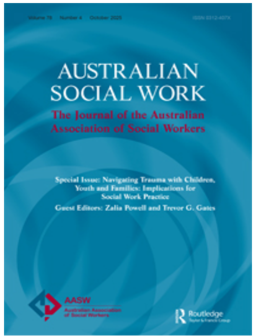

Australian Social Work

ISSN: 0312-407X (Print) 1447-0748 (Online) Journal homepage: www.tandfonline.com/journals/rasw20

Trauma-Informed Primary Healthcare for Parents: Multidisciplinary Experiences in Rural Service Implementation

Carol Reid, Fran Smullen, Shannon K. Bennetts, Lisa H. Amir & Catherine Chamberlain

To cite this article: Carol Reid, Fran Smullen, Shannon K. Bennetts, Lisa H. Amir & Catherine Chamberlain (2025) Trauma-Informed Primary Healthcare for Parents: Multidisciplinary Experiences in Rural Service Implementation, Australian Social Work, 78:4, 379-394, DOI: 10.1080/0312407X.2023.2284179

To link to this article: https://doi.org/10.1080/0312407X.2023.2284179

© 2025 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 17 Dec 2023.

Submit your article to this journal

Article views: 1382

View related articles

View Crossmark data

Citing articles: 2 View citing articles

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=rasw20

AUSTRALIAN SOCIAL WORK
2025, VOL. 78, NO. 4, 379–394
https://doi.org/10.1080/0312407X.2023.2284179

Trauma-Informed Primary Healthcare for Parents: Multidisciplinary Experiences in Rural Service Implementation

Carol Reid [a,b], Fran Smullen[c], Shannon K. Bennetts [a,d], Lisa H. Amir [a], and Catherine Chamberlain [a,e,f]

[a]Healing the Past by Nurturing the Future Project, Judith Lumley Centre, School of Nursing and Midwifery, George Singer Building, La Trobe University, Bundoora, Victoria, Australia; [b]Rural Health Academic Network, Department of Rural Health, The University of Melbourne, Shepparton, Victoria, Australia; [c]Department of Rural Health, The University of Melbourne, Shepparton, Victoria, Australia; [d]Intergenerational Health Group, Murdoch Children's Research Institute, Parkville, Victoria Australia; [e]NGANGK YIRA: Murdoch University Research Centre for Aboriginal Health and Social Equity, Murdoch University, Perth, Western Australia; [f]indigenous Health Equity Unit, Melbourne School of Population and Global Health, The University of Melbourne, Parkville, Victoria, Australia

ABSTRACT

Trauma-informed approaches to service delivery increase awareness of the pervasiveness of trauma exposure and acknowledge the lifelong effects of traumatic stress on health and wellbeing. This study explored workforce experiences of trauma-informed primary healthcare for parents. A face-to-face workshop was conducted with 14 Victorian rural professionals in 2021. Local workforce survey results ($n = 63$) about trauma-informed care were presented to the group (50% social workers) and they discussed strategies for system implementation. Content analysis was used to develop four categories from the transcribed workshop discussion: (1) primary healthcare understanding of complex trauma; (2) primary healthcare responses to parents; (3) trauma-informed care training; and (4) community and relational strategies to foster trauma-informed care. Our findings highlighted that structural barriers relating to resource control and restrictive program design negatively impact trauma-informed approaches. In contrast, trauma-informed service delivery is enabled by collaboration and building relationships between clients, the workforce, and organisations. In discussing these findings, we draw upon notions of power: namely, *discursive*, *epistemic,* and *material* power, which affect equity. To ensure the client's voice is prioritised when planning trauma-informed care, we recommend the integration of local knowledge and the embedding of community-based strategies throughout all implementation processes.

IMPLICATIONS

- Preparation for trauma-informed care implementation in rural primary healthcare requires strategies to identify and address structural barriers.

ARTICLE HISTORY
Received 5 June 2023
Accepted 13 November 2023

KEYWORDS
Trauma-Informed Service Delivery; Trauma-Informed Care; Social Work Research; Rural Workforce; Equity; Implementation Framework; Primary Health Care; Rural Health Care Systems; Health Care Strategies; Implementation Science; Mental Health Care

CONTACT Carol Reid c.reid@latrobe.edu.au

© 2025 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

- Increased use of implementation frameworks would enhance multidisciplinary innovation in trauma-informed practice and adaptation when supporting parents.
- Employing a typology of discursive, epistemic, and material power to implementation processes has beneficial application in social work to challenge systemic reproduction of inequity.

Traumatic events or circumstances which leave a person feeling threatened and powerless can adversely affect an individual's functioning and wellbeing and have ongoing impacts (Van Der Kolk, 2014). Responses to trauma experiences, such as childhood sexual abuse and interpersonal violence, can culminate in psychological, physical, emotional, social, and spiritual consequences throughout life (Herman, 1992; Mersky et al., 2019; Van Der Kolk, 2014). When the effects of traumatic stress undermine health and social welfare, it becomes a human rights and social justice issue that requires universal public health responses (Mersky et al., 2019).

Trauma-informed care is a service system response that fosters awareness of the pervasiveness of trauma, increases understanding of the effects of trauma on people's lives, helps to mitigate its consequences, and prevent client retraumatisation (Hopper et al., 2010; Sweeney & Taggart, 2018). Core principles underpinning universal trauma-informed care include safety; trustworthiness and transparency; peer support; collaboration and mutuality; and empowerment, voice, and choice (Hamberger et al., 2019; Substance Abuse and Mental Health Services Administration, 2014). In addition, trauma-informed approaches to care must recognise the contextual influences of individual and community-specific trauma experiences and as such, use strategies that address intersectional issues surrounding cultural, historical, and gendered aspects of traumatic stress (Shramko et al., 2019; Substance Abuse and Mental Health Services Administration, 2014; Sweeney & Taggart, 2018).

A trauma-informed primary healthcare (PHC) system would enhance client engagement, foster effective service utilisation, increase follow-up support and encourage positive outcomes for all sectors of the community (Chamberlain, Gee, Harfield et al., 2019; Fiolet et al., 2021). An important PHC client group are parents and their children. Parents are frequent users of various PHC services particularly during pregnancy and early parenthood. Hence, this is an opportune service contact point to recognise the impact of trauma experiences, to develop trusting provider and parent relationships, and to support trauma healing and recovery (Chamberlain, Gee, Harfield et al., 2019; Olsen, 2018).

Effective implementation of trauma-informed care in PHC requires a systemic approach that includes a whole-of-system implementation strategy complemented by policy and structural resourcing to enable change across service settings (Atwool, 2019). Implementation planning is critical to support organisational responsibility to embed trauma-informed approaches into all aspects of service delivery, and for the workforce to adopt the approach into their day-to-day engagement with clients (Birnbaum, 2019; Sweeney & Taggart, 2018). Implementation science offers frameworks, strategies, and processes to promote the translation and uptake of practices, such as trauma-informed care (Nilsen, 2015; Proctor et al., 2011).

Implementation researchers have recognised that inequities can be inadvertently reproduced when introducing interventions or practice models into health and social

care systems (Stanton et al., 2022). For example, Stanton et al. (2022) examined equity in trauma-informed mental healthcare provision for human immunodeficiency virus (HIV) positive clients. They explained how three different types of power can influence equity within implementation processes: *discursive power*, *epistemic power*, and *material power* (Stanton et al., 2022, pp. 3–4).

Discursive power relates to who defines the issue, the type of intervention, and the subsequent narratives shaping the implementation process. Epistemic power is apparent in whose knowledge is valued in decision making and recreated through knowledge production and dissemination. Material power involves the control and distribution of resources, factors that influence access, and who benefits from the intervention (Stanton et al., 2022, pp. 3–4).

The typology of power developed by Stanton and colleagues is relevant to social work research and practice where interest in and use of implementation science to consolidate evidence-based practice is low (Palinkas et al., 2017; Proctor et al., 2011). Integrating social work expertise, practice knowledge, and contextually specific experiences into programs and policies is an ongoing professional issue for social work (Cabassa, 2016). Implementation science can strengthen the quality and rigour of social work research to enable professionals to describe the processes and mechanisms of evidence-based practice.

Implementation frameworks provide a means to test "real-world" social work innovation, to articulate evidence about effectiveness for clients and then, how to transfer these models into systems and structures to improve equity (Cabassa, 2016; Usubillaga et al., 2023). Experiences in the United States and the United Kingdom provide examples of integrating implementation science into social work research to reduce racial and ethnic disparities in mental health services (Cabassa, 2016), and to facilitate the transfer of Child Protection Policy into practice (Usubillaga et al., 2023). Advocating for change across health and social care systems is vital in social work to challenge inequity for vulnerable populations (Eslava-Schmalbach et al., 2019; Hicks, 2016; Voith et al., 2020; Wilson & Beresford, 2000).

Few Australian social work studies use implementation science to support evidence about the dismantling of power to better serve disadvantaged groups. The current study examined the barriers to and enablers of trauma-informed care in rural primary healthcare. This article presents the views and experiences of a group of multidisciplinary professionals who, as part of the study, attended a workshop to discuss and plan for trauma-informed care to support rural parents.

Method

This mixed-methods research was undertaken in northern Victoria, Australia, and is embedded within a more extensive Australian study: The Healing the Past by Nurturing the Future (HPNF) project. This Aboriginal-led research aims to codesign culturally appropriate and feasible strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma (Chamberlain, Gee, Brown et al., 2019). The current study was underpinned by implementation science utilising the Exploration, Preparation, Implementation and Sustainment (EPIS) Framework (Aarons et al., 2011). The EPIS Framework proposes a multilevel, four-phase model developed by the

California Evidence-Based Clearinghouse for Child Welfare in affiliation with the Child and Adolescent Services Research Centre (Aarons et al., 2011). Figure 1 provides an adapted illustration of the EPIS Framework and indicates the focus of this article is the Preparation phase.

The four-phases of the EPIS depict implementation as influenced by the interplay between the Outer context (i.e., system and structural elements) and Inner context (i.e., services and workforce features) (Aarons et al., 2011; Moullin et al., 2019). Interconnections are examined via Bridging factors and Innovation factors. Bridging factors refer to the structures and processes that span the outer and inner contexts and impact practice. These are dynamic and positively or negatively influence implementation processes. Innovation factors involve the characteristics of the practice and the appropriateness or contextual adaptability of the practice given the system, service settings, and users (i.e., providers and clients) (Becan et al., 2018; Moullin et al., 2019; Stanton et al., 2022).

The Exploration Phase

A cross-sectional survey of rural primary healthcare workers (n = 63) was previously undertaken (March–August 2021) as part of the Exploration phase (Reid et al., 2023). This phase is essential for baseline information about stakeholder awareness of the issue, and considers the evidence, need, and potential fit of the practice in relation to the implementation context (Aarons et al., 2011; Moullin et al., 2019). The survey results highlighted that barriers to trauma-informed service delivery were primarily structural factors. Enablers included a supportive service environment and practitioner motivation to understand complex trauma (Reid et al., 2023).

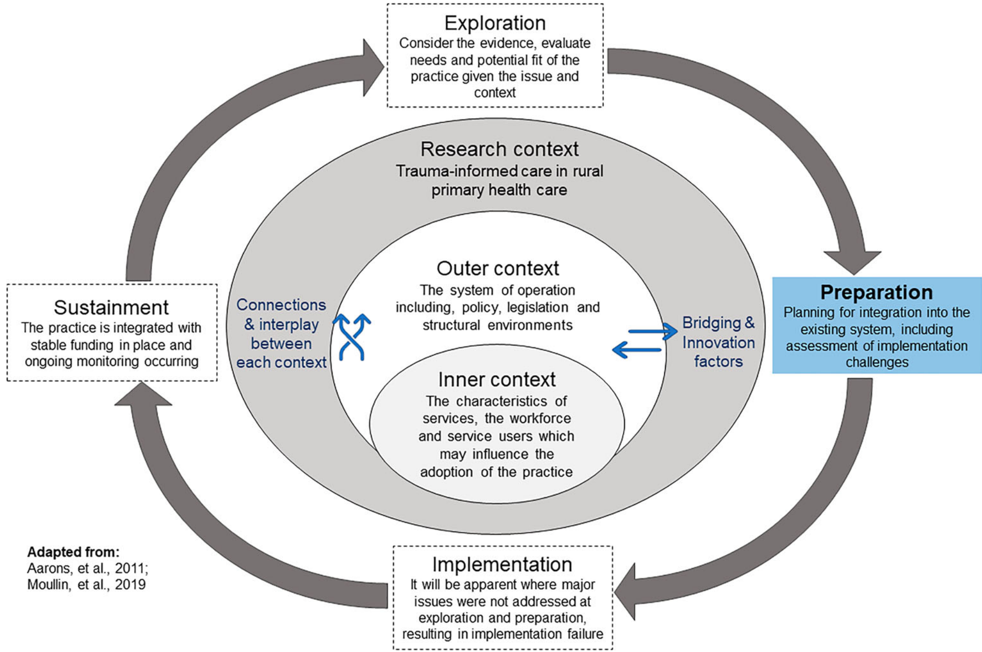

Figure 1 An adapted illustration of the EPIS Framework

The Preparation Phase

This qualitative research reports on the EPIS Preparation phase of the study which entailed a face-to-face workshop with members of the rural PHC workforce. The Preparation phase is critical for identifying gaps and for facilitators to integrate the practice and to assess adaptation requirements. It supports the development of a contextually appropriate implementation plan (Aarons et al., 2011; Moullin et al., 2019). The workshop was approved in 2021 by the La Trobe University Human Ethics Committee ID: HEC20531. Participants signed a hard copy consent form (agreeing to audio recording) at the beginning of the workshop. Participants did not receive any incentives to engage in the workshop.

Researcher Reflexivity

The first and second authors were rural social workers living and practising in the geographical and social context of the research setting. Both participated in the workshop and conducted the data analysis. The authorship team has practice and research expertise in psychology, community development, general practice, public health, and midwifery.

Study Setting

The geographical setting is in northern Victorian. The main regional township is home to many migrant and refugee communities with over 45 different languages represented, such as Hazaraghi, Punjabi, Arabic, Italian, and Swahili. The Aboriginal and Torres Strait Islander population is significant at 3.9% (regional Victoria 1.0%), the largest outside metropolitan Melbourne (Australian Bureau of Statistics, 2021; Infrastructure Victoria, 2019). The area has been determined to have high intergenerational disadvantage and, as a result, it is a location for service policy interventions that involve welfare conditionally: Compulsory Income Management and the ParentsNext Program (Goldblatt, 2021; Mendes et al., 2023). Income management withholds between 50% and 90% of a person's income support payment (Mendes et al., 2023). The ParentsNext Program requires engagement in parenting, education, or work preparedness activities. Failure to comply can result in suspension, reduction, or loss of support payments (Goldblatt, 2021). These are arguably a punitive form of behaviour change or welfare compliance through coercion and control.

Recruitment and Procedure

An invitation to attend the workshop was extended to all rural primary healthcare workers who engaged in the exploration (survey) phase (described above). Prior to the workshop confirmed attendees received (i) a workshop agenda and (ii) a six-page plain language summary report of the survey results. The report and the workshop presentation provided information about the EPIS Framework and described the Outer and Inner contexts. Based on the sensitive nature of the topic and participants' possible experiences of trauma and exposure to vicarious trauma, information about support services was made available (e.g., websites, helplines).

The two-hour workshop was held in November 2021 at a regional university. It was rescheduled three times due to COVID-19 restrictions and a local outbreak. At each cancellation confirmed participant numbers reduced. An independent facilitator moderated the workshop to minimise any perceived conflicts of interest as the researchers potentially had personal and professional relationships with some participants due to living and working in the area. The workshop format involved a presentation of survey results (author 1) that highlighted the structural barriers encountered by rural professionals: for example, low system awareness of the benefits of trauma-informed approaches and the scarcity of universal referral pathways and therapeutic-specific services for parents. Survey respondents' free-text comments, included in the presentation, recognised poor transfer of trauma-informed training into institutional structures. After this, workshop participants engaged in a discussion about the results and shared their experiences of trauma-informed care for parents accessing rural primary healthcare.

Data Analysis

The first author transcribed the audio recording of the workshop discussion. A summative approach to content analysis was utilised to examine the transcription (Krippendorff, 2018). Content analysis is a flexible technique to systematise qualitative data and is beneficial for interpretation in consideration of context (Hsieh & Shannon, 2005; Krippendorff, 2018). To de-identify participants a unique number was assigned to each. The first and second authors read and reread the transcript independently, coding and extracting text excerpts using tables in Microsoft Word. Through discussion and refinement, these were grouped to become overarching categories of participants' views and experiences (Hsieh & Shannon, 2005; Krippendorff, 2018). The EPIS Framework, using the descriptors of Outer and Inner contexts and Bridging and Innovation factors, was employed deductively to position participants' experiences into subcategories.

Findings

Participants ($n = 14$) were aged over 25 years and mainly female ($n = 13$). Table 1 provides participants' workforce characteristics.

Table 1 Participant Workforce Characteristics

		N ($n = 14$)	%
Organisational setting	Child and family services	5	36
	Community health	7	50
	Private practice	2	14
Workforce position	Case manager	4	29
	Executive team	4	29
	Practitioner	3	21
	Program coordinator	3	21
Discipline	Health promotion	1	7
	Mental health nurse	3	21
	Paramedic	1	7
	Psychologist	3	21
	Social worker	7	50

Categories Describing Participant's Views and Experiences

Participants' views and experiences about the provision of trauma-informed care to support rural parents were grouped into four categories. We presented the categories and subcategories alongside illustrative quotes.

Category 1. Primary Healthcare Understanding of Complex Trauma

When participants spoke about PHC's understanding of complex trauma from their experiences of broader systems, other services, and workers, they indicated that this ranged from "minimal" to "highly skilled". For PHC to understand complex trauma to support parents, a participant stated: "We have to think from the perspective of people with trauma" (#P12).

Outer context: Participants' examples of parents' experiences when engaging with PHC illustrated the interplay between structural systems and the social determinants of health. For example, the following quote demonstrates the determinantal impact of overlooking these connections:

> If you are talking about what's happened to a person, well you're talking about all the systems that impacts a person and maintains a hold over the person to keep them in place with the possibilities they might have in their life, like putting a roof over their head etc. (#P08)

Inner context: There is an identified need for innovation at the inner context to counter the siloed thinking and increase PHC workforce understanding. One workshop participant understood this limiting way of thinking as inhibiting parent recovery:

> They [workforce] are very siloed in their thinking, they are very compartmentalised about "this is my job, this is my role". Workers are not really thinking about recovery for parents. It's not just thinking about the tick box of service system. It's actually about someone's whole life journey. You can't compartmentalise this recovery from being a parent. (#P12)

Category 2. Primary Healthcare Responses to Parents

Gaps in rural PHC responses to parents experiencing complex trauma were identified. The group discussion revealed structural weaknesses that constrain appropriate, person-centred responses to complex trauma. When making the connection to system barriers, one participant reacted with "Often services don't get it either", highlighting such limitations. Other participants noted responses that are not effective, specifying the general practice context with:

> We will often have clients that have gone to a GP [general physician] and mentioned they have a sexual abuse history. The GP has gone "right, you need a mental healthcare plan, and you need to see a psychologist only". Then six months later they are back because it didn't work for them. So, they are automatically pigeonholed into "this is what they need". (#P02)

Outer context: Participants identified the characteristics of general practice as a restrictive system in the way PHC responds to complex trauma, as indicated by these examples: "General Practice is very much a gatekeeper to other services" (#P06) and "Trying to get GPs to the table to understand what genuine trauma-informed care is, they would use a multitude of different allied health professionals. It doesn't have to be a psychologist" (#09).

Bridging factors: The structures and processes connecting the PHC system (outer), and service (inner) contexts also restrict parent-centred, strengths-based responses. Participants made links between model parameters and funding: “Mainstream services are captured by their funding; they are captured by what they have to offer and the length of time a program is going to run for” (#P08) and “Services are not really designed about the person; it’s about the funding model; it’s about the data and the numbers to get the funding, rather than what they [the clients] need” (#P04).

Category 3. Trauma-Informed Care Training

Participants’ experiences and opinions about trauma-informed care training reflected high-level structural weaknesses such as gaps in university course curricula, and inner context weaknesses of workforce indifference. However, strengths cited by participants acknowledged training improvements, particularly during COVID-19, such as increased access for rural professionals, local collaborative endeavours to share training costs, and practitioners’ desire to improve.

Outer context: A structural level concern for participants was the variability in the foundational knowledge for practice of the emerging PHC workforce, as indicated by this opinion:

> I think that teaching and in terms of the curriculum, in terms of quality of graduates we are getting from a whole range of courses, as new employees into the sector, it is incredibly variable. Quite often that understanding of trauma-informed practice is quite lacking. (#P11)

Bridging factors: Participants identified a lack of supportive infrastructure that values education and training, as a prerequisite to foster systemic change, undermines efforts to promote trauma-informed care. As one participant stated: “You can put on as much training as you like, but if the infrastructure doesn’t allow you to implement changes within the system to gain the benefit from what the practitioners have learnt, nothing changes” (#P06).

Inner context: When exploring ideas to move forward, participants spoke of the difficulties encountered in encouraging staff uptake of training, for example: “Even if training is accessible, how do we engage and motivate workers to do it?” (#P12)

Innovation factors: Strengths were identified regarding trauma-informed care training that participants could further explore within their organisations to increase uptake:

> Access to training has improved if you are willing to do it over Skype or Zoom. I have attended some really good training facilitated by some experienced facilitators. It works quite well. Which is much more accessible than going down to Melbourne or waiting for people to come up. (#P09)

Another noted: “We have our training coordinated. So, its [referring to trauma-informed care] very much in all our frameworks, as a person-centred service” (#P02).

Category 4. Community and Relational Strategies to Foster Trauma-Informed Care

This last category highlighted discussions about planning and provision of trauma-informed care that is adaptable and contextually relevant to the care setting, client group, and geographical setting. The value of employing community development approaches was indicated by the following comment:

> Today really made me think again about the importance of being grounded in the community and working with the community from the bottom up. Rather than the one-to-one therapeutic model that's very western that doesn't really allow a lot of space for diversity in terms of what's on offer. (#P08)

Innovation factors: Participants spoke about being "time-rich" or "time-poor", making links to the importance of building relationships and trust. A participant highlighted the importance of "having that capacity to be time-rich", noting that "being time-rich is not really fostered all that well in mainstream services" (#P08). Others provided examples of service innovation developed by PHC during COVID-19 to support and build trust with clients. They noted the critical role of relationships and safety in the provision of care that is trusted. The following quotes reflect such features about time and trust:

> That trust overcame some of the trauma implications and deep mistrust triggered during COVID. You cannot put a figure on this, these people are never going to go to a hub [referring to a vaccination centre] but taking the service to them alleviated some of that mistrust. (#P11)

> The key concept of trauma-informed care is about relationships and building trust and having trust with the people you work with. But we can just turn over so much, it's about that time, everyone is time-poor, and everyone is time-limited to do that. (#P04)

Discussion

This study was undertaken in a diverse rural location with high socioeconomic disadvantage (Australian Bureau of Statistics, 2021; Infrastructure Victoria, 2019). The workshop discussion with PHC workforce members identified structural barriers that hinder rural trauma-informed service delivery. Participants made connections to features which can positively shape trauma-informed care to support clients, the workforce, and organisations. The typology of power, as posed by Stanton et al. (2022), is used to critically reflect on these findings and enrich this discussion.

Primary healthcare's understanding of complex trauma, as the first category, would be improved by using clear, positive, and nonjudgemental language that counter discourse that is victim blaming. As workshop participants repeatedly emphasised, complex trauma must be understood through the lived experience of those who have experienced trauma (Kezelman & Stavropoulos, 2018). This is essential in planning for trauma-informed PHC systems (Chaudhri et al., 2019).

These findings highlight epistemic power in whose knowledge is valued in PHC service delivery development. It is essential that the views of parents and their individual needs in trauma experiences is embedded at a systems level, supported through the application of an intersectional lens. Intersectionality refers to the interconnections between different aspects of a person's identity, which can expose them to overlapping forms of discrimination and marginalisation (Mattsson, 2014).

In PHC service development, prioritising the intersectional nature of parents' identities, such as cultural background or gender or location, can expose power dynamics and where these forces intersect to increase vulnerability to inequity (Shramko et al., 2019; Stanton et al., 2022). This aligns with the views of participants in the current study

and supports the importance of increasing PHC understanding of the social, cultural, economic, historical, and gender issues associated with experiences of trauma (Mattsson, 2014; Shramko et al., 2019).

The category of primary healthcare responses to parents reflected participants' experiences of fixed attitudes and practices that inhibit trauma-informed responses. Such systemic barriers are strongly linked to discursive and epistemic power. PHC structural responses need to shift from views of individual disorder or dysfunction in asking "What's wrong with you?", to enquiries which validate the impact of overwhelming traumatic stress by asking "What's happened to you?" (Harris & Fallot, 2001; Johnstone & Boyle, 2018). Additionally, drawing on these findings, to support strengths-based PHC responses, we recommend the additional enquiries of "What's right about you?" and "What support is right for you?" (Ginwright, 2018). This illustrates that PHC responses must align with parents' priorities and preferences. The structural context of PHC has created narrow responses for support. Workshop participants emphasised an overreliance on the mental healthcare plan to "fix" the person. This indicates interventions framed in the discursive and epistemic power of diagnostic criteria and psychiatry disempower parents and are unable to capture their unique strengths and resilience factors or "what's right" about them. Material power, in the control over and distribution of resources, prevents change when PHC responses are not meeting the needs of parents (Stanton et al., 2022). A trauma-responsive PHC system requires material power to enable flexible resourcing and funding models that ask parents "What support is right for you?" The benefits of promoting choice in self-selection of care interventions increase equity through empowering individuals and communities to manage their health and wellbeing; providing a means to strengthen efficient use of (government) resources for health; and, potentially, providing a way of improving primary healthcare outcomes (World Health Organization, 2022).

The third category from our findings identified that training in trauma-informed care is essential to shift the narrative that this knowledge is only for specialised practitioners. System approaches advocate for universal trauma-informed care that recognises training is essential for those in those in non-clinical positions, from the boardroom to the reception desk (Champine et al., 2022; Substance Abuse and Mental Health Services Administration, 2014). It also is critical to acknowledge that trauma-specific interventions are specialised, therapeutic practice areas with different training and educational needs (Kezelman & Stavropoulos, 2018). Training content primarily must be informed by lived experience and take account of the voices of survivors for epistemic credibility (Mahboub et al., 2023). Discursive and epistemic power, in whose knowledge is valued in the design and content of training, is interconnected to material power, regarding who within the PHC workforce has access to and is provided with training. As identified by the workshop participants there is also a need to embed trauma-informed concepts into higher education curricula for any discipline that will work in the health and social care sectors. We argue, from these findings, that trauma-informed education and training instilled early in our emerging workforce would reduce the limiting features of discursive, epistemic, and material power responsible for the reproduction of inequity in health and social care systems moving forward.

Community and relational strategies to foster trauma-informed care, as highlighted by our findings, are facilitated through partnerships. In social work practice, Relational

Theory emphasises that the client is the expert in their life (Quinn & Grumbach, 2015). This allows the client to name and lead the narrative surrounding the issue. In contrast, technical solutions, or technique-based interventions (e.g., the mental healthcare plan), developed without community consultation highlight imposed PHC discursive power in the naming and framing of the issues and the supports needed. Community and relational strategies challenge discursive and epistemic power. Community development "dialogical approaches" work alongside people for transformation, focusing on enriching conversations that build shared understanding (Westoby & Dowling, 2009, p. 10). Such an approach can be used in PHC by promoting listening to and hearing community voices. We recommend cocreating a shared agenda and breaking down barriers by prioritising and valuing the knowledge of those with lived experience of trauma, and valuing their views on the impacts on their health and wellbeing and what support they need for healing.

Context matters in research and in social work. As established in our discussion, issues of epistemic, discursive, and material power are intensified by the rural research setting. In the local area, for example, PHC access and service choice is a significant concern, with fewer General Practitioners and allied health professionals available per person compared to metropolitan centres (The Royal Australian College of General Practitioners, 2022). Communities in rural locations encounter geographical isolation and transport barriers, which add to disparities in health and wellbeing status (Wakerman & Humphreys, 2019).

These findings and connections to Stanton et al.'s (2022) typology of power are summarised in Figure 2. Drawing from participants' views and experiences, it illustrates the tensions for PHC professionals operating within systems to promote equity in health and social care. The figure reflects the identification of Bridging and Innovation factors in Context, and that these can either, increase or alleviate factors associated with inequity in PHC trauma-informed service delivery.

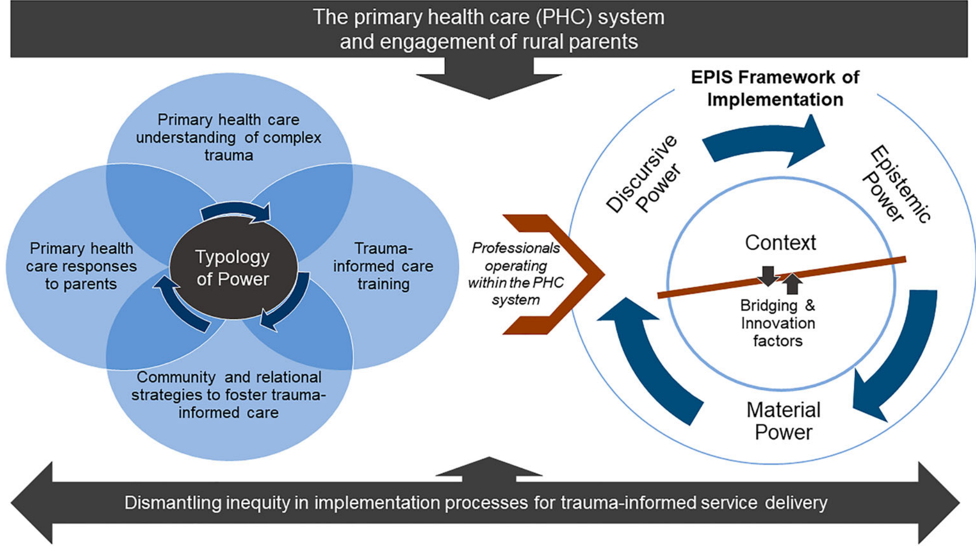

Figure 2 Preparing for trauma-informed PHC and power in implementation processes

Implications

Workshop participants' exposure to the EPIS Framework illustrated the value of employing an implementation framework to advance research and progress the translation of evidence to practice (Palinkas et al., 2017; Voith et al., 2020). The application of the typology of power to discuss our findings highlighted an opportunity to interrogate power dynamics inherent in the design of services or approaches to care (Stanton et al., 2022). Further, in social work research and practice, this typology would provide a useful structure to critically reflect on implementation processes using an equity lens; more clearly articulate evidence about unfair systems that adversely impact upon marginalised and disadvantaged groups; and promote antioppressive practice. The typology would be valuable to apply to other areas, such as when undertaking a community needs assessment or when developing a rationale to advocate for policy change.

Strengths and Limitations

A study strength was the use of collaborative strategies for knowledge production. This included plain language information in the form of the preworkshop report, the presentation of the survey results at the workshop and the engagement of participants' views about the results. This promoted learning and local ownership. Conversely, the survey results presentation may have shaped the participants' discussion. A study limitation was the small number of participants and their lack of representativeness: all self-selected to participate, were skilled professionals, and already had an interest in and good understanding of trauma-informed care and practice. This may limit the transferability of these findings and their application to the broader PHC sector. A larger and more diverse group could yield different information and identify experiences not included here.

Conclusion

The experiences of these rural professionals underscore that trauma-informed PHC service delivery requires preimplementation planning. This process is critical to identifying and addressing barriers and to leverage existing enablers to improve support for rural parents. We recommend embedding community-based strategies in all planning for trauma-informed service delivery approaches to examine power and disrupt unfair assumptions, and to identify inequalities in access to services which are trauma-informed. In addition, local knowledge should be integrated into all processes involved with the development and evaluation of trauma-informed approaches to care.

Acknowledgements

The authors acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Peoples and the Traditional Owners and Custodians of the land. The study was conducted within a broader research project: Healing the Past by Nurturing the Future (HPNF). The aims of the HPNF project include identifying culturally appropriate and feasible support strategies for Aboriginal and Torres Strait Islander parents who may be experiencing complex trauma. We acknowledge the support from HPNF investigators, project partners, and critical friends.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Funding

The first author is a PhD candidate with a scholarship funded by La Trobe University and an additional stipend from Healing the Past by Nurturing the Future Project. The *Healing the Past by Nurturing the Future* work is supported by the Lowitja Institute and a National Health and Medical Research Council (NHMRC) project [grant number 1141593]. The principal supervisor (author 5) is supported by an NHMRC Career Development Fellowship [grant number 1161065].

ORCID

Carol Reid http://orcid.org/0000-0003-0332-8047
Shannon K. Bennetts http://orcid.org/0000-0003-3758-0398
Lisa H. Amir http://orcid.org/0000-0002-2510-1399
Catherine Chamberlain http://orcid.org/0000-0003-3446-0227

References

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 4–23. https://doi.org/10.1007/s10488-010-0327-7

Atwool, N. (2019). Challenges of operationalizing trauma-informed practice in child protection services in New Zealand. *Child & Family Social Work*, *24*(1), 25–32. https://doi.org/10.1111/cfs.12577

Australian Bureau of Statistics. (2021). *Greater Shepparton 2021 Census*. Retrieved 25 March 2022 from https://www.abs.gov.au/census/find-census-data/quickstats/2021/LGA22830

Becan, J. E., Bartkowski, J. P., Knight, D. K., Wiley, T. R., DiClemente, R., Ducharme, L., Welsh, W. N., Bowser, D., McCollister, K., Hiller, M., Spaulding, A. C., Flynn, P. M., Swartzendruber, A., Dickson, M. F., Fisher, J. H., & Aarons, G. A. (2018). A model for rigorously applying the Exploration, Preparation, Implementation, Sustainment (EPIS) framework in the design and measurement of a large scale collaborative multi-site study. *Health & Justice*, *6*(1), Article 9. https://doi.org/10.1186/s40352-018-0068-3

Birnbaum, S. (2019). Confronting the social determinants of health: Has the language of trauma informed care become a defense mechanism? *Issues in Mental Health Nursing*, *40*(6), 476–481. https://doi.org/10.1080/01612840.2018.1563256

Cabassa, L. J. (2016). Implementation science: Why it matters for the future of social work. *Journal of Social Work Education*, *52*(sup1), S38–S50. https://doi.org/10.1080/10437797.2016.1174648

Chamberlain, C., Gee, G., Brown, S. J., Atkinson, J., Herrman, H., Gartland, D., Glover, K., Clark, Y., Campbell, S., Mensah, F. K., Atkinson, C., Brennan, S. E., McLachlan, H., Hirvonen, T., Dyall, D., Ralph, N., Hokke, S., & Nicholson, J. (2019). Healing the past by nurturing the future—co-designing perinatal strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma: Framework and protocol for a community-based participatory action research study. *BMJ Open*, *9*(6), Article e028397. https://doi.org/10.1136/bmjopen-2018-028397

Chamberlain, C., Gee, G., Harfield, S., Campbell, S., Brennan, S., Clark, Y., Mensah, F., Arabena, K., Herrman, H., & Brown, S. (2019). Parenting after a history of childhood maltreatment: A scoping review and map of evidence in the perinatal period. *PLoS One*, *14*(3), Article e0213460. https://doi.org/10.1371/journal.pone.0213460

Champine, R. B., Hoffman, E. E., Matlin, S. L., Strambler, M. J., & Tebes, J. K. (2022). What does it mean to be trauma-informed?": A mixed-methods study of a trauma-informed community initiative. *Journal of Child and Family Studies*, *31*(2), 459–472. https://doi.org/10.1007/s10826-021-02195-9
Chaudhri, S., Zweig, K. C., Hebbar, P., Angell, S., & Vasan, A. (2019). Trauma-informed care: A strategy to improve primary healthcare engagement for persons with criminal justice system involvement. *Journal of General Internal Medicine*, *34*(6), 1048–1052. https://doi.org/10.1007/s11606-018-4783-1
Eslava-Schmalbach, J., Garzón-Orjuela, N., Elias, V., Reveiz, L., Tran, N., & Langlois, E. (2019). Conceptual framework of equity-focused implementation research for health programs (EquIR). *International Journal for Equity in Health*, *18*, 80. https://doi.org/10.1186/s12939-019-0984-4
Fiolet, R., Roberts, V., & Bloomer, M. J. (2021). Trauma-informed care: Why is it so important in primary health care? *Collegian*, *28*(3), 253–254. https://doi.org/10.1016/j.colegn.2021.03.005
Ginwright, S. (2018). *The future of healing: Shifting from trauma informed care to healing centered engagement*. Occasional Paper, 25. https://kinshipcarersvictoria.org/wp-content/uploads/2018/08/OP-Ginwright-S-2018-Future-of-healing-care.pdf
Goldblatt, B. (2021). Equal access to social and economic rights in Australia – the troubling case of ParentsNext. *Australian Journal of Human Rights*, *27*(3), 597–603. https://doi.org/10.1080/1323238X.2021.2003567
Hamberger, L. K., Barry, C., & Franco, Z. (2019). Implementing trauma-informed care in primary medical settings: Evidence-based rationale and approaches. *Journal of Aggression, Maltreatment & Trauma*, *28*(4), 425–444. https://doi.org/10.1080/10926771.2019.1572399
Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *2001*(89), 3–22. https://doi.org/10.1002/yd.23320018903
Herman, J. (1992). A healing relationship. In J. Herman (Ed.), *Trauma and recovery* (pp. 133–154). Basic Books.
Hicks, S. (2016). Theory and social work: A conceptual review of the literature. *International Journal of Social Welfare*, *25*(4), 399–414. https://doi.org/10.1111/ijsw.12215
Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, *3*(2), 80–100. https://doi.org/10.2174/1874924001003020080
Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687
Infrastructure Victoria. (2019). *Addressing regional disadvantage Goulburn fact sheet*. https://www.infrastructurevictoria.com.au/wp-content/uploads/2019/11/Addressing-Regional-Disadvantage_Goulburn-Fact-Sheet.pdf
Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An alternative non-diagnostic conceptual system. *Journal of Humanistic Psychology*. Advance online publication. https://doi.org/10.1177/0022167818793289
Kezelman, C., & Stavropoulos, P. (2018). *Talking about trauma: Guide to conversations, screening and treatment for primary health care providers*. Blue Knot Foundation: National Centre of Excellence for Complex Trauma. https://blueknot.org.au
Krippendorff, K. (2018). *Content analysis: An introduction to its methodology*. Sage publications.
Mahboub, L., Martin, R., & Hodgson, D. (2023). A program for valuing mental health lived experience in social work education. *Australian Social Work*, *76*(4), 441–454. https://doi.org/10.1080/0312407X.2022.2101013
Mattsson, T. (2014). Intersectionality as a useful tool: Anti-oppressive social work and critical reflection. *Affilia*, *29*(1), 8–17. https://doi.org/10.1177/0886109913510659
Mendes, P., Roche, S., Marston, G., Peterie, M., Staines, Z., & Humpage, L. (2023). The social harms outweigh the benefits: A study of compulsory income management in greater Shepparton and Playford. *Australian Social Work*, *76*(1), 19–33. https://doi.org/10.1080/0312407X.2020.1820536

Mersky, J. P., Topitzes, J., & Britz, L. (2019). Promoting evidence-based, trauma-informed social work practice. *Journal of Social Work Education*, *55*(4), 645–657. https://doi.org/10.1080/10437797.2019.1627261

Moullin, J. C., Dickson, K. S., Stadnick, N. A., Rabin, B., & Aarons, G. A. (2019). Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. *Implementation Science*, *14*(1), Article 1. https://doi.org/10.1186/s13012-018-0842-6

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, *10*(1), Article 53. https://doi.org/10.1186/s13012-015-0242-0

Olsen, J. M. (2018). Integrative review of pregnancy health risks and outcomes associated with adverse childhood experiences. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *47*(6), 783–794. https://doi.org/10.1016/j.jogn.2018.09.005

Palinkas, L. A., He, A. S., Choy-Brown, M., & Hertel, A. L. (2017). Operationalizing social work science through research–practice partnerships: Lessons from implementation science. *Research on Social Work Practice*, *27*(2), 181–188. https://doi.org/10.1177/1049731516666329

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

Quinn, C. R., & Grumbach, G. (2015). Critical race theory and the limits of relational theory in social work with women. *Journal of Ethnic & Cultural Diversity in Social Work*, *24*(3), 202–218. https://doi.org/10.1080/15313204.2015.1062673

Reid, C., Bennetts, S. K., Nicholson, J. M., Amir, L. H., & Chamberlain, C. (2023). Rural primary care workforce views on trauma-informed care for parents experiencing complex trauma: A descriptive study. *Australian Journal of Rural Health*, *31*(1), 98–113. https://doi.org/10.1111/ajr.12922

Shramko, M., Pfluger, L., & Harrison, B. (2019). *Intersectionality and trauma-informed applications for maternal and child health research and evaluation: An initial summary of the literature*. Minnesota Department of Health. https://www.health.state.mn.us/docs/communities/titlev/itiappmhresearcheval.pdf.

Stanton, M. C., Ali, S. B., & SUSTAIN Center Team. (2022). A typology of power in implementation: Building on the exploration, preparation, implementation, Sustainment (EPIS) framework to advance mental health and HIV health equity. *Implementation Research and Practice*, *3*, 1–16. https://doi.org/10.1177/26334895211064250

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. https://store.samhsa.gov/system/files/sma14-4884.pdf

Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, *27*(5), 383–387. https://doi.org/10.1080/09638237.2018.1520973

The Royal Australian College of General Practitioners. (2022). *General Practice Health of the Nation* 2022. The Royal Australian College of General Practitioners. www.racgp.org.au/hotn

Usubillaga, J., Diaz, C., & Forrester, D. (2023). How are policies implemented in children's services? Developing an initial programme theory to evaluate the implementation of the new Child Sexual Exploitation guidance in Wales. *Child & Family Social Work*, *28*(1), 268–278. https://doi.org/10.1111/cfs.12959

Van Der Kolk, B. (2014). *The body keeps the score: Mind brain and body in the transformation in trauma*. Penguin Random House.

Voith, L. A., Hamler, T., Francis, M. W., Lee, H., & Korsch-Williams, A. (2020). Using a trauma-informed, socially just research framework with marginalized populations: Practices and barriers to implementation. *Social Work Research*, *44*(3), 169–181. https://doi.org/10.1093/swr/svaa013

Wakerman, J., & Humphreys, J. S. (2019). “Better health in the bush”: Why we urgently need a national rural and remote health strategy. *Medical Journal of Australia*, *210*(5), 202–203. https://doi.org/10.5694/mja2.50041

Westoby, P., & Dowling, G. (2009). Re-imagining communty life and community work. In P. Westoby, & G. Dowling (Eds.), *Dialogical community development: With depth, hospitality and solidarity* (pp. 23–60). Tafina Press.

Wilson, A., & Beresford, P. (2000). Anti-oppressive practice: Emancipation or appropriation? *British Journal of Social Work*, *30*(5), 553–573. https://doi.org/10.1093/bjsw/30.5.553

World Health Organization. (2022). *WHO guideline on self-care interventions for health and well-being, 2022 revision*. https://www.who.int/publications/i/item/9789240052192