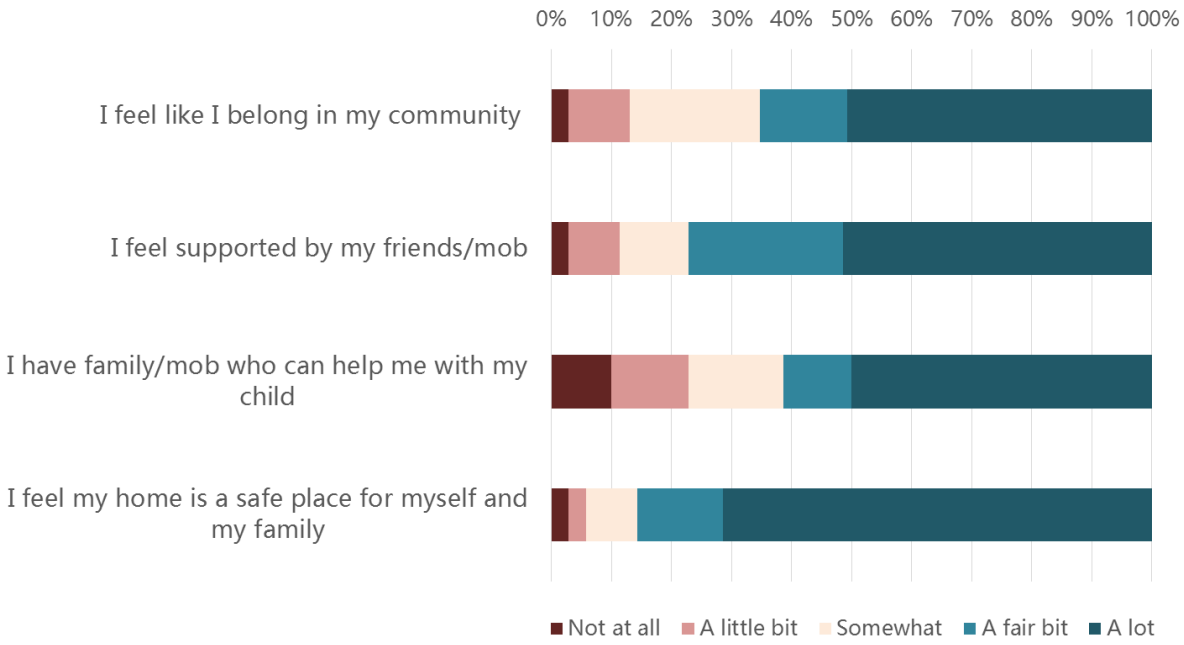

Figure 7. First Nations parents' views on some aspects of relationships

5.2. Individual Group Discussions and Reflections

Workshop participants were randomly allocated to four breakout rooms. There were nine participants in each breakout room. Participants were asked to reflect on the content of the presentations, and discuss what they felt were the most important issues to be considered in designing a public health emergency framework. A workshop team member from each group summarised breakout room discussions for the wider group.

Breakout room discussions were guided by three prompts which asked participants to consider the following in relation to a culturally responsive trauma-informed public health emergency framework for First Nations communities:

1. Reflections from any of the presentations and how these might be relevant for the framework.

2. Reflections about important aspects not covered in the presentations (e.g. drawn from own professional or personal experience).

3. Any additional strategies or factors for consideration not already proposed that participants consider relevant.

Workshop participants identified that there were similar themes emerging across the studies. The following observations were shared by breakout room spokespersons:

- Concern that government restrictions could re-trigger past traumatic experiences for some First Nations people.
- The ability of some people to stay connected to culture, community and family, while others struggled to stay connected was highlighted. This variation in people's experiences may be influenced by location. For example, Melbourne has experienced significantly more time in lockdown compared to other locations in Australia. Spending more time in lockdown may have influenced some people's ability to maintain connections. It was suggested that it would be valuable to consider how the framework might relate to those people and families that did struggle to stay connected.
- Evidence from the studies showed that restrictions and lockdowns had interfered with people's ability to hold a grieving space or allow healing to begin leading to unresolved collective grief. It was noted that in NSW many communities went straight from bushfires to COVID-19, and there just wasn't enough time to grieve. Sorry Business has been continuous, and community still have not overcome the effect of the bushfires.
- The importance of messaging and communication, and how social media was often a source of miscommunication during the pandemic was discussed. In particular, First Nations people living in remote areas may be more likely to obtain their information from social media, and it is important to distinguish and explore informed and misinformed sources within families.
- The importance of framing conversations about vaccination without pointing blame in relation to families who are reluctant to get vaccinated, and the utility of providing simplified information (e.g., a short summary sheet) about how vaccination may mitigate the effects of COVID-19. The importance of consideration regarding where information was being obtained, and the benefit of people obtaining information from their communities was highlighted.
- Lack of information around (and the need for) positive health messaging. It was expressed that there is a need to focus on reframing the narrative. A preventative approach which focuses on how people can stay healthy and in control of their life and health would be more self-determining than a punitive approach outlining repercussions for breaches of lockdown rules.
- Participants reflected on a "new normal" way of doing things, and on how "we can't go back to before, because before was broken, but we can do things better.
- Strength in community in helping people survive. Across the research studies presented, there were consistent messages of survival, strength and endurance, and these traits were supported by a connection to Country, culture and community.
- The importance of community leadership and Eldership, as well as celebrating culture, was evident in the content of the presentations. There is a need for targeted funding in culturally appropriate, community-led prevention programs.

- Difficulty for many women around birthing due to limited support and restrictions on family members attending birth during the pandemic.
- Consideration of the physical components of de-escalating trauma, and the therapeutic benefits of walking, massage, plant medicine and pets.
- A need for recognition that different age groups are affected in different ways, and consideration for the impact on children and adolescents.
- Important to consider ways of supporting people needing palliative care while they are at home.
- Overcrowding, a lack of water supply and sanitation/hand washing facilities can be problems in remote communities.

5.3. Collating Framework Components / Further Discussion and Reflection

Dr Christina Heris collated and presented the key framework components that participants contributed to the word cloud. Participants were encouraged to vote for different components, and to add any additional components. These were subsequently ranked in order of importance. This over-inclusive list of components is presented in **Appendix B**.

The connections between framework components, and other important considerations when developing a framework were discussed in a whole group forum. Key points raised during this discussion included:

- The term ***engagement*** refers to a number of things, including engagement with community and engagement with elders.
- ***Strength-based approaches*** and ***trust*** were the two highest voted components. There is a connection between these two components.
- The component ***leadership*** should refer to ***community leadership*** as leadership comes from ***community***. Culturally there are existing leaders and emerging leaders, and this needs to be put into context.
- The importance of ***trust*** was recognised. However, feedback from the yarning circles with Stolen Generation survivors suggests a lack of trust exists. A feeling of being back under control, and of a sense of being back under the Protection Act was expressed by some community members. There is fear of, and ***mistrust in the government***.
- Redressing historical trauma is necessary if there is to be any ***trust*** in a ***relationship***. For example, governments have not historically had community needs at the forefront of their decision making. This rightfully leads to scepticism.

- It is possible that ***mistrust in the government*** is influenced by what is happening at a given city/town/region of Australia (e.g., types of restrictions, lockdowns, vaccine availability and regulations regarding vaccination).
- ***Community leadership***, ***trust***, and ***reframing the narrative*** can work together to impact government engagement, policy and the deficit narrative.
- It is ***community leadership*** and ***engagement*** that builds ***trust***.
- With regard to vaccination, the importance of ***engagement*** and ***messaging*** needs to be acknowledged. Some of the most important ***messaging*** from community is coming from people such as Kelvin Kong, a trusted First Nations surgeon and Worimi man. His video clips have been extremely powerful. He has also reached out to community and taken the time to yarn with community members about their concerns around COVID-19 vaccination. These community leaders play an incredibly important role in building trust. That ***messaging*** will be taken into consideration if it is coming from a person that people ***trust***.
- It has been sad to see some highly respected ***Elders*** and strong advocates in community get trolled and shamed on social media for coming out with pro vaccination ***messaging***.
- Many people are uncertain about how to (or whether they should) engage in **conversation about vaccination**. However, there have been some constructive conversations about the individual and collective benefit of vaccination. ***Elders*** have spoken about getting through past pandemics. They have reported on their strength and survival, and on how they would not have been able to get through those pandemics without vaccines.
- There is a polarity created when people use words such as ‘anti-vax’ and ‘pro-vax’. This ***terminology/language*** does not include a group of people who may have concerns about, but are not completely against vaccination. Use of this language prevents constructive dialogue and increases the risk of pushing people to polarities. There is a need for a dialogue between people who have opposing views, to try to find a middle ground. It is important to avoid ‘othering’ members of the community as has occurred in the past.
- It was proposed that there may be a ***spectrum of trust***. One end of the spectrum may relate to those people who have a low level of trust in the effectiveness and safety of vaccines. This can be one way of moving away from the ‘othering’ language. It can also allow for constructive thought about why some people’s level of trust is so low.
- It is important (and challenging) to determine how to best facilitate safe and constructive ways of engaging with ***community*** members who are angry or ambivalent. It is also important to identify high quality and reliable First Nations ***information*** sources.

- It is important to consider palliative care as deaths are a COVID-19 related outcome. It is also important to think about choices, preferences, and how to immerse patients in significant ***cultural practices*** and rituals. It is important to recognise that there have been long standing traditions and rituals practiced at end of life that need to be considered during the pandemic, such as returning back to Country. Furthermore, palliative care can be re-traumatising. Therefore, this space also needs to be ***trauma-informed***.
- During the pandemic many children have not seen family members, such as grandparents. It is important to consider ***how we care for children*** during a pandemic. Children and young people have experienced significant developmental milestones while living in a completely different world that is changing at a rapid rate. There have been new developments each week and the future remains uncertain. It is important to think about how to provide stability to young people in a time of such turbulence. Some Elders spoke of using technology such as FaceTime and Zoom for the first time as a means of staying connected with grandchildren.
- During the pandemic, people have missed many significant milestones, such as birthdays and anniversaries. In certain areas, people are unable to connect with their mob. Those things have been particularly challenging and emphasise the importance of ***connection***.

5.4 Reflection on the Day

To conclude Day One of the workshop, Prof. Chamberlain reflected on the key challenges and lessons learnt. Key challenges facing First Nations communities at this important time in the pandemic include vaccine hesitancy, which is exacerbated by the understandable lack of trust in governments and medical institutions, and related spread of misinformation. Many factors were raised throughout the day as important considerations for a trauma-informed response framework and these are summarised in **Figure 8**.

Figure 8. Important factors of a trauma-informed response as reported by workshop participants.

This project, and point in time, during one of the biggest public health challenges in Australian history, presents an important window of opportunity to get things right through the development of a trauma-informed public health emergency response framework that will be critical not only for the current COVID-19 pandemic but also for future public health emergencies. A culturally appropriate public health response would empower communities and, as previous research has shown, assist in effective recovery from the COVID-19 pandemic and other emergency situations.

Rhys Paddick presented a visual representation capturing the key messages of the day through the image shown in **Figure 1**

Day One closed with a 'visit to Country' sitting meditation guided by Dr Carlie Atkinson.

Day Two

6. Acknowledgement to Country

Dr Michelle Kennedy welcomed participants to Day Two of the workshop and acknowledged the land of the Awabakal people (the Land from which she was connecting). She also paid her respects to Elders past, present and emerging, and acknowledged their legacy and leadership in First Nations health. Participants were encouraged to use the Zoom chat function to acknowledge the Land they were on.

7. Recap and Plan for the Day

Prof. Chamberlain during outlined the plan for Day Two of the workshop and highlighted that some clear themes had emerged from the many rich discussions in Day One of the workshop.

8. Findings from a Rapid Review of Trauma-Informed Public Health Emergency Frameworks

Dr Christina Heris presented the findings of a rapid evidence review that aimed to identify important key features of trauma-informed public health emergency frameworks (Heris et al., 2021; Heris et al., 2021, October 8). The research questions underpinning the review were:

1. What are the core conceptual features of a trauma-informed public health emergency approach?
2. What outcomes are reported from application of trauma-informed public health emergency approaches?

A systematic literature search was conducted of relevant databases yielding almost 10,000 articles. After screening these for relevance, 40 studies were included in the review.

Analysis led to the identification of many components recommended in the establishment of a trauma-informed public health emergency response (**Figure 9**):

- *Safety* was acknowledged and the need to prioritise ensuring physical safety from the threat.
- *Trustworthiness and transparency* were identified as having transparent, informative communication can build trust and decrease misinformation.

- *Connectedness and collaboration* were seen as essential concepts, particularly as people need to feel connected and that there is a sense of looking out for each other.
- *Empowerment* (at both a community and individual level) enhances confidence and strength.
- *Cultural responsiveness* is necessary to ensuring that approaches used are safe and appropriate to the local context.
- *Holistic support* is essential to ensuring the promotion of social, emotional, physical, and spiritual wellbeing.
- Demonstrating *compassion* through kindness and caring is beneficial for building resilience.
- *Leadership* needs to be visible as it provides reassurance to community members.
- *Communication* needs to be clear, consistent and minimise distress.

Figure 9. Core components identified in rapid review (Heris et al., 2021)

8.1 Individual Group Discussions and Reflections

Workshop participants discussed the review findings in breakout rooms and again considered any potential additional components considered relevant for the framework under development. Voting from Day One was updated in Poll Everywhere by adding the components identified in the review.

Breakout room discussions were guided by three questions which asked participants to consider:

1. Are there any components identified in the review and conceptual framework that should be added to the list identified on Day One?
2. Are there any components that should to be removed?
3. How can we visually present the key components and their relationships with one another?

Discussion points from each breakout room were shared with the wider group. These included:

- The term ***'cultural responsiveness'*** needs to be discussed and defined, and more clarity is needed around what the framework is being culturally responsive to. Discussion determined that the framework is being culturally responsive to communities and individuals who have experienced trauma. It is thus important to understand trauma and recognise that prior traumatic experiences can exacerbate the impact of COVID-19. There needs to be an acknowledgement of the different traumas that people have experienced, such as intergenerational trauma, systemic racism and lateral violence. It may be valuable to name the three layers of trauma; individual, collective and historical trauma, under the framework diagram.
- Value of ***strength-based approaches***. The importance of empowerment was highlighted. It was discussed that stigma should be avoided and strengths from adversity recognised. Participants suggested that goals should include the opportunity for community advancement, which will give community members a sense of achievement. There may be opportunities for communities to grow and build on existing strengths.
- ***Compassion and protection*** were agreed to be important components for a culturally responsive trauma-informed framework, people need to have compassion for themselves and their families.
- ***Cultural safety and dignity*** were highlighted as core components of the framework.
- Feeling **connected** is of significant importance to First Nations people, and it was agreed that this should be acknowledged in the framework.

- ***Respect***, ***choice*** and **dignity** may also need to be recognised in the framework.
- The importance of ***leadership*** including that leadership may need to be referred to as community or local leadership. It was suggested that there may be differences between leadership and ***Eldership***. The importance of identifying how Elders and young people can support each other, through connecting Elders with young emerging leaders was discussed.
- It was agreed that ***young people*** should be involved in a public health emergency response and have some control and responsibility, as this can help in building their resilience.
- The importance of maintaining ***partnerships*** and investing in ongoing relationships. The need for multilevel responses was highlighted, as well as the importance of agencies and community organisations to work together in emergency responses. For example, ensuring that emergency services communicate with local communities to ensure all community members is spoken for.
- The ***narrative*** used in an emergency response is important, and information should be conveyed in ways that limit fear.
- Different supports should be considered for people of ***different ages***.
- ***Implementation*** will require each framework component to be clearly defined.
- The model needs to be fluid and ***allow for change***.
- ***Healing*** should be an essential outcome of the framework.
- With regard to the actual framework diagram, it was suggested that each component (e.g., leadership) could be linked to its own smaller circle that offers more information about that component.

Many of the components identified in Day One aligned with those identified in the review of international literature, providing confidence in the validity of these findings.

8.2 Developing a Conceptual Framework

Key components identified in Day One were presented on screen as text boxes (**Figure 10**) along with the previously presented visual representation/diagram of the concepts identified in the review (**Figure 9**). A whole group discussion was conducted to discuss how to improve and incorporate the agreed additional important components into the framework figure. Some of the key points raised during this discussion included:

- It may be valuable to have an outer circle of **cultural connectedness**. Cultural safety and humility could also be integrated into that outer circle. The different types of trauma could be placed at the bottom of the diagram. The outer

(encompassing) circle represents what the other components rely on and should include cultural humility, safety, and responsiveness.

- Each key component could **branch out** into its own image/circle where more detailed information is provided.
- Rainbow serpents, knowledge pools or *ganma*, and water/rivers are useful **metaphors** to aid in the visual representation of components and the relationships between components. Water could represent the flexibility, adaptability and fluidity of the model.
- **Eldership and leadership** are two different philosophical ways of working with people. These two components could be separated in the diagram, with each branching off into a separate circle providing additional information.
- **Hope and healing** need to be in the centre for the circle whereby they are held firmly by cultural safety, humility, and responsiveness.
- **Birth and grief** need to be reinforced. Along with individual, collective, and historical trauma, grief could also be depicted at the bottom of the diagram.
- The 'messages' and 'information' components could be replaced with the higher-level theme, 'culturally informed strengths-based communication'. This could be placed in the centre of the circle.
- Human rights, respecting dignity and justice could be combined.
- Equity is an important individual component of the framework.
- Complex trauma can occur in the immediate or distant past. Therefore, it is important to think about the temporal context of this framework.
- There may be a way of recognising the hard work that people do under extremely challenging circumstances. For example, when having to immediately stop a virus outbreak by temporarily shutting down a factory. It is important to support people in these roles.
- Consideration needs to be given to the work required to address the cultural and social inequalities.
- It is important to consider the value of Elders and their cultural knowledge.
- This framework is not just for First Nations people. Others can learn from the information.
- The framework can potentially allow organisations to move from being trauma-informed to being trauma-integrated. This would involve organisations constantly demonstrating the integration of trauma-informed principles in their service provision.
- It is important to consider where the framework sits within policy practice models, and how it might inform policy. The framework could be used at a macro level for planning and for education purposes. It could be educational for

many different people, including policy makers, police officers and health workers.

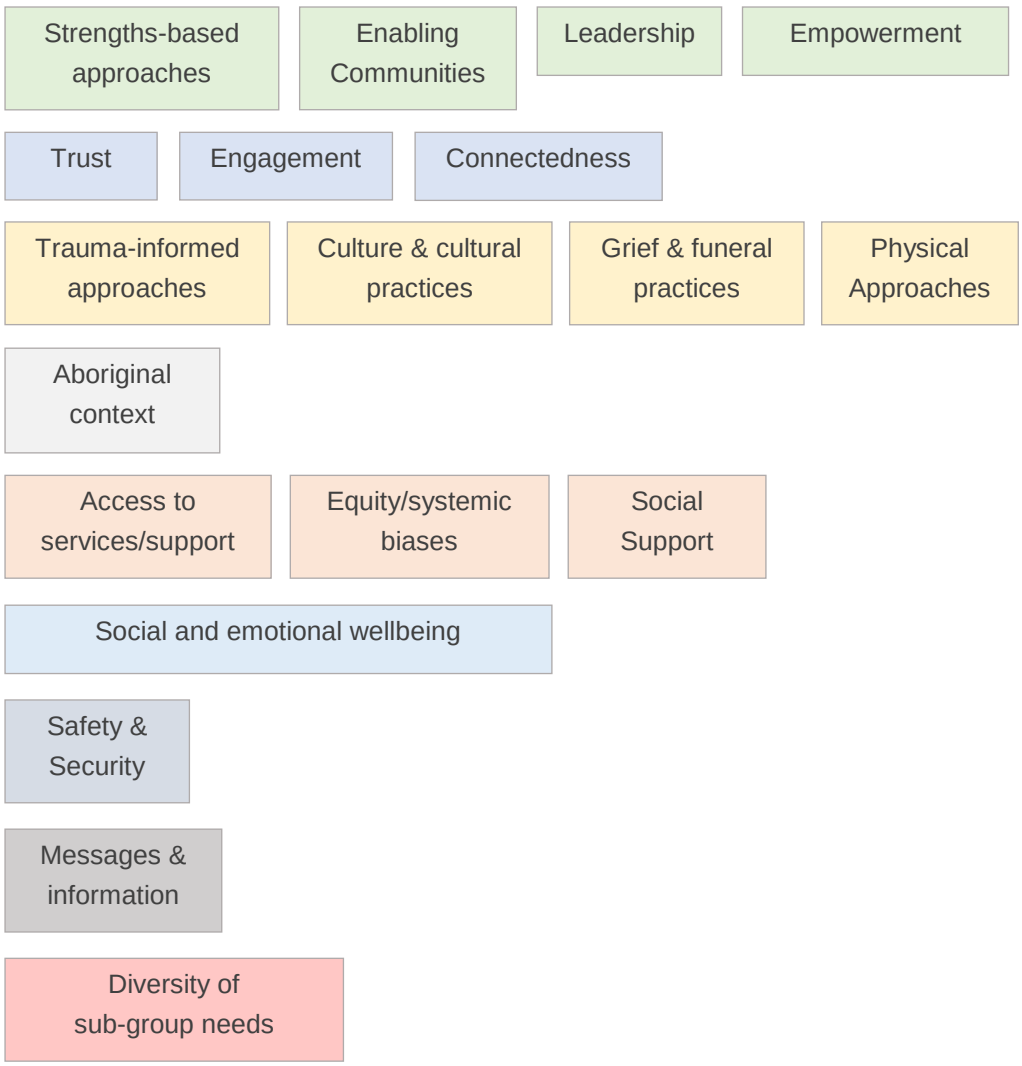

Figure 10. Suggested key components of a culturally responsive trauma-informed public health emergency response framework for First Nations communities generated in the workshop.

9. Next Steps

To conclude the workshop, Prof. Chamberlain outlined the next steps for the project, highlighting the plan to capture the richness of the information presented, including the practical suggestions made by participants, in a report which would be shared in draft form with all participants for approval and feedback, and the preparation of several articles to be submitted for publication. Participants were also invited to contact the team by email or in person regarding any issues that they may have felt they didn't

have a chance to discuss or that may come up, and this message was reinforced in a follow-up email the next day with contact details provided.

10. Summary

The aim of this two-day virtual workshop was to develop a culturally responsive trauma-informed public health emergency framework for First Nations communities. The research findings presented were generated from studies conducted across a variety of populations including: remote First Nations communities, Stolen Generations survivors, First Nations people living in Western Sydney, the Victorian First Nations community, and First Nations parents from the Northern Territory, South Australia, and Victoria.

Important components of a culturally responsive trauma-informed emergency response were extracted from this research evidence, and these concepts were summarised with those developed through a rapid review of the literature on trauma-informed public health emergency responses. The resulting components were discussed and voted upon by workshop participants and a final set of important framework components were agreed.

Key framework components identified were: strengths-based approaches, enabling communities, leadership, empowerment, trust, engagement, connectedness, trauma-informed approaches, culture and cultural practices, grief and funeral practices, physical approaches, Aboriginal context, access to services/support, equity/systemic biases, social support, social and emotional wellbeing, safety and security, messages and information, and diversity of sub-group needs (Figure 10).

Summary of Workshop Evaluation

Evaluation forms were distributed online to all participants following the workshop. Participants were asked to respond to 10 questionnaire items; items 1-7 used a 5-point scale from 1=strongly disagree to 5=strongly agree, and items 8-10 were open ended questions.

Of 36 workshop participants, 22 evaluation responses were received, a response rate of 61%.

Figure 11 shows the responses to individual survey items. Most respondents agreed (23%) or strongly agreed (68%) that the workshop was useful and informative for their work. Similarly, all respondents agreed (23%) or strongly agreed (77%) that the workshop was useful and informative personally. In addition, all participants agreed

(36%) or strongly agreed (64%) that the knowledge generated in the workshop will help First Nations communities.

All respondents felt they could contribute their thoughts and ideas (23% agree, 77% strongly agree), and felt safe participating (14% agree; 86% strongly agree). All participants felt that support was available if needed at the workshop (23% agree; 77% strongly agree).

Figure 11. Responses to individual survey items

<u>Responses to open-ended questions</u>

Is there anything you particularly liked about the workshop?

In total, 19 respondents answered this question. Overall, many participants reported the workshop was well-facilitated, and a safe space for discussion especially in the break-out groups. The welcome packs were very well received, and participants liked the opportunities for self-care in the workshop such as the chocolate, meditation, and

colouring. The involvement of graphic artist Rhys Paddick who illustrated the workshop received positive feedback.

The word cloud below (**Figure 12**) presents the most frequently used words and phrases by participants on the evaluation form, such as discussion, self-care, safe, and facilitator.

Figure 12. Common phrases used by workshop participants

Snapshot of responses:

> *"It was so deep and the conversations were very important to establish a culturally appropriate framework"*
>
> *".. the team have mastered the Zoom environment and managed to create space for really productive discussion."*
>
> *"Lots of space for self-care, nicely paced and very interactive"*

Is there anything you particularly didn't like about the workshop? If so, what could be improved?

Five participants felt that the workshop would have been better in person. Two participants felt that the discussions were not accessible for all participants, particularly large group discussions. A snapshot of responses is provided below.

"Would love more face-to-face interaction"

"I prefer to discuss things in smaller groups so I found the larger group discussion less accessible but overall it was all great."

"I felt that some people were not given a fair voice or turn, difficult when so many strong researchers in the room."

Any other comments or suggestions you would like to make?

Ten participants provided comment for this question. Most responses were positive messages about the importance of the work and thanking workshop organisers. One respondent suggested including the voices of Elders and youth in future.

"Great initiative and such an important piece of work for our communities. Thank you"

"Community consultation is very important in Aboriginal communities, so it would of been great to hear the voices of some of the Elders and youths associated with the organisations present"

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Appendices

Appendix 1: Workshop Program

APPRISE
AUSTRALIAN PARTNERSHIP FOR PREPAREDNESS RESEARCH ON INFECTIOUS DISEASE EMERGENCIES

WORKSHOP PROGRAM

HEALING THE PAST BY NURTURING THE FUTURE

Thursday 14th & Friday 15th October 2021

Developing a culturally responsive trauma-informed public health emergency response framework for First Nations families and communities during COVID-19

Day 1: Thursday 14th October 2021

Informal coffee and chat from 9.45am – Set up zoom background of favourite or Country (and add mob/Country you are on in zoom name)
and 'Aboriginal relaxation' music https://open.spotify.com/playlist/4ajE0iinVDeT1a519nBBSU#login

10:00	**START**	• Acknowledgement to Country • Cultural grounding exercise (Dr Caroline Atkinson) https://www.youtube.com/watch?v=tow2tR_ezL8 (Dadirri 3 mins)	Dr Michelle Kennedy (facilitator) Sharing what doing that is fun or gives joy during pandemic/ share screensaver content Dr Carlie Atkinson
10.20 **(20 mins)**	**Introduction, aims of the project, and purpose of the day** ▪ Why a First Nations trauma-informed public health emergency response framework? Discussion - 10 mins		
10.40 **(10 mins)**	**Creating our safe space and getting to know each other** ▪ Ice breaker Introductions to the group and reflect on why they are here		Prof Cath Chamberlain
10.50 (10 mins each)	▪ Community experiences of COVID-19 (Dr Mark Wenitong, Lowitja Institute) ▪ Stolen generation experiences (Ms Jo Thitchener, Healing Foundation)		
11.10-11.30	**MORNING TEA** **Stretching video:** "2 min stretching routine at the office" PhilaMassages 2013: https://www.youtube.com/watch?v=TCiEB_ahzc8		
11.30 **(10 mins each)**	**Sharing and understanding First Nations communities' experiences of COVID-19** ▪ Perspectives of adolescents in Western Sydney (Dr Simon Graham) ▪ Experiences of COVID-19 in Victoria (Ms Kasia Wojcik and Dr Jane Goller) ▪ Parents' experiences (Dr Michelle Kennedy) ▪ Summary of parent experience data (Dr Christina Heris and Dr Shannon Bennetts)		Summary written up by graphic facilitator to share
12.10 **(30 mins)**	**Break out room group discussions 1: experiences** ▪ Experiences of group – reflect on what they have heard and key issues that **may not** have been covered.		Breakdown name for each team Notes to share
12.40 **(1 hour)**	**LUNCH** And https://www.youtube.com/watch?v=tAUf7aajBWE (6 mins, Yoga at your desk with Adrienne) (Update pics with Rhys)		
1.40pm **(30 mins)**	**1: framework components** (continued) ▪ Summary of key issues identified ▪ What are the key features of a culturally-responsive trauma-informed public health emergency framework? Goals, enablers etc.		Break out rooms 5-6 people
2.10	**Sharing and collating frameworks components** ▪ And ranking (poll everywhere/cahoots)		Collate into diagram
2.50	**Reflections on the day (including with Rhys)**		
3.00	**THANK YOU AND CLOSE** Mini Meditation: desk break - Classic Flow - ABC Radio (4 mins)		

1

Day 2: Friday 15th October 2021

Registration and coffee from 8.45am (and sharing Rhys' summary picture)

Music: RN's Nature Track https://www.abc.net.au/radionational/programs/nature-track/gippsland-rainforest-lyrebird-morning/13481746

9.00	START	Acknowledgement to country	Dr Michelle Kennedy
9.05	Visual recap of previous day (Rhys) and plan for today (Cath)		Rhys/Cath Chamberlain
9.10	**Findings from a systematic review of trauma-informed public health emergency frameworks** ▪ Presentation of Systematic Review findings ▪ Overview of HPNF conceptual framework and domains		Dr Christina Heris
9.40	Discussion about domains from systematic review cover the issues identified yesterday and whether we need to add additional domains		Break out rooms
10.00	Share findings of break out rooms and new things to add to conceptual framework ideas		
10.30	MORNING TEA https://www.abc.net.au/radio/programs/classicflow/mini-meditation-muscle-relaxation/10701664 4min		
10.50	Overview of framework domains and shaping into conceptual framework **Visual recap by Rhys and Cath**		
11.40	Next steps – cultural grounding exercise and self-care tips (including Karabena self-care course https://courses.karabenacoaching.com)		Carlie and Michelle
11.50	THANK YOU, EVALUATION link, AND CLOSE https://redcap.link/lv808k9b		

12.00-12.45 pm Optional Wayapa Yoga with Lee Couch

Thank you for attending the APPRISE Workshop.

We hope you've had the opportunity to share and learn in this co-design process. It is important to look after yourself when working in trauma, so we encourage you to spend some time after this workshop in ways that are meaningful to you, for your own self-care. This might include spending time; with family, sitting and playing with children, or watching children playing; in nature, breathing in, taking off your shoes and physically grounding yourself in the dirt or sand; preparing healthy food and drinking lots of water; as well as all the different ways we move our bodies through caring, work, housework, and exercise.

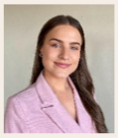
Support available at APPRISE Workshop

Presenter Biographies

Mr Rhys Paddick (Graphic facilitator)

Rhys Paddick is an artist with a genuine passion to draw and to make people laugh - this is both a personal and professional domain of work. His goal is to share Aboriginal culture in an easily accessible and digestible with a *wholesome* approach.

Ms Kasia Wojcik



Kasia is a non-Indigenous student in her final semester of the Master of Public Health at the University of Melbourne. Her capstone research project explores the impact of COVID-19 restrictions in Aboriginal communities in Victoria. Previously she attained a Bachelor of Science. Kasia also volunteers providing health literacy workshops to VCAL students in Melbourne's West.

Dr Jane Goller

Based at the University of Melbourne, Jane is an experienced non-indigenous researcher whose work focuses on the epidemiology and health service interventions for sexually transmissible infections. She currently works on a NHMRC partnership project toward strengthening chlamydia management in general practice. Previously she has collaborated with Aboriginal Community Controlled Organisations to contribute to STI surveillance systems and Master's level teaching about Aboriginal Health. In 2020-21 she has provided technical input into an Aboriginal led survey investigating the impact of COVID-19 restrictions on Victorian Aboriginal community.

Ms Jo Thitchener

Jo Thitchener is Team Leader of the Engagement and Delivery team at The Healing Foundation and has been leading healing initiatives including the COVID resilience project working with Stolen Generations organisations, the Queensland Healing Strategy and developing resources to improve Social and Emotional Wellbeing outcomes for Aboriginal and Torres Strait Islander children. Jo has over thirty years of experience in project management, policy development, strategic planning, marketing, communications, community development and stakeholder engagement with a wide range of experience working across Aboriginal and Torres Strait Islander community-controlled organisations, not for profit community organisations, corporate and government.

Dr Mark Wenitong

Dr Wenitong is from the Kabi tribal group of South Queensland. He has extensive expertise and experience in public health and has been involved in both clinical and policy work throughout his career, including as past president and founder of the Australian Indigenous Doctors Association.

Meet the project team

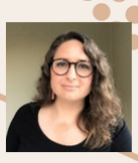
Professor Catherine Chamberlain

Catherine Chamberlain is a Palawa Trawlwoolway woman, NHMRC Career Development Fellow and Professor of Indigenous Health at the Centre for Heath Equity, The University of Melbourne. She has over 25 years' experience in public health and is Principal Investigator for the Healing the past by nurturing the future – which aims to co-design perinatal awareness, recognition, assessment and support strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma and this APPRISE program of work.

Dr Michelle Kennedy

Michelle Kennedy is a Wiradjuri woman and NHMRC Early Career research fellow at the Thurru Indigenous Health Unit at the University of Newcastle. Michelle will facilitate the workshop over the two days. Michelle will summarise key themes emerging from interviews the research team have conducted with Aboriginal and Torres Strait Islander families in South Australia, Northern Territory and Victoria around the impact of COVID 19 and provide insight to what families found most helpful and recommend.

Dr Christina Heris



Dr Christina Heris is a research fellow with the Healing the Past by Nurturing the Future project and within the Aboriginal and Torres Strait Islander Health Program at the Australian National University with interests in health communications, tobacco control and adolescent health. Christina has been working on a review to inform the development of a trauma-informed public health emergency response framework and will present findings from a synthesis of emergency response procedures against trauma-informed principles; as well as an early overview of survey data of the experiences of Aboriginal and Torres Strait Islander parents during the COVID-19 outbreak.

Dr Simon Graham

Simon Graham is a NHMRC fellow based at the Peter Doherty Institute for Infection and Immunity, University of Melbourne. He is a part of a COVID-19 qualitative research project with Aboriginal young people in Western Sydney and a prospective cohort study in Perth of Aboriginal young people.

Dr Caroline Atkinson

Dr Caroline Atkinson BSW (Hon), PhD, MAASW (Acc) is an accredited Social Worker who has focused her career on the interplay between trauma and violence in Aboriginal peoples in Australia. She developed the first culturally sensitive, reliable, and valid psychometric measure in Australia that determines PTSD in Australian Aboriginal peoples. She has worked in a variety of community-based positions and participated on a number of research projects and program developments for government and non-government organizations that focus on social justice issues, family violence, post-graduate course development in the area of trauma, humanitarian aid, community development and empowerment and PTSD and trauma-based disorders including intergenerational trauma. She holds a PhD specialising in trauma, particularly intergenerational trauma and community and family violence, which extends to the aftermath of war-based trauma on an international level. Caroline is considered a leader in the area of intergenerational trauma in Indigenous Australia. She currently works for her family organisation, We Al-li, designing and co-ordinating the delivery of culturally sensitive trauma informed care training to Aboriginal organisations and communities across Australia.

Dr Cindy Woods

Dr Cindy Woods is a research fellow with the Healing the Past by Nurturing the Future project based within the Centre for Health Equity, Melbourne School of Population and Global Health. Cindy is currently coordinating recruitment and data collection with Aboriginal and Torres Strait Islander parents in South Australia, Northern Territory and Victoria. She is also conducting an early analysis of survey data of the experiences of Aboriginal and Torres Strait Islander parents during the COVID-19 outbreak.

Dr Shannon Bennetts

Dr Shannon Bennetts is a Research Fellow in the parenting team within the Judith Lumley Centre at La Trobe University. Dr Bennetts' research focuses on supporting and understanding the needs of parents, children, and families. Her research interests include parent and child mental health and wellbeing, children's learning and development, parenting during adversity, the work-family interface, and the role of social media in contemporary parenthood. Dr Bennetts has worked on a number of large research projects, including the Early Home Learning Study; a cluster randomised controlled trial evaluating the smalltalk early childhood parenting program. Dr Bennetts also leads the Parents, Pets & Pandemic project, which aims to understand the benefits and challenges of having a cat or dog for Australian families with children. She completed her PhD in 2017 with The University of Melbourne, based at the Murdoch Children's Research Institute.

Dr Janine Mohamed

Janine Mohamed is a proud Narrunga Kaurna woman from South Australia. Over the past 20 years, Janine has worked in nursing, management, project management, and workforce and health policy in the Aboriginal and Torres Strait Islander health sector. Many of these years have been spent in the Aboriginal Community Controlled Health sector at state, national and international levels, and most recently as the previous CEO at the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). Janine is now based in Melbourne as the CEO of the Lowitja Institute. She was awarded an Atlantic Fellows for Social Equity Fellowship in 2019, and, in January 2020, was awarded a Doctorate of Nursing honoris causa by Edith Cowan University.

Ms Leanne Slade

Leanne Slade is an Administrative Officer with the Healing the Past by Nurturing the Future project based within the Centre for Health Equity, Melbourne School of Population and Global Health.

Appendix 2: Key Components as Voted by Workshop Participants

Strengths-based approaches Empowerment Enabling Communities Leadership	Reframing narratives Community Youth Leaders	Inclusive not divisive language Elders	Respect
Trust Connection and connectedness Engagement	Mistrust in Government Engagement (Multi-sectoral & stakeholder)	Recognising the historical context of government power and control as a key factor in vaccine hesitancy and a compounding trigger Engagement elders	
Trauma-informed approaches (recognising triggering, avoiding compounding trauma) Culture and cultural practices/approaches Grief/funeral access Physical Approaches (music, dance, hands on healing practices, etc)	Understanding trauma histories Respect for cultural practices and for all Advanced care planning and self advocation for planning at end of life. Including care of children.	Cultural/creative practice (weaving, art, tool-making, etc)	Accessing cultural healing
Aboriginal specific context (ways / people / services / communities)			
Access to services / support (incl financial) Social Support Equity / systemic biases	Housing Relationships (e.g. family) Structural approaches		
Social and Emotional Wellbeing	Resilience		
Safety and security	Fear		
Messaging, information and media			
Diversity of population sub-groups	Age-specific needs	Life-course approach	Prisons People who use drugs