

# Creating healing-informed, strengths-based and culturally responsive services: Transforming health professional practice through the Australian fetal alcohol spectrum disorder (FASD) Indigenous Framework



Nicole Hewlett (Palawa)<sup>a,b,\*</sup>, Vivian Lyall (Australian Settler, English/Scandinavian ancestry)<sup>a</sup>, Lorian Hayes (Iningai/Bidjara)<sup>a</sup>, Lindsay Wolfson (Settler in Canada with Polish/Russian ancestry)<sup>c</sup>, Robyn Williams (Noongar)<sup>d</sup>, Deborah Askew (New Zealand Pakeha)<sup>e</sup>, Karen Scofield (Margany)<sup>f</sup>, Natasha Reid (Settler in Australia with Irish/English ancestry)<sup>a</sup>

<sup>a</sup>Child Health Research Centre, The University of Queensland, Brisbane, Queensland, Australia

<sup>b</sup>Centre for Alcohol Policy Research, La Trobe University, Melbourne, Victoria, Australia

<sup>c</sup>Centre of Excellence for Women's Health, Vancouver, British Columbia, Canada

<sup>d</sup>Medical School, Curtin University, Perth, Western Australia, Australia

<sup>e</sup>General Practice Clinical Unit, The University of Queensland, Brisbane, Queensland, Australia

<sup>f</sup>Carbal Medical Service, Toowoomba, Queensland, Australia

## Abstract

**Purpose** Health professionals play a central role in facilitating access to essential prenatal alcohol exposure (PAE) and Fetal Alcohol Spectrum Disorder (FASD) services. However, deficit-oriented narratives around PAE and FASD can undermine the capacity of health professionals to provide appropriate and meaningful knowledge and support, leading to unrecognised and unsupported complex developmental, health, and social and emotional wellbeing needs. For Aboriginal peoples, these unmet needs are compounded by the intergenerational impacts of colonisation, racism and disability, perpetuating cycles of inequity, injustice and harm. This study explored what non-Aboriginal health professionals need to know, be and do to deliver healing-informed, strengths-based and culturally responsive PAE and FASD knowledge and

\*Corresponding author.

E-mail address: [n.hewlett@latrobe.edu.au](mailto:n.hewlett@latrobe.edu.au) (N. Hewlett).

© 2025 The Author(s). Published by Elsevier B.V. on behalf of Lowitja Institute (National Institute for Aboriginal and Torres Strait Islander Health Research Ltd). This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).  
<https://doi.org/10.1016/j.fnhli.2025.100095>





support to Aboriginal peoples. The findings were interpreted through the Australian FASD Indigenous Framework, to deepen understanding and guide practice transformation.

**Methods** Grounded in the Indigenous methodologies of *Dadirri* (deep listening from a place of still awareness) and yarning, 20 Aboriginal and non-Aboriginal knowledge holders connected to the outreach team at Carbal Medical Service, who generously shared their knowledge, perspectives and experiences. Collaborative yarning and narrative analysis informed the collective story and its underpinning storylines.

**Main findings** The study highlighted that rebuilding trust, fractured by colonisation, is central to equitable healthcare. Key shifts include understanding the enduring impacts of colonisation, unlearning unconscious biases and colonial dynamics, and adopting healing-informed, strengths-based and culturally responsive approaches that prioritise connection, deep listening, self-determination and walking alongside Aboriginal peoples.

**Principal conclusions** In the context of PAE and FASD, this study revealed how Western practices have broken the trust of Aboriginal peoples and how current systems continue to maintain this harm. It also offers a powerful story of hope, showing how embedding Aboriginal ways of knowing, being and doing can transform health professional practice and create strengths-based, healing-informed and culturally responsive services that benefit all Australians.

**Keywords:** Fetal alcohol spectrum disorder (FASD); Prenatal alcohol exposure; Australian FASD Indigenous Framework; Healing-informed practice; Aboriginal health equity; Culturally responsive healthcare

## Highlights

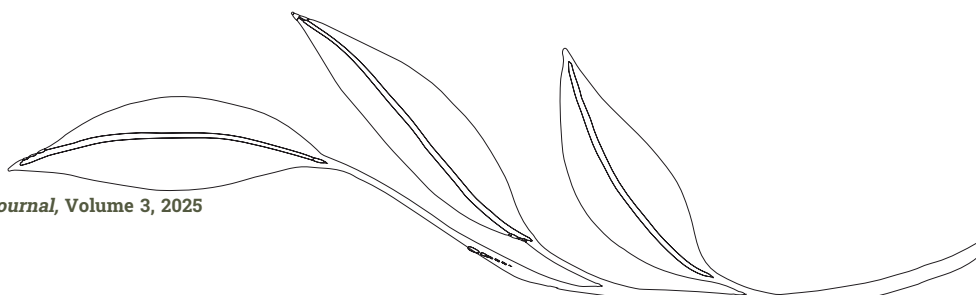
- Rebuilding trust is central to equitable healthcare access for Aboriginal peoples.
- Healing-informed and strengths-based practices can disrupt ongoing colonisation.
- Health professionals must unlearn colonial biases to foster culturally responsive care.
- Confidentiality and client control are central to healing-informed approaches.
- Advocacy is essential to dismantle systemic barriers and support family wellbeing.

## Introduction

Australians are born into a predominantly Western biomedical healthcare system, which often reflects a standardised, biologically focused and deficit-oriented perspective on health and wellbeing (Rocca and Anjum 2020). The biomedical model tends to prioritise biological explanations for health and illness, which inadvertently overlooks the influence of historical, social, behavioural and environmental determinants of health (Rocca and Anjum 2020). In doing so, greater

emphasis is placed on individual responsibility for health outcomes. This dominant worldview can give rise to blame and shame narratives, and unconsciously influence the knowing (knowledge), being (attitudes and beliefs) and doing (practices) of health professionals trained within the biomedical system (Hewlett et al. 2023).

Health professionals are central to facilitating equitable access to healthcare. To enable this, health



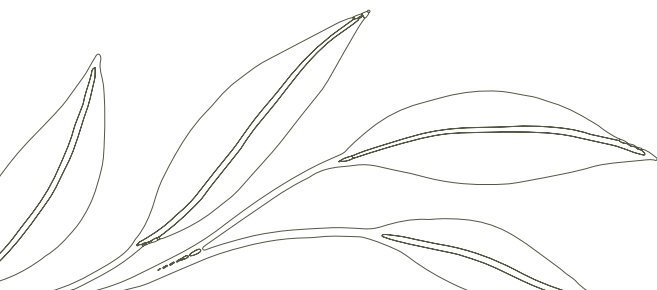


professionals must be equipped with the knowledge and skills to integrate holistic care that respects and responds to needs and experiences of diverse Australians ([Australian College of Nursing 2024](#)). This is especially true when it comes to facilitating access to knowledge and support regarding prenatal alcohol exposure (PAE) and fetal alcohol spectrum disorder (FASD) ([Hewlett et al. 2023](#)). Fetal alcohol spectrum disorder or neurodevelopmental disorder associated with PAE is a diagnostic term used to describe the lifelong impacts on the brain and body that individuals exposed to alcohol during pregnancy can experience ([Australian FASD Guidelines Development Group 2025](#)).

In alignment with the biomedical model's focus on pathology, efforts to prioritise PAE and FASD as public health concerns have, at times, placed considerable emphasis on the impairments experienced by individuals with FASD, overshadowing people's strengths and lived experiences ([Bell et al. 2016](#); [Skorka et al. 2020](#)). These types of deficit-focused narratives can fuel blame, shame and stigma of those living with FASD and their families ([Choate and Badry 2019](#)). Stigma and bias frame individuals living with FASD as the objects of pity (i.e. shame) or burdensome, and label women who consume alcohol during pregnancy as 'bad mothers', 'unfit for parenting' or 'child abusers' ([Aspler et al. 2018](#); [Bell et al. 2016](#); [Corrigan et al. 2019](#)). These views and beliefs influence the healthcare system and the attitudes, practices, policies and research of health professionals ([Lyll et al. 2021](#); [Wolfson and Poole 2023](#)). The impacts of such stigma and bias are twofold: individuals can be reluctant to disclose PAE or avoid services altogether for fear of consequence ([Lyll et al. 2021](#)) and, as a result, health professionals can experience a lack of confidence, knowledge and skills to discuss and provide appropriate support or referral pathways for PAE or FASD ([Kerimofski et al. 2024](#)).

Barriers to accessing essential knowledge, assessments, diagnosis and support for PAE and FASD can result in complex developmental, health, and social and emotional wellbeing needs of individuals being unrecognised and unmet. For Aboriginal peoples, these barriers are further compounded by colonialism and racism ([Hollinsworth 2013](#)). Importantly, PAE and FASD are not issues exclusive to Aboriginal communities; rather, they are less visible in non-Aboriginal populations, despite evidence that nearly half (48%) of Australians report alcohol use during pregnancy ([Young et al. 2022](#)). It is well-established that racism continues to be a significant barrier to service access for Aboriginal peoples, with many avoiding healthcare settings due to fears of discrimination and hostility ([Hine et al. 2023](#)). In the context of FASD where Aboriginal peoples do access assessment services, they may face a higher risk of over-diagnosis of FASD due to negative stereotyping and the use of culturally inappropriate assessment approaches, which can exaggerate perceived impairments ([Hollinsworth 2013](#)). Even with a diagnosis, a lack of appropriate support can lead to serious consequences, including increased rates of child removal, homelessness, suicide, substance dependency and involvement with the justice system ([Blagg et al. 2017](#)). These outcomes not only reflect systemic failures, but also reinforce colonial narratives, further deepening the inequities, injustices and harms experienced by Aboriginal peoples ([Williams 2018](#)).

The Australian FASD Indigenous Framework brings together the strengths of Aboriginal wisdom and Western knowledges to improve access to PAE and FASD knowledge, assessments, diagnosis and support ([Hewlett et al. 2023](#)). It guides health professionals to move beyond deficit-based models by embedding strengths-based, holistic approaches that nurture





trust, build genuine relationships, create cultural, psychological and emotional safety and address power imbalances. Central to the FASD Indigenous Framework are the critical shifts needed in the knowing (knowledge), being (self-awareness and behaviours) and doing (practices) of health professionals to facilitate equitable access to PAE and FASD services.

This qualitative study explored the perspectives of Aboriginal and non-Aboriginal knowledge holders connected to a regional Aboriginal medical service. It aimed to understand what non-Aboriginal health professionals need to know, be and do to deliver strengths-based, healing-informed and culturally responsive PAE and FASD knowledge and support. The Australian FASD Indigenous Framework was used to interpret the study findings and guide recommended practice changes for health professionals.

## Methods

### Who the authors are

The authors are a diverse team of Aboriginal (NH, LH, RW, KS) and non-Aboriginal (VL, LW, DA, NR) researchers and healthcare practitioners, united by a shared commitment to healing-informed, strengths-based and culturally responsive practice. Their collective expertise spans Indigenous methodologies, participatory action research, clinical psychology and community-led health service delivery.

NH is a Palawa PhD candidate and public health researcher who is passionate about challenging colonial deficit thinking around disability and embedding Indigenous worldviews in health, justice and education reform. Her work focuses on decolonising health systems and generating new evidence through yarning, storying and *Dadirri*. LH is a senior Iningai and Bidjara Elder and research fellow with over 55 years of

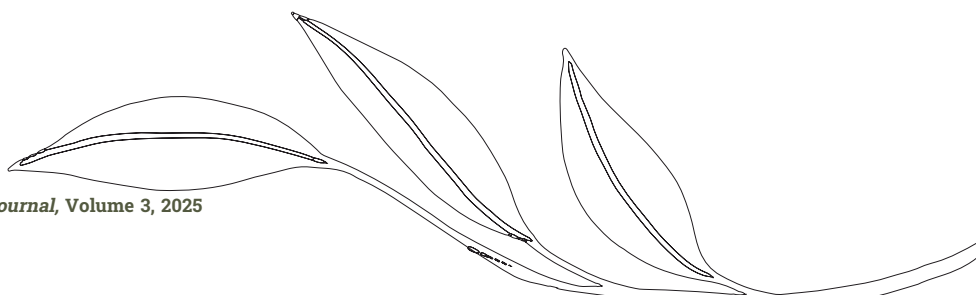
experience translating FASD knowledge across Aboriginal communities; she is committed to improving health literacy and advocacy at a grass roots level. RW is a Noongar associate professor whose work privileges Aboriginal sovereignty and challenges deficit-based narratives in health through culturally safe, community-led responses. KS is a Margany nurse and healthcare worker deeply embedded in community-controlled healthcare, with longstanding relationships and commitment to local wellbeing.

The non-Aboriginal team members bring complementary expertise and a strong commitment to Indigenous governance and relational ethics. VL is a qualitative researcher with nearly a decade of experience working alongside Aboriginal Medical Services. LW collaborates with Indigenous communities across Turtle Island (North America) and Australia, focusing on stigma reduction and perinatal substance use. DA is a health equity researcher dedicated to decolonising policy and strengthening community self-determination. NR is a clinical psychologist and senior researcher focused on participatory and community-driven approaches that prioritise collaboration and the translation of findings into meaningful change.

Together, they share a deep commitment to and practice of privileging and prioritising voices, values and beliefs of Aboriginal peoples. They understand the critical importance and strength of amplifying Aboriginal wisdom when it comes to healing the impacts of unrecognised and unsupported PAE and FASD alcohol harm and specifically PAE across all Australian society.

### How the study began

This qualitative study was conducted on Giabal and Jarowair Country, in collaboration with Carbal Medical





Services (Carbal) and the Aboriginal community of Toowoomba, Queensland. Carbal, a regional Aboriginal Medical Service, partnered with the University of Queensland on the Strong Start, Bright Future project in 2021 to co-create culturally informed and service-wide approaches to FASD prevention and support. This study formed part of the broader project by focusing on how to facilitate equitable access to the co-created approaches to FASD prevention and support.

### How the study was culturally and ethically governed

To challenge colonised and deficit-based approaches to Aboriginal research, the Carbal Research Governance Group (Governance Group) was formed to uphold community and cultural integrity across the lifespan of the project. The Governance Group comprised three Aboriginal Carbal staff (two clinic managers and an outreach manager) and two non-Aboriginal Carbal staff (clinic manager and outreach team leader). The Governance Group was responsible for leading all aspects of the project, and Aboriginal members specifically ensured that culture and community were at the centre of the research. Ethical clearance was obtained from the University of Queensland (2021/HE001203) and adhered to the core values of spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility laid out in the National Health and Medical Research Council's ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities (National Health and Medical Research Council 2018).

### How the study approached knowledge gathering

Consistent with the FASD Indigenous Framework, this study privileged Aboriginal ways of knowing, being and doing, which are inherently holistic, strengths-based, healing-informed and culturally-inclusive (Hewlett et al. 2023). These ways were centred and celebrated

as sovereign and foundational throughout the study. Western paradigms were respectfully and responsively engaged through approaches that were accountable to an Indigenous standpoint. This approach respects the strength and sovereignty of Aboriginal ways of knowing, being and doing (Martin and Mirraboopa 2003) and brings Western knowledge into the conversation in a collaborative spirit – not to compare or make equal, but to listen, learn and respond with respect, accountability and reciprocity.

In the context of Indigenous research methodology, Aboriginal ways of knowing, being and doing are interconnected cultural and spiritual concepts that influence how knowledge is understood (knowing), created (being) and used (doing) (Martin and Mirraboopa 2003). These ways are not just methods – they reflect a worldview and a lived experience that is sovereign and grounded in Country, kinship and spirit. Through the practices of yarning and *Dadirri*, the study prioritised relationships, reciprocity and the dynamic processes of knowledge sharing and creation for community benefit. Yarning is a culturally grounded practice of knowledge sharing and exchange that prioritises storytelling, connection and deep listening (i. e. *Dadirri*) from a place of trust and mutual respect (Bessarab and Ng'andu 2010). *Dadirri* is a practice gifted from Miriam-Rose Ungunmerr, an Ngan'gikurunggurr Elder of the Daly River in the Northern Territory. It is the practice of deep, respectful listening from a place of inner awareness (Ungunmerr-Baumann et al. 2022). It involves being present, still and attentive, not just to the words spoken, but also to the inner world of thoughts and emotions. The unscripted and dynamic nature of yarning and *Dadirri* enables a reciprocal and circular exchange, where diverse perspectives, experiences and stories generate new understandings and shared learnings for all involved (Holland 2016; Ober and Bat 2007).





## Who was involved

To honour the layered richness and depth of the knowledge shared, this article adopted the term knowledge holder instead of participant (Murrup-Stewart et al. 2021). This choice aligns with decolonising methodologies and affirms the value of language that recognises and upholds the relational, experiential and personal authority of those who contributed to the study. The term knowledge holder reflects a holistic perspective, acknowledging the interconnected relationships, experiences and wisdom that shape a person's ways of knowing, being and doing (Murrup-Stewart et al. 2021).

The knowledge holders in this study comprised Aboriginal and non-Aboriginal individuals connected to the outreach team at Carbal Medical Service. KS, an Aboriginal health worker at Carbal, invited 20 knowledge holders to participate in yarning about healthy pregnancies, alcohol and other substance use and FASD. The knowledge holders included six Aboriginal staff members, seven non-Aboriginal staff members, and seven Aboriginal community members not employed by Carbal but with relationships to the service, such as service users, collaborators or referrers. To express gratitude for their contributions, each knowledge holder received a \$30 gift voucher.

It is important to note that no knowledge holders identified as Torres Strait Islander and therefore these perspectives were not captured in this paper. The authors acknowledge and respect the rich ways of knowing, being and doing that are unique to Torres Strait Islander peoples. With their deepest respects, the authors do not imply that the knowledges in this study reflect Torres Strait Islander voices and therefore use Aboriginal throughout. Nevertheless, the findings may hold relevance for Torres Strait Islander peoples living in the Toowoomba region.

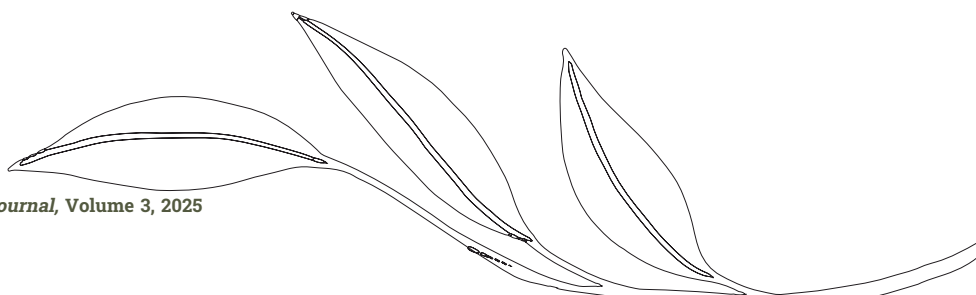
## Gathering the knowledge

The yarning sessions were conducted by KS and VL. KS, an Aboriginal health worker at Carbal, had worked in the local community for many years and had existing relationships with each knowledge holder. Her presence helped create a culturally safe and respectful space. VL, a non-Aboriginal researcher, approached the yarns as a learner, remaining mindful of her role and the power dynamics involved, and regularly reflecting on her position throughout the process.

Before each yarn, knowledge holders were taken through a clear and respectful consent process that outlined their rights, including confidentiality and the option to withdraw at any time without consequence.

In line with advice from the Governance Group and to honour Indigenous ways of sharing knowledge, scripted questions or a formal interview guide were not used. Instead, gentle prompts supported open conversation around three key topics: alcohol and other substance use, FASD and healthy pregnancies. These topics were identified in collaboration with the Governance Group and reflected shared priorities. This approach allowed knowledge holders to guide the direction and depth of the yarns, ensuring that what was shared came from their own lived experiences, cultural knowledge and values, rather than being shaped by researcher agendas.

The yarning method was chosen to uphold Indigenous sovereignty and self-determination by centring community voices and ways of knowing. While the yarns were open-ended, they were grounded in a clear research aim: to explore community understandings and experiences related to alcohol use, FASD and healthy pregnancies, with the goal of informing culturally safe and relevant health promotion strategies.





Yarning sessions took place between December 2021 and February 2022, in locations chosen by knowledge holders for their comfort and convenience. All sessions were audio recorded and transcribed verbatim, except for one where notes were taken. Transcripts were de-identified by VL before being shared with the research team, ensuring confidentiality and respectful handling of the data.

### Understanding the knowledge

Understanding the overarching collective story (i.e. identification of the core story; Emden 1998) and the underpinning storylines was informed by Emden's (1998) narrative analysis approach, which centres on core story creation and emplotment, that is: weaving together events, experiences and actions into a coherent and meaningful story. This study extended Emden's method by entwining it with collaborative yarning (Shay 2021), translating theoretical narrative analysis into a culturally grounded, relational and practice-based approach. By embedding Indigenous principles of relationality, reciprocity and self-determination (Kennedy et al. 2022) into the analytical process, Emden's (1998) emphasis on meaning-making was shifted from the individual researcher to the collective, ensuring that knowledge was co-created through culturally safe and ethically accountable processes.

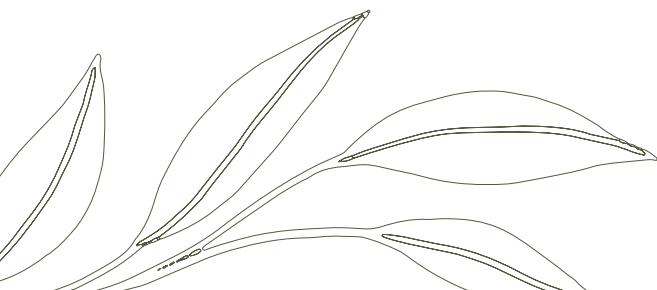
Shay's (2021) collaborative yarning enriched Emden's (1998) theory by introducing iterative, co-constructed analysis that is culturally accountable and grounded in Aboriginal ways of knowing, being and doing. While Emden's emplotment seeks coherence and significance across stories, collaborative yarning adds cultural safety, reflexivity and collective interpretation, deepening the analytical process and transforming it into a decolonising methodology that privileges Aboriginal voices. This fusion generates profound new

knowledge by honouring Indigenous sovereignty and relational accountability, and by creating space for stories to be interpreted through shared cultural and experiential lenses.

Importantly, this approach responds directly to the concerns raised by Kennedy et al. (2022), who cautioned against superficial or tokenistic applications of yarning and called for rigorous, transparent and culturally safe research practices that uphold Indigenous ownership, stewardship and leadership. By privileging Aboriginal-led analysis, iterative co-reflection and relational ethics, this study ensured that yarning was not only methodologically sound but also ethically grounded. The integration of Emden's narrative analysis and Shay's collaborative yarning exemplifies how theory and practice come together to guide health professionals in understanding what they need to know, be and do to deliver healing-informed, strengths-based and culturally responsive PAE and FASD support.

The first step involved two Aboriginal researchers (NH and a senior researcher with extensive experience in FASD who chose not to be listed as a co-author) and two non-Aboriginal researchers (VL and LW) each independently reading the yarning transcripts and reflecting on the knowledge shared. Each researcher documented their reflections in different ways, including written notes, NVivo coding, or structured tables, depending on their preferred analytical style and methodological orientation. These reflections informed the collaborative yarns that followed.

NH and the senior Aboriginal researcher then led three collaborative yarns across four months with VL, DA and LW. These yarns were not audio-recorded but were documented through detailed field notes and reflective annotations. The purpose of these yarns was to explore what each researcher had learned





from the transcripts, how their perspectives were shaped by their positionality, and how these learnings could be understood in relation to the study's aim.

In all yarns, Aboriginal researcher voices (NH and the senior Aboriginal researcher) were privileged. Their insights prompted further learning and reflection for VL, DA and LW, challenging initial assumptions and enabling deeper understanding. Through the process of collaboratively yarning about their personal reflections, they came to recognise that the emerging storylines strongly resonated with the Australian FASD Indigenous Framework (see [Figure](#); [Hewlett et al., 2023](#)). Thus, the FASD Indigenous Framework was not a predetermined analytical lens but rather a culturally resonant way to understand the knowledge that organically surfaced from the data.

Following this, NH and VL re-read the transcripts with the goal of identifying what learnings emerged for non-Aboriginal health professionals and Aboriginal communities. In this context, learnings refer to insights and understandings gained by the researchers as a result of knowledge holders generously sharing their lived/living experiences, perspectives and beliefs. These learnings were not extracted or categorised but were interpreted through ongoing yarns and mentorship. NH was mentored by two senior Aboriginal FASD researchers (LH and RW) and a senior non-Aboriginal FASD researcher and clinician (NR), all of whom were co-creators and cultural/clinical authorities on the development of the FASD Indigenous Framework.

NH held numerous yarns with LH, RW and NR to deepen her understanding of the stories and their implications. From this developed perspective, NH used Prezi ([Prezi Inc](#), San Francisco, USA) software to visually present the learnings as an overarching collective story and its underpinning storylines. These

storylines were not constructed through thematic coding but through relational interpretation and collaborative refinement. A follow-up yarn with VL, DA and LW enabled further reflection and validation of the collective story.

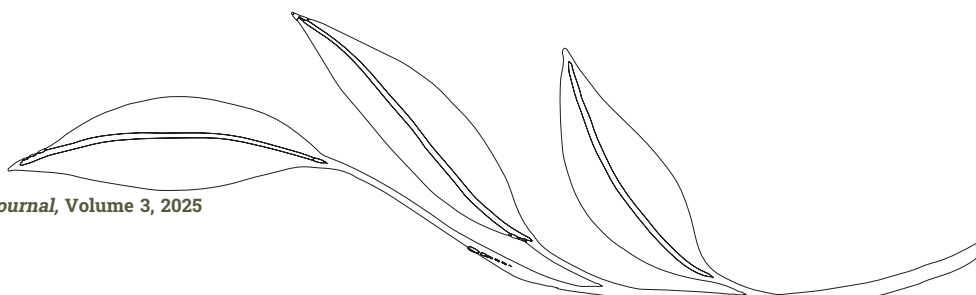
Finally, NH presented the refined collective story and storylines to the Governance Group in a format that was accessible and culturally meaningful. Two of the knowledge holders, in addition to KS (author), were also members of the Governance Group, contributing both their lived experience and professional and cultural leadership to the interpretation and validation of the findings. The Governance Group's feedback and approval ensured that the stories remained true to the knowledge shared and reciprocated with new insights that strengthened Carbal's service capacity.

## Results

This section shares the collective story that emerged through yarning with Aboriginal and non-Aboriginal knowledge holders. Rather than fragmenting the yarns into discrete themes, the findings are presented in storylines to reflect the voices, lived experiences and wisdom shared. The overarching story is one of rebuilding trust, a trust fractured by colonisation and sustained through systemic inequities. The yarns revealed what non-Aboriginal health professionals need to know, be and do to walk alongside Aboriginal peoples in ways that are healing-informed, strengths-based and culturally responsive. These insights were interpreted through the Australian FASD Indigenous Framework, which guided understanding of the shifts required in health professional practice.

### **Knowing: 'You will never meet an Aboriginal person that doesn't have some sort of trauma'**

Consistent with the FASD Indigenous Framework, the knowing component calls for a deep understanding of





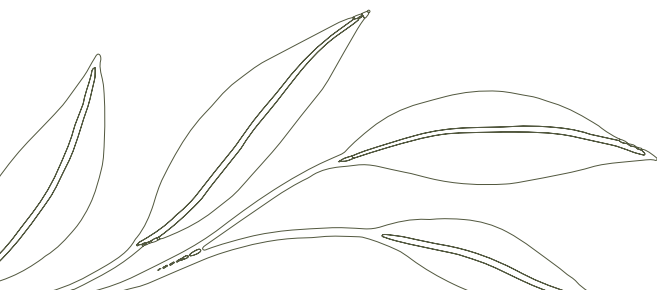
**Figure:** The non-Aboriginal side of the current Australian FASD Indigenous Framework (partly reproduced with permission from Hewlett et al. 2023)

the historical and ongoing impacts of colonisation. Aboriginal knowledge holders spoke openly about trauma as a shared reality:

*You will never meet an Aboriginal person that doesn't have some sort of intergenerational trauma. We all got that. Or their own trauma or both. You can't really get through life treated like less than by an entire country that you are born to without having some sort of traumatic reaction to it. Community member, knowledge holder 5.*

This collective experience of trauma was not presented as pathology, but as a consequence of systemic and sustained colonial violence. Alcohol and substance use were described not as isolated behaviours, but as responses to deep pain and suffering:

*It's always going to come back to the trauma. It's always going to come back to whatever the person's got going on mentally. And if they're using that particular thing [alcohol or other substance use] as a crutch and a coping mechanism. Find them different*





*... coping mechanisms first. But you're not going to get rid of the grog by looking at that as the one issue.*

Community member, knowledge holder 5.

These insights reflect the need to understand alcohol use within the broader context of trauma, rather than through deficit-based, pathologised or individualised lenses.

The FASD Indigenous Framework also emphasises that knowing must include understanding how colonisation continues to operate through systems such as child protection, where the fear of child removal remains a pervasive and deeply felt reality for many Aboriginal families. The yarns revealed that these fears are not abstract but grounded in lived experience, where contemporary practices mirror historical policies of forced removal:

*...there are parts of the child protection system that's still like the Stolen Generation, except [now] it's formalised.* Staff member, knowledge holder 7.

This fear shapes how Aboriginal families engage with – or avoid – health services:

*If like the families already dealing with, um, like DoCS [Department of Child Safety] or anything like that... they might not be wanting to come to the doctors until later on in the pregnancy. Um, just not to flag anyone.* Staff member, knowledge holder 14.

Avoiding the disclosure of alcohol and other substances was described as a protective strategy, particularly among Aboriginal women:

*...because they're [Aboriginal women] worried that if they do open up and if they do say something, that it's going to jeopardise them losing their children.* Community member, knowledge holder 3.

*... they're White and what are they going to do with that information? They're going to go straight to Child Safety... I'm not going to tell them nothing.* Staff member, knowledge holder 19.

These quotes illustrate the deep mistrust of mainstream services and the strategic decisions that Aboriginal women make to protect their families. Knowledge holders described how Aboriginal families are highly vigilant when disclosing information, knowing that doing so can result in punishment rather than support:

*They won't ask for help when they need it because they're scared of the consequences. And that is exactly what it is. Not help. Not assistance. Consequences.* Community member, knowledge holder 5.

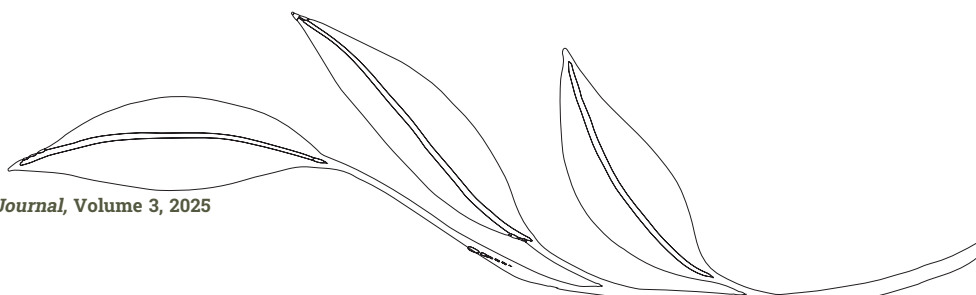
There was also a shared understanding that once an Aboriginal person or family is in the out-of-home care system, it is difficult to break the cycle and the racist, stigmatising attitudes that accompany it:

*I got bombarded by Child Safety, telling me ...that a leopard never changes [their] spots. Like that's how they greeted me.* Community member, knowledge holder 1.

This storyline reflects the critical need for health professionals to know how the systems they work for are experienced by Aboriginal peoples not as care – but as surveillance and punishment. Knowing, in this context, requires more than awareness; it demands accountability to the lived realities of Aboriginal families and the ongoing impacts of colonisation.

## **Being: Because what do White people do? They interrogate**

In line with the FASD Indigenous Framework, this storyline focuses on being and asks health





professionals to critically reflect on their own identities, power and behaviours. Knowledge holders described how clinical practices often feel unsafe and retraumatising for Aboriginal peoples. One knowledge holder described how mainstream interactions can feel more like an interrogation than care:

*Because what do White people do? They interrogate. Lots of talk. So that's what they do. [Aboriginal peoples] are not going to tell you anything....* Staff member, knowledge holder 19.

This sense of being interrogated rather than supported contributes to a lack of trust and openness in clinical settings. The way information is shared – particularly through written materials – was also identified as potentially harmful.

*...leaving anything [pamphlets, fact sheets, booklets etc] with them will create an issue, like DV [domestic violence] in their homes.* Staff member, knowledge holder 9.

Knowledge holders emphasised that resources must be used with discernment and accountability, recognising that even well-intentioned actions can carry unintended consequences if not grounded in trust, connection and safety:

*...you need to use [resources] very wisely, not just giving to the client thinking, hey, I'm giving now something really helpful to these clients – you have to make a choice how the client is actually going to use that?* Staff member, knowledge holder 15.

This storyline shows that being healing-informed, strengths-based and culturally responsive requires more than good intentions. It demands critical

self-reflection, a process of unlearning, and recognising how well-intentioned actions may reinforce colonial dynamics.

### **Doing: 'You've got to have that connection'**

The third component of the FASD Indigenous Framework, doing, is about transforming practice. Despite the legacies of colonisation and the sensitive nature of the topic, the yarns were overwhelmingly solutions focused. Knowledge holders described how important connection and trust are in understanding and supporting clients:

*If you have a really good bond with your client you're going to be able to [understand them] ...you've got to have that connection. And if you don't have that connection you need to find that connection...* Community member, knowledge holder 3.

Another knowledge holder described how sharing personal vulnerability helped initiate a genuine and ongoing relationship of trust:

*I shared something that was very much very, very private. And that opened the gate of trust, you know. She knew that I was for real, not pretend.* Staff member, knowledge holder 19.

Yarning and storying in particular was described not merely as a technique, but essential to building trust and understanding:

*...it's taking the time and telling a story. And taking the time to listen to the story about absolutely nothing sometimes. Because that absolutely nothing has probably got a lot of story in there.* Staff member, knowledge holder 19.





Connection was also described as non-verbal. One knowledge holder explained how body language can signal openness or resistance:

*...blackfellas are good at reading body language. If your body language is saying, 'I don't really want to have this conversation' they're not going to have a conversation. Community member, knowledge holder 2.*

Another emphasised the importance of patience and space:

*So sometimes clients sit here for 15 minutes saying nothing – you need to give them space and time. Staff member, knowledge holder 15.*

Relationships and support were described as collective, with a strong emphasis on family-centred care and walking alongside clients in ways that nurture trust and openness. One knowledge holder explained:

*You have to build the relationship with your families or they're not going to talk to you. They're not going to be open to a conversation about anything, let alone FASD, like, you know what I mean? Community member, knowledge holder 2.*

Others knowledge holders mentioned how support must be responsive to where clients are at – ongoing, flexible and able to wrap around them in ways that reflect their lived realities:

*Knowing that Carbal can help you and support you through those recovery roads and it's okay to lapse... Staff member, knowledge holder 14.*

*...if they disclose, and with their consent ...knowing that there's a whole team there that can wrap around them*

*... they're having that ongoing support, hug them from all areas. Staff member, knowledge holder 14.*

Client autonomy and self-determination were also prioritised. One knowledge holder described how supporting clients means ensuring that they retain control over decisions and are empowered to make informed choices based on their own expressed needs and preferences:

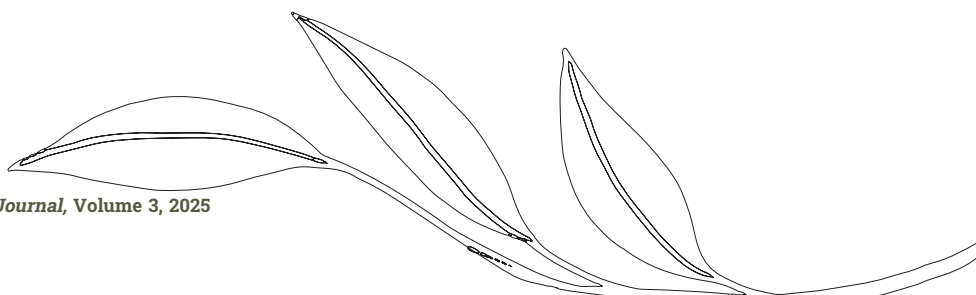
*Making sure that all choices are the clients' choice. So making sure that they've got a say in it, um, and it's what they want. And then just helping them with whatever they're wanting or needing. Staff member, knowledge holder 14.*

Knowledge holders described how they actively worked to protect families from punitive systems, particularly child protection:

*...the doctors and most of us know that if Child Safety needs to be called we try to do as much as we can through our side... We try to soften [the crisis], try to get that sorted before Child Safety gets called, because that's our last port of call is to call Child Safety. Staff member, knowledge holder 13.*

*I said, 'What gets said in this room doesn't go any further than the doctor. If we refer you, it's limited information, nothing goes to DoCS [Department of Child Safety] or anything like that.' And the relief on her face... Staff member, knowledge holder 16.*

Advocacy emerged as a powerful expression of commitment and support, with non-Aboriginal knowledge holders describing how they actively used their roles to navigate barriers, amplify voices and ensure that Aboriginal clients' needs were recognised and addressed:





*So that's where sometimes we become the advocates and the support for them... We do different appointments that we don't normally do, like as part of our role but it's to be that support person for them so they feel safe... Staff member, knowledge holder 9.*

This storyline highlights that healing-informed, strengths-based and culturally responsive practice is not about ticking boxes or following protocols – it is about walking alongside Aboriginal families in respectful ways that uphold self-determination and meaningfully respond to their needs with compassion.

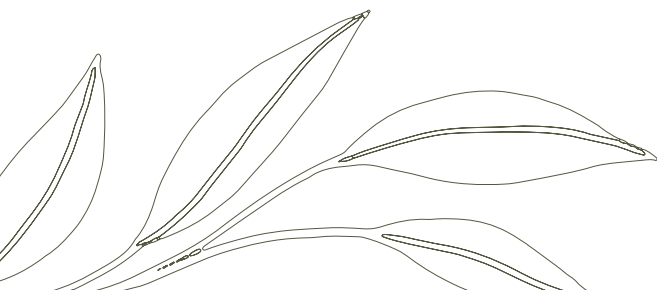
These storylines do not stand alone; they are woven together through the collective story of how health professionals can rebuild trust with Aboriginal peoples. Importantly, each quote and insight shared by knowledge holders directly informed the practical model presented in the [Table](#). For example, the emphasis on trauma, systemic harm and mistrust in the 'knowing' storyline shaped the need for health professionals to understand colonisation's enduring impact and the role of protective behaviours. The 'being' storyline, which highlighted the experience of interrogation and the unintended consequences of clinical practices, informed the need for reflexivity, humility and critical self-awareness in everyday interactions. The 'doing' storyline, rich with examples of connection, deep listening, advocacy and walking alongside clients, translated into actionable practices such as family-centred care, unpressured spaces and wrap-around support. Together, these insights were not simply interpreted, they were translated into the knowing, being and doing framework that underpins the [Table](#). This table offers a practical guide, grounded in lived experience and cultural wisdom, for transforming health professional practice in ways that are healing-informed, strengths-based and culturally responsive.

## Discussion

This qualitative study explored the perspectives of knowledge holders at a regional Aboriginal medical service to understand what non-Aboriginal health professionals need to know, be and do to deliver healing-informed, strengths-based and culturally responsive PAE and FASD knowledge and support. The findings were interpreted through the Australian FASD Indigenous Framework, which provided a culturally responsive lens for understanding and articulating the shifts required in health professional practice. The discussion that follows reflects on the significance of these shifts, the implications for health service delivery, and the transformative potential of centring Aboriginal ways of knowing, being and doing for facilitating equitable access to FASD and PAE knowledge and support for all Australians.

### What do non-Aboriginal health professionals need to know?

The findings highlight the vital importance of a critical shift in the knowing of non-Aboriginal health professionals when working with Aboriginal communities. As articulated in the FASD Indigenous Framework ([Hewlett et al. 2023](#)), one of the foundational shifts required is a critical understanding of the ongoing legacies of colonisation and how they continue to influence Aboriginal perspectives of and experiences with health systems. Consistent with the FASD Indigenous Framework, the stories shared by knowledge holders revealed how colonisation and its profound legacies of trauma, shame and guilt have manifested in a powerlessness, deep distrust and fear among many Aboriginal peoples using any health services. These findings emphasise the need for health systems to critically examine their entanglement with child protection services, which can undermine trust and deter engagement. The experiences shared described how Aboriginal women





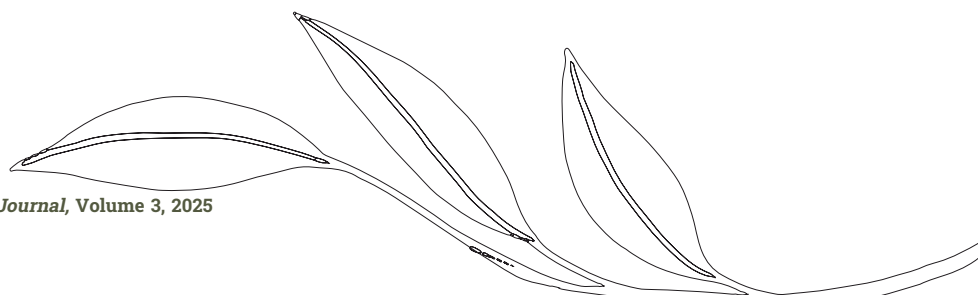
	Healing-informed	Strengths-based	Culturally responsive
Knowing	<ul style="list-style-type: none"> <li>Knowing the impacts of colonisation and ongoing trauma, poverty, racism, grief and loss that may lead to alcohol use as a coping strategy.</li> <li>Knowing that systemic racism in colonial systems contributes to Aboriginal peoples avoiding antenatal care for safety.</li> <li>Knowing the deep mistrust Aboriginal peoples have of antenatal services and the valid fear of child removal if alcohol use is disclosed.</li> </ul>	<ul style="list-style-type: none"> <li>Knowing how deficit narratives fuel blame, shame and racism.</li> <li>Knowing that alcohol use reflects unmet needs and systemic failure, and not everyone can stop drinking during pregnancy.</li> <li>Knowing the importance of building trust to provide meaningful PAE and FASD support.</li> </ul>	<ul style="list-style-type: none"> <li>Knowing the strengths of Aboriginal worldviews and the value of integrating Aboriginal ways of knowing, being and doing.</li> <li>Knowing that clients are experts in their own lives and define what culture, safety and support mean to them.</li> <li>Knowing the vital role that health professionals play in enabling access to PAE and FASD knowledge and support.</li> <li>Knowing that culturally-driven, community-led antenatal services can redress colonisation and increase safety for Aboriginal peoples</li> </ul>
Being	<ul style="list-style-type: none"> <li>Cultivating compassion for individuals who may not be able to stop drinking during pregnancy.</li> <li>Critically reflecting on the power and privilege held as a health professional and how it may impact clients.</li> <li>Examining personal biases and considering whether actions serve your needs or those of your clients.</li> </ul>	<ul style="list-style-type: none"> <li>Developing self-awareness around judgements or assumptions when alcohol use is discussed and explore their origins.</li> <li>Challenging stereotypes and colonial conditioning that reinforce deficit-based thinking.</li> <li>Recognising the limitations of the dominant biomedical model and question assumptions of its superiority.</li> </ul>	<ul style="list-style-type: none"> <li>Avoiding homogenising beliefs that suggest equal treatment means treating everyone the same.</li> <li>Listening and learning from clients as equals, acknowledging their expertise in their own lives.</li> <li>Embracing discomfort and mistakes as opportunities for growth and transparency.</li> <li>Valuing the mutual benefits of compassionate, human connection in care relationships.</li> </ul>
Doing	<ul style="list-style-type: none"> <li>Prioritising client confidentiality, sense of agency and wellbeing in all interactions.</li> <li>Using yarning to create culturally safe, unpressured spaces where clients are in control of what they share.</li> <li>Supporting client autonomy through informed choice.</li> </ul>	<ul style="list-style-type: none"> <li>Focusing on building trusting, supportive relationships rather than solely on clinical outcomes.</li> <li>Identifying and building on client strengths to support their goals and challenges.</li> <li>Responding to client needs without trying to 'fix' them; walking alongside clients with compassion.</li> <li>Involving and supporting families when guided by the client's preferences.</li> </ul>	<ul style="list-style-type: none"> <li>Using deep listening practices such as <i>Dadirri</i> to understand client priorities, needs and circumstances.</li> <li>Committing to approaches that strengthen and keep families together.</li> <li>Advocating for access to meaningful resources and wrap-around services.</li> <li>Advocating for systemic reform to ensure services are equipped to meet complex needs related to PAE and FASD.</li> </ul>

**Table: Facilitating strengths-based, healing-informed and culturally responsive approaches to prenatal alcohol exposure (PAE) and fetal alcohol spectrum disorder (FASD)**

often delay or avoid antenatal and perinatal care – not due to negligence or lack of concern, but as an act of survival and protection in the face of systems that continue to threaten their families, self-determination and cultural identities (Hine et al. 2023; Krakouer et al. 2018). It is also important to note that this distrust and survival strategies are rooted in and compounded by the intergenerational trauma of forced Aboriginal child removals and the contemporary echoes of these policies and practices within the current health and child protection system (Krakouer et al. 2023). This has direct implications for clinical practice; without

this critical shift in ways of knowing, well-intentioned health professionals risk perpetuating harm and reinforcing distrust by engaging in practices that often exacerbate fear and powerlessness for Aboriginal clients.

For health professionals to safely support Aboriginal peoples in having healthy, alcohol-free pregnancies, it is critical to understand how the legacies of colonisation contribute to why and how alcohol is used by some Aboriginal peoples. Consistent with the FASD Indigenous Framework and extensive previous





literature, knowledge holders emphasised that alcohol use can only be understood in the context of colonial history and the excessive levels of stress that accompany pervasive grief, trauma and racism (Gonzales et al. 2021; Reid et al. 2021; Williams 2018). This insight underscores a pressing need for health education curricula and policy frameworks to move beyond individualised behavioural models and instead embed historical, social and systemic determinants of health. Without this shift, health professionals risk perpetuating harm by interpreting alcohol use through a lens of personal choice and moral judgement – an approach that reflects the biomedical system’s failure to acknowledge its inherent systemic racism and holistically respond to needs. Understanding the context and role of alcohol use in an Aboriginal person’s life is not only essential to counteracting blame and shame narratives, but also foundational to delivering PAE and FASD knowledge and support that is healing-informed, strengths-based and culturally responsive (Gonzales et al. 2021; Hewlett et al. 2023; Williams 2018).

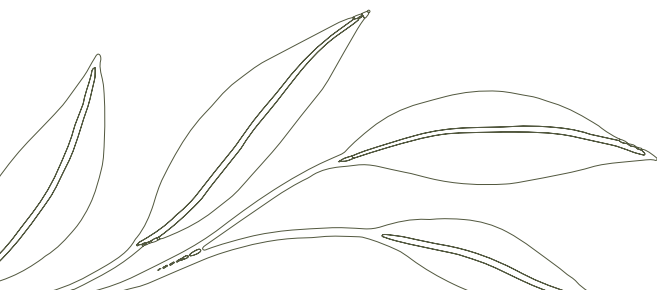
### **Who do non-Aboriginal health professionals need to be?**

As emphasised in the FASD Indigenous Framework, to shift ways of being, non-Aboriginal health professionals need to engage in ongoing and critical reflective practices, to unlearn the colonial privilege, power and biases that perpetuate cycles of broken trust and undermine access to services for Aboriginal peoples (Hewlett et al. 2023). These findings highlight the critical importance of shifting the being of non-Aboriginal health professionals in their relationships with Aboriginal peoples, that is: developing a deeper self-awareness of how privilege, unconscious bias and colonial conditioning influence behaviour and decision-making. These insights suggest that professional training must move beyond cultural awareness to include critical reflection on how clinical

practices, tools and resources – rooted in Western norms – may unintentionally reinforce colonial dynamics and silence Aboriginal voices (Dudgeon and Walker 2015). For example, resources such as pamphlets and practices such as clinical interviews (‘interrogating’) may feel familiar and effective to health professionals but they can retraumatise and alienate Aboriginal clients, particularly in the areas of PAE and FASD.

This unconscious reliance on Western practices reflects the homogenising one-size-fits-all approach of the biomedical model. Some health professionals may view this approach as one of equality, that is: treating everyone the same and giving access to the same opportunities (D’Costa et al. 2025). However, equality assumes that everyone has the same resources, privilege and power, which could not be further from the truth in the lives of Aboriginal peoples needing PAE or FASD support (Gonzales et al. 2021; Tujague and Ryan 2023). These approaches can entrench unconscious bias, privilege and power, which govern the decisions, behaviours and practices of health professionals and ultimately undermine a healing-informed, strengths-based and culturally responsive relationship with Aboriginal peoples (D’Costa et al. 2025; Webster et al. 2022).

The being component of the FASD Indigenous Framework (Hewlett et al. 2023) is likely the most challenging for health professionals, as it demands an inward journey of unlearning and sitting with hard truths. Yet, despite requiring no resources *per se*, it is arguably the most neglected and misunderstood aspect of health service delivery in Australia. The authors suggest that it is the underlying and under-recognised force informing all levels of inequity for Aboriginal peoples across the social, commercial and political determinants of health in Australia.





Prioritising the shifts in being through reflective practice, humility and accountability offers one of the most powerful opportunities to transform Australian healthcare into a system that is not only more accessible for Aboriginal peoples, but also more ethical, equitable and effective for all. The reciprocity of this transformation is profound: health professionals who commit to this journey often experience personal and professional growth, renewed purpose and a deeper, more meaningful connection to the communities they serve.

### **What do non-Aboriginal health professionals need to do?**

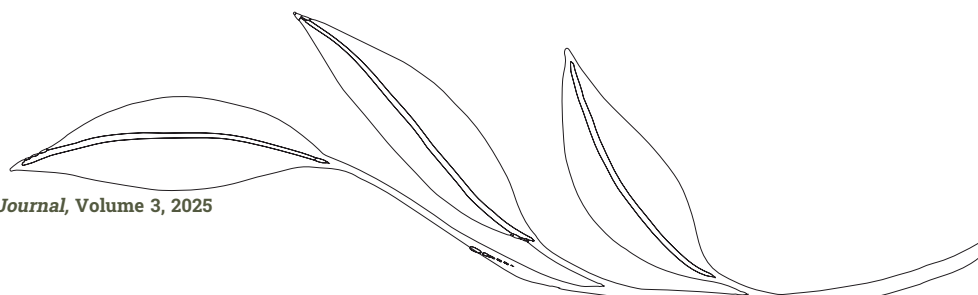
The current study provides an insightful and practical pathway for how the FASD Indigenous Framework's knowing and being translates into doing at a local health service delivery level. It demonstrated that the shift in doing is not about ticking boxes or adding new tasks to clinical checklists but rather it is about transforming how PAE and FASD knowledge and support is delivered through healing-informed, strengths-based and culturally responsive practices that rebuild trust. Aligned with the FASD Indigenous Framework, the stories shared by Aboriginal and non-Aboriginal knowledge holders consistently centred trust as the foundation of effective healthcare, yet trust cannot be assumed or hastened; it must be cultivated through practices that prioritise connection, deep listening and walking alongside clients in ways that honour their lived experiences and cultural strengths.

This study highlighted how practices such as yarning, family directed care, strengths-based wellbeing approaches and advocacy all serve to build genuinely safe, trusting and supportive relationships with Aboriginal peoples (Hewlett et al. 2023). These are not simply culturally appropriate, they are essential to dismantling the colonial dynamics embedded in

mainstream service delivery. Health professionals who prioritise unpressured spaces, deep listening and client-led decision-making are better able to understand and respond to the unmet needs of Aboriginal clients and families. The wisdom here lies in understanding that a health professional does not need systemic shifts, new infrastructure or specific resources to build trust and connection with Aboriginal peoples and families; it requires humility, consistency and a willingness to embed Aboriginal ways of knowing, being and doing into everyday practice in ways that prioritise trust, respect and cultural safety.

The implications for policy and workforce development are significant. Embedding these practices into service models, training programs and organisational standards can help move health systems away from transactional, compliance-driven models and toward relational, community-defined care that is grounded in trust, reciprocity and respect. This includes recognising that wellbeing is collective, and that supporting families – not just individuals – is central to effective FASD and PAE support (Puszka et al. 2022). It also means resisting the biomedical impulse to report and 'fix problems' and instead responding to the whole person with compassion, confidentiality and respect for their agency.

At the heart of this shift in doing is advocacy. Health professionals must use their roles not only to support individual clients, but also to advocate for systemic reform, ensuring that services are equipped to meet the complex needs of those living with unrecognised and unsupported PAE and FASD. This includes advocating for wrap-around support, culturally safe and strengths-based pathways and organisational accountability to Aboriginal communities. When health professionals walk alongside Aboriginal





peoples in this way, they contribute to healing, not just at the individual level, but within the broader systems that have historically caused harm.

To consolidate these insights into a practical resource for health professionals, the [Table](#) synthesises the critical shifts in knowing, being and doing required to deliver healing-informed, strengths-based and culturally responsive PAE and FASD services. Rather than summarising raw data, the table reflects the deeper significance of the findings and offers a guide for embedding Aboriginal ways of knowing, being and doing into everyday practice.

### Limitations

While the study offers valuable insights into Aboriginal knowledges and lived experiences, it does not include perspectives from Torres Strait Islander peoples. This absence limits the applicability of the findings for health professionals working with Torres Strait Islander communities, whose cultural contexts, histories and health experiences are distinct and equally important. Additionally, the research was grounded in a specific community in Queensland. As such, findings may not fully reflect the diversity of Aboriginal peoples' knowledges, experiences and health priorities across other regions of Australia.

### Future research

Future research should actively and respectfully include Torres Strait Islander peoples to incorporate their wisdom, values, perspectives and experiences. Expanding the research to include a broader range of Aboriginal communities across Australia would also enrich the knowledge base and support the development of more inclusive, culturally responsive approaches to PAE and FASD knowledge, services and support. Future research could also explore the potential benefits of adopting healing-informed, strengths-based and culturally responsive practices

on the wellbeing of non-Aboriginal health professionals and whether such approaches also facilitate service access for non-Aboriginal Australians.

### Implications for policy and practice

This study identified a range of critical system-level barriers that hinder service access for Aboriginal peoples in the context of PAE and FASD. One particularly significant concern raised by knowledge holders was the avoidance of antenatal care due to fears of child removal. Mandatory reporting laws, which require certain professionals to report suspected child abuse or neglect, vary across Australian states and territories ([Kenny et al. 2023](#)). Future research is needed to explore how health professionals understand and implement reporting obligations, particularly in relation to substance use during pregnancy. This includes examining how reporting practices differ across jurisdictions, and how these practices may unintentionally contribute to the barriers to antenatal care experienced by Aboriginal families. Moreover, there is a pressing need to investigate how systems and policies can be reformed to prioritise culturally safe, family-centred wraparound approaches that support families rather than trigger punitive responses.

### Conclusion

This study contributes critical insight into the structural, relational and cultural barriers that Aboriginal peoples face in accessing PAE and FASD knowledge and support. Through the findings of the current study, it is evident that healing the fractured relationship between Aboriginal communities and health systems requires more than culturally appropriate resources, training or policy reform: it requires deep, sustained change in the ways of knowing, being and doing of health professionals.





Ultimately, the findings call for a shift away from transactional, system-centred models of care toward relational, culturally anchored practices that prioritise trust, family and community-defined wellbeing. When health professionals actively work to dismantle the biases, behaviours and institutional norms of Western healthcare that instinctively continue to colonise Aboriginal peoples, they create the conditions for genuine connection, safety and healing. This work is not easy and is never complete; however, it is essential if equitable, respectful and effective pathways to PAE and FASD knowledge and support can be realised to transform healthcare for the benefit of all Australians.

## Author contributions

D. Askew, V. Lyall, N. Hewlett and N. Reid informed the design and concept of the study. V. Lyall and K. Scofield collected the data. Reading and interpretation of the data were conducted by N. Hewlett, V. Lyall, L. Wolfson and D. Askew. The manuscript was drafted by N. Hewlett, V. Lyall and N. Reid. All authors contributed to reviewing and editing the manuscript. All authors reviewed and approved the final manuscript. N. Hewlett, L. Hayes and R. Williams provided cultural oversight to ensure the study's cultural integrity.

## Data sharing

The project was developed on the principles of Indigenous Data Sovereignty. The raw data include transcripts of yarns with knowledge holders, who explored sensitive topics such as trauma, colonisation and alcohol and substance use. Therefore, to respect and protect the interests and privacy of knowledge holders, raw data are not made available.

## Declaration of interests

The authors declare no competing interests.

## Funding

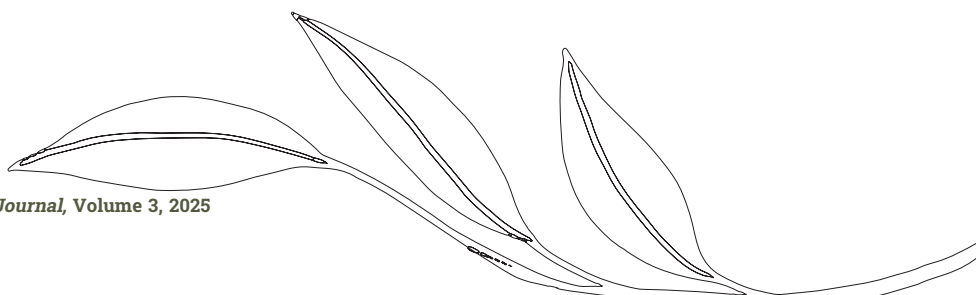
The study was funded by a National Health and Medical Research Council (NHMRC) Ideas Grant (APP1184466). The NHMRC did not have any role in the design of the study; in the collection, analysis or interpretation of the data; in the writing of the manuscripts; or the decision to submit the manuscript for publication.

## Declaration of AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used ChatGPT to meet the character count specified for the 'Highlights' section. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

## Acknowledgements

We acknowledge that we stand in footsteps millennia old and pay our deepest respects for the custodians of all the unceded lands, waters and sky we draw nourishment from. We thank the incredible Aboriginal and non-Aboriginal knowledge holders connected to the Outreach Team at Carbal, who generously shared their stories, experiences and wisdom in order to benefit Aboriginal communities locally and more broadly. We would *especially* like to acknowledge the deeply respected and highly regarded Charlie Rowe and Joy-Anne Clarke, Carbal's Outreach Team Leaders, whose 24-hour roles and unwavering commitment to walking alongside and bringing healing to those most forgotten and rejected in society are why this study and knowledge cultivated was possible. We would like to thank the governance, guidance and support of the Carbal Research Governance. We would also like to acknowledge Heather D'Antoine for participating in and contributing





to the collaborative yarns that supported our understanding of the knowledge and stories shared.

### Author biographies

Nicole Hewlett is a proud Palawa mother of two daughters, passionate about knowledge translation approaches that bring healing and make a meaningful, real-world difference to the lives of Aboriginal and Torres Strait Islander peoples. Her work focuses on challenging colonial deficit thinking and embedding Indigenous worldviews in health, justice and education reform. Based in Meanjin, Nic extends her deepest respects and gratitude to the Turrbal and Yuggera peoples, whose irrepressible spirituality flows through their unceded and sovereign Country and inherently guided the writing of this article.

Vivian Lyall is a settler in Australia of English and Scandinavian ancestry who grew up on the traditional Country of the Wurundjeri Woi Wurrung people in Victoria and is now raising her family on Turrbal and Yuggera Country. Vivian is a researcher with the Child Health Research Centre, where she focuses on progressing FASD prevention and support.

Lorian Hayes is a seventh generation Iningai/Bidjera woman from central western Queensland. Her bush name, *Murrindji*, means ‘holder of language, lore and knowledge’, as it relates to health. Language, in this context, refers to the knowledge and lore held around FASD and translated to diverse communities. When representing *Murrindji*, an unfolding occurs of the many cultural dimensions of what it means to gift knowledge and how such a gift instils a vibration of health that resonates with those present. There is not a single area of the Aboriginal FASD space that has not been touched by the ripples of *Murrindji* in the past 53 years.

Lindsay Wolfson is a Canadian with settler and refugee ancestry. She has worked in Canada and internationally with organisations dedicated to community health, including those supporting research, policy and practice around perinatal substance use and healthy beginnings. Lindsay situates relational practice at the core of her work. She has been an honoured guest and collaborator to diverse Indigenous communities across Turtle Island and Australia. As a non-Indigenous person, she recognises this immense honour and takes it as an opportunity to reflect on the different ways of knowing, and how she can take further action to decolonise the systems that perpetuate inequities.

Robyn Williams is a Noongar woman and research advocate from the south-west of Western Australia, with kinship ties to the Kimberley region of WA. As a young woman, Williams lived and worked in an Aboriginal community and has documented this experience in her doctoral study. Aboriginal communities have practised culture as intervention since time immemorial. Her PhD on FASD in Noongar Country was completed in 2018.

Deborah Askew is a New Zealand Pakeha primary healthcare researcher with over 15 years’ experience of working with Aboriginal and Torres Strait Islander peoples and communities to improve the delivery of accessible and appropriate healthcare.

Karen Schofield is a Margany enrolled nurse and Aboriginal health worker at Carbal Medical Services.

Natasha Reid is a settler in Australia with Irish/English ancestry who was born on the lands of the Maranganji people of western Queensland and now lives on the lands of the Turrbal and Yuggera peoples. Natasha is a senior research fellow and clinical psychologist at the

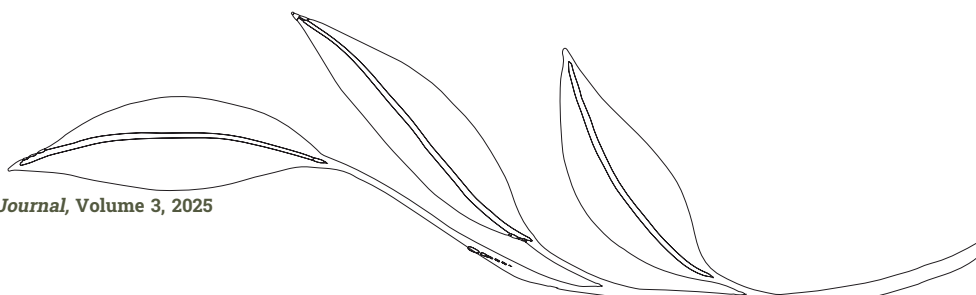




University of Queensland, Child Health Research Centre, where she is group leader of the perinatal and early life exposures research team.

## References

- Aspler, J., Zizzo, N., Di Pietro, N., Racine, E., 2018. Stereotyping and stigmatising disability: a content analysis of Canadian print news media about fetal alcohol spectrum disorder. *Can J Disabil Stud* 7, 89–121. <https://doi.org/10.15353/cjds.v7i3.452>.
- Australian College of Nursing, 2024. *Achieving a socialised model of healthcare in Australia with nurse leadership*. ACN [White Paper]. ACT, Australia.
- Australian FASD Guidelines Development Group, 2025. Australian clinical practice guidelines for the assessment and diagnosis of fetal alcohol spectrum disorder. The University of Queensland, Child Health Research Centre. Accessed on 5 June 2025 at: <https://child-health-research-centre.uq.edu.au/fasd-guidelines>.
- Bell, E., Andrew, G., Di Pietro, N., Chudley, A.E., Reynolds, J.N., Racine, E., 2016. It's a shame! Stigma against fetal alcohol spectrum disorder: examining the ethical implications for public health practices and policies. *Public Health Ethics* 9, 65–77. <https://doi.org/10.1093/phe/phv012>.
- Bessarab, D., Ng'andu, B., 2010. Yarning about yarning as a legitimate method in Indigenous research. *Int J Crit Indig Stud* 3, 37–50. <https://doi.org/10.5204/ijcis.v3i1.57>.
- Blagg, H., Tulich, T., Bush, Z., 2017. Indefinite detention meets colonial dispossession: Indigenous youths with foetal alcohol spectrum disorders in a white settler justice system. *Soc Leg Stud* 26, 333–358. <https://doi.org/10.1177/0964663916676650>.
- Choate, P., Badry, D., 2019. Stigma as a dominant discourse in fetal alcohol spectrum disorder. *Adv. Dual Diagn* 12, 36–52. <https://doi.org/10.1108/ADD-05-2018-0005>.
- Corrigan, P.W., Shah, B.B., Lara, J.L., Mitchell, K.T., Combs-Way, P., Simmes, D., Jones, K.L., 2019. Stakeholder perspectives on the stigma of fetal alcohol spectrum disorder. *Addict Res Theory* 27, 170–177. <https://doi.org/10.1080/16066359.2018.1478413>.
- D'Costa, I., Russell, L., Adams, K., 2025. Truth-telling is required for health equity for Aboriginal peoples: a qualitative study. *Int J Nurs Stud* 167, 105066. <https://doi.org/10.1016/j.ijnurstu.2025.105066>.
- Dudgeon, P., Walker, R., 2015. Decolonising Australian psychology: discourses, strategies, and practice. *J Soc Polit Psychol* 3, 276–297. <https://doi.org/10.5964/jssp.v3i1.126>.
- Emden, C., 1998. Conducting a narrative analysis. *Collegian* 5, 34–39. [10.1016/S1322-7696\(08\)60299-1](https://doi.org/10.1016/S1322-7696(08)60299-1).
- Gonzales, K.L., Jacob, M.M., Mercier, A., Heater, H., Nall Goes Behind, L., Joseph, J., Kuerschner, S., 2021. An Indigenous framework of the cycle of fetal alcohol spectrum disorder risk and prevention across the generations: historical trauma, harm and healing. *Ethn Health* 26, 280–298. <https://doi.org/10.1080/13557858.2018.1495320>.
- Hewlett, N., Hayes, L., Williams, R., Hamilton, S., Holland, L., Gall, A., Doyle, M., Goldsbury, S., Boaden, N., Reid, N., 2023. Development of an Australian FASD Indigenous framework: Aboriginal healing-informed and strengths-based ways of knowing, being and doing. *Int J Environ Res Public Health* 20, 5215. <https://doi.org/10.3390/ijerph20065215>.
- Hine, R., Krakouer, J., Elston, J., Fredericks, B., Hunter, S.-A., Taylor, K., Stephens, T., Couzens, V., Manahan, E., DeSouza, R., Boyle, J., Callander, E., Cunningham, H., Miller, R., Willey, S., Wilton, K., Skouteris, H., 2023. Identifying and dismantling racism in Australian perinatal settings: Reframing the narrative from a risk lens to intentionally prioritise connectedness and strengths in providing care to First Nations families. *Women Birth* 36, 136–140. <https://doi.org/10.1016/j.wombi.2022.04.007>.
- Holland, T., 2016. Two-way learning as respectful community practice: knowledge stories of the men of the Mimosa Creek Healing Centre. *Int J Narrat Ther Commun Work* 1–12.
- Hollinsworth, D., 2013. Decolonizing Indigenous disability in Australia. *Disabil Soc* 28, 601–615. <https://doi.org/10.1080/09687599.2012.717879>.



- Kennedy, M., Maddox, R., Booth, K., Maidment, S., Chamberlain, C., Bessarab, D., 2022. Decolonising qualitative research with respectful, reciprocal, and responsible research practice: a narrative review of the application of Yarning method in qualitative Aboriginal and Torres Strait Islander health research. *Int J Equity Health* 21, 134. <https://doi.org/10.1186/s12939-022-01738-w>.
- Kenny, M.C., Mathews, B., Pathirana, M., 2023. Responses to prenatal opioid and alcohol abuse: a review of US and Australian mandatory reporting laws. *Child Abuse Rev* 32, e2775. <https://doi.org/10.1002/car.2775>.
- Kerimofski, K.L., Panton, K.R., Pestell, C.F., 2024. Australian psychologists' knowledge, confidence, and practices in fetal alcohol spectrum disorder diagnostic assessment. *Alcohol Clin Exp Res* 48, 653–666. <https://doi.org/10.1111/acer.15275>.
- Krakouer, J., Nakata, S., Beaufils, J., Hunter, S.-A., Corrales, T., Morris, H., Skouteris, H., 2023. Resistance to assimilation: expanding understandings of First Nations cultural connection in child protection and out-of-home care. *Aust Soc Work* 76, 343–357. <https://doi.org/10.1080/0312407X.2022.2106443>.
- Krakouer, J., Wise, S., Connolly, M., 2018. 'We live and breathe through culture': conceptualising cultural connection for Indigenous Australian children in out-of-home care. *Aust Soc Work* 71, 265–276. <https://doi.org/10.1080/0312407X.2018.1454485>.
- Lyll, V., Wolfson, L., Reid, N., Poole, N., Moritz, K.M., Egert, S., Browne, A.J., Askew, D.A., 2021. 'The problem is that we hear a bit of everything...': A qualitative systematic review of factors associated with alcohol use, reduction, and abstinence in pregnancy. *Int J Environ Res Public Health* 18, 3445. <https://doi.org/10.3390/ijerph18073445>.
- Martin, K., Mirraabooa, B., 2003. Ways of knowing, being and doing: a theoretical framework and methods for indigenous and indigenist re-search. *J Aust Stud* 27, 203–214. <https://doi.org/10.1080/14443050309387838>.
- Murrup-Stewart, C., Whyman, T., Jobson, L., Adams, K., 2021. Understanding culture: the voices of urban Aboriginal young people. *J Youth Stud* 24, 1308–1325. <https://doi.org/10.1080/13676261.2020.1828844>.
- National Health and Medical Research Council, 2018. *Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities: guidelines for researchers and stakeholders*. Commonwealth of Australia, Canberra, Australia.
- Ober, R., Bat, M., 2007. Paper 1: Both-ways: the philosophy. *Ngoonjook J Aust Indig Issues* 31, 64–86.
- Prezi Inc [software]. (Version 2024) [Computer software]. Accessed on 10 October 2024.
- Puszka, S., Walsh, C., Markham, F., Barney, J., Yap, M., Dreise, T., 2022. Towards the decolonisation of disability: a systematic review of disability conceptualisations, practices and experiences of First Nations people of Australia. *Soc. Sci. Med.* 305. <https://doi.org/10.1016/j.socscimed.2022.115047>.
- Reid, N., Hawkins, E., Liu, W., Page, M., Webster, H., Katsikitis, M., Shelton, D., Wood, A., O'Callaghan, F., Morrissey, S., Shanley, D., 2021. Yarning about fetal alcohol spectrum disorder: outcomes of a community-based workshop. *Res Dev Disabil* 108, 103810. <https://doi.org/10.1016/j.ridd.2020.103810>.
- Rocca, E., Anjum, R.L., 2020. Complexity, reductionism and the biomedical model. In: Anjum, R.L., Copeland, S., Rocca, E. (Eds.), *Rethinking Causality, Complexity and Evidence for the Unique Patient: A Cause Health Resource for Healthcare Professionals and the Clinical Encounter*. Springer International Publishing, Cham, pp. 75–94. [https://doi.org/10.1007/978-3-030-41239-5\\_5](https://doi.org/10.1007/978-3-030-41239-5_5).
- Shay, M., 2021. Extending the yarning yarn: collaborative yarning methodology for ethical Indigenist education research. *Aust J Indig Educ* 50, 62–70. <https://doi.org/10.1017/jie.2018.25>.
- Skorka, K., McBryde, C., Copley, J., Meredith, P.J., Reid, N., 2020. Experiences of children with fetal alcohol spectrum disorder and their families: a critical review. *Alcohol Clin Exp Res* 44, 1175–1188. <https://doi.org/10.1111/acer.14335>.
- Tujague, N., Ryan, K., 2023. *Cultural safety in trauma-informed practice from a First Nations perspective: billabongs of knowledge*. Springer International Publishing, Cham. <https://doi.org/10.1007/978-3-031-13138-7>.



- Ungunmerr-Baumann, M.-R., Groom, R.A., Schuberg, E.L., Atkinson, J., Atkinson, C., Wallace, R., Morris, G., 2022. Dadirri: an Indigenous place-based research methodology. *Altern Int J Indig Peoples* 18, 94–103. <https://doi.org/10.1177/11771801221085353>.
- Webster, C.S., Taylor, S., Thomas, C., Weller, J.M., 2022. Social bias, discrimination and inequity in healthcare: mechanisms, implications and recommendations. *BJA Educ* 22, 131–137. <https://doi.org/10.1016/j.bjae.2021.11.011>.
- Williams, R.D., 2018. Understanding fetal alcohol spectrum disorder (FASD) through the stories of Nyoongar families and how can this inform policy and service delivery. Curtin University.
- Wolfson, L., Poole, N., 2023. Supportive alcohol policy as a key element of fetal alcohol spectrum disorder prevention. *Womens Health* 19, 17455057231151838. <https://doi.org/10.1177/17455057231151838>.
- Young, S.L., Steane, S.E., Kent, N.L., Reid, N., Gallo, L.A., Moritz, K.M., 2022. Prevalence and patterns of prenatal alcohol exposure in Australian cohort and cross-sectional studies: a systematic review of data collection approaches. *Int J Environ Res Public Health* 19, 13144. <https://doi.org/10.3390/ijerph192013144>.

