



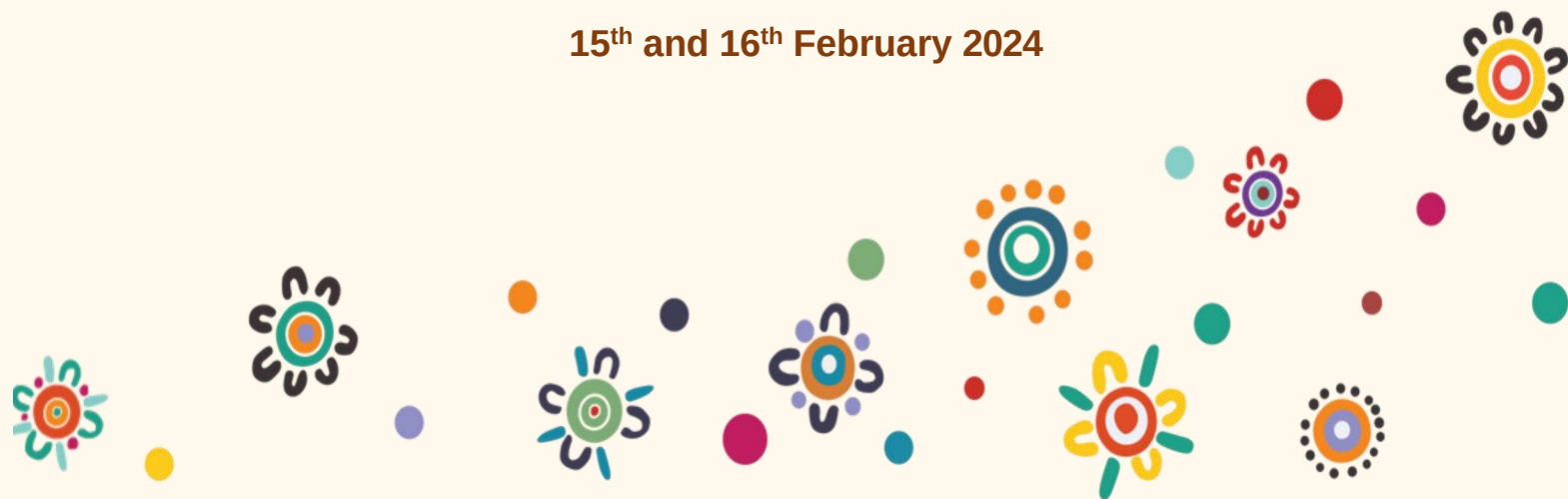
Replanting the Birthing Trees

Valerie Ah Chee, © 2022

Replanting the Birthing Trees:

Wise Counsel Service Provider Co-Design Workshop Report

15th and 16th February 2024



* There are many diverse First Nations populations in Australia. This report uses the term 'Aboriginal and Torres Strait Islander' peoples. As well as 'non-Indigenous' to refer to people who do not identify as Aboriginal and/or Torres Strait Islander. The term 'mum' is used throughout. However, we acknowledge this can include gender-diverse parents, and we recognise the essential role of men in birthing and childrearing practices.

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- The Replanting the Birthing Trees project team, students, and critical friends.



Replanting the Birthing Tree Project

Funder

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Government of **Western Australia**
Department of **Health**



Peak Body Organisations (Governance)



VACCA
Connected by culture

VICTORIAN ABORIGINAL CHILD CARE AGENCY



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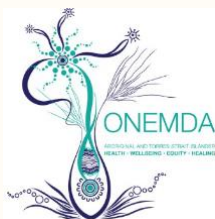


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Executive Summary

Background

The **Supporting Aboriginal and Torres Strait Islander Families to Stay Together from the Start** (SAFeST Start) Coalition was established in response to growing concerns about the increasing number of Aboriginal and Torres Strait Islander newborns being removed from their families. The conception of a 'Wise Counsel' model arose from the Healing the Past by Nurturing the Future (HPNF) project, particularly in the Parent Discussion Groups, Service Provider Discussion Groups, and key stakeholder workshops 3 and 4. The HPNF project aims to co-design perinatal strategies to support Aboriginal and Torres Strait Islander parents experiencing complex trauma. The discussions emphasised a need for greater preventive actions that facilitate collective and transparent decision-making with parents of Aboriginal and Torres Strait Islander babies who are at risk of child protection involvement from pregnancy and up until the child is two years old (i.e., 'the perinatal period').

A 'Wise Counsel' model

It is proposed that a Wise Counsel consisting of individuals with the 'right expertise', notably informal and community supports, be established when practitioners (e.g., a hospital social worker) initially perceive a child protection-related 'risk/s'. A Wise Counsel model intends to utilise the collective wisdom of champions selected by the family to provide holistic support and assist in generating (at times, creative) solutions to keep families together from the start, where possible. Within the current service systems, there appears to be an overly heavy reliance on tertiary interventions, like a child protection referral. Instead of providing comprehensive, culturally appropriate, and self-determining support to Aboriginal and Torres Strait parents 'in-house' prior to commencing a referral. Thus, a Wise Counsel model intends to promote wraparound support and services other than child protection to hold the 'risk/s' and work with families to provide support for a range of complex issues during the perinatal period, rather than referring to child protection services, where it can be avoided.

Ethics approval

The Wise Counsel model falls under a broader research project called *Replanting the Birthing Trees* (RBT). This research project was assessed against Indigenous research criteria developed to promote ethical and culturally appropriate research. It received ethics approval for Victoria from the St Vincent's Human Research Ethics Committee (**St Vincent's HREC 148/23**). An emotional and cultural safety protocol based on community consultation was developed to guide all project activities, including the Wise Counsel workshop.

Aim of the workshop

This workshop is one of a series of co-design workshops for the RBT project. Although the SAFeST Start Coalition has completed extensive work over several years (Figure 1), this is the first workshop exclusively dedicated to discussing a Wise Counsel model. The aims of the workshop were to:

1. Share and discuss what is already known about integrated models of care for women and families who are at risk of child protection involvement in the perinatal period,
2. Refine the aims, objectives, and core components of a Wise Counsel model,
3. To identify barriers and anticipated challenges, as well as facilitators and enablers; and finally,
4. To discuss practical implementation and evaluation of the model.

The intent of a Wise Counsel is to foster collective wisdom to generate solutions to provide nurturing support to Aboriginal and Torres Strait Islander parents and families, with the aim to ensure children grow up safe and thriving, and where possible, prevent child protection from removing an Aboriginal and/or Torres Strait Islander baby at birth.

The workshop sought to ask conceptual co-design questions that may not generate definitive answers about what a Wise Counsel model is. Rather, the aim was to generate discussion about what participants value for the model of care and what a Wise Counsel could be. To this end, the purpose of the Wise Counsel model itself remained unclear at the conclusion of the workshop.

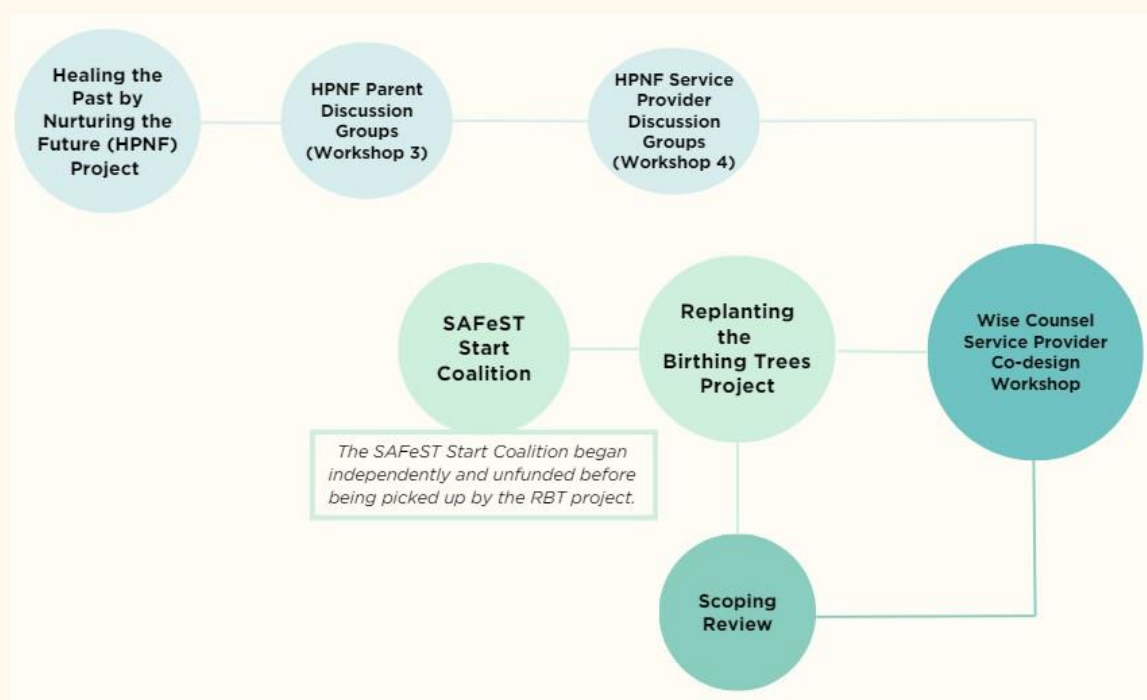


Figure 1 Work undertaken to date

Participants

The workshop was held over two days in Naarm (Melbourne), Victoria. Approximately half of all participants were Aboriginal and/or Torres Strait Islander peoples on both days. Across the two days, approximately, 23 people attended, 12 of which were Aboriginal and/or Torres Strait Islander participants (52% of participants). We also had 13 team members present (facilitators, note-takers, and support staff), eight of whom were Aboriginal and/or Torres Strait Islander people (62% of team members). Therefore, across the two days, 56% of the people at the Workshop were Aboriginal and/or Torres Strait Islander people. On day one, there were five tables with two RBT project members at each table (a facilitator and a note-taker). On the second day, there were slightly fewer participants, and the groups merged into four tables. Some intended facilitators (PG, RG) engaged as participants on day two.

Attendees came from New South Wales, South Australia, Queensland, Western Australia, and Victoria, with representatives from at least 11 different First Nations groups present. Participants included Aboriginal and/or Torres Strait Islander people with lived experience of child protection removal, Aboriginal and Torres Strait Islander and non-Indigenous health care providers (Aboriginal Liaison Officers, social workers and midwives), Aboriginal and Torres Strait Islander and non-Indigenous partners of the RBT project (e.g., Victorian Aboriginal Child Care Agency (VACCA), and Aboriginal and Torres Strait Islander and non-Indigenous RBT project members (e.g., SAFeST Start Coalition members).

Workshop introduction

Dr Jacynta Krakouer presented an overview of the Wise Counsel model concepts, and the work completed. At the time, the Wise Counsel model remained a predominantly abstract concept, and the workshop aimed to discuss whether it could be developed into a tangible model. It was noted that the core components, such as the Wise Counsel's decision-making abilities, were the least developed aspects of the model.

Session 1: Refining the Wise Counsel principles

During the discussions, participants emphasised the importance of strengths-based, family-centred and place-based approaches underpinning a possible Wise Counsel model. Although there was consensus on the Wise Counsel Vision, Purpose, and Values Statement (Appendix C), it was noted that reframing to elevate Indigenous ways of knowing, being, and doing by embedding more 'doing/action' words was necessary. Participants discussed the subtle meanings conveyed by language and raised the importance of using appropriate language. For instance, 'shared ownership' was preferred over 'shared power'. The term 'shared power' raised several concerns and was discussed at length. Other principles identified as potentially necessary to include in the statement were transparency,

collaboration, curiosity, two-way learning, respect, transformation, and culture as foundational. Participants also discussed the challenges of implementing these principles into practice.

Session 2: Refining the core components

Six posters were presented in session 2 (a blank example is shown in Appendix D). Each poster displayed a core component, featuring key personnel, lead agency, collaborators, decision-making, family and community involvement, and steps taken to prevent removal. This section raised more questions than answers, which may have been reflective of the complexity inherent in how the core components interacted with one another. For example, discussions relating to key personnel involved in the delivery of a Wise Counsel model fed into discussions about family and community involvement in the model, as well as how agencies would be involved. Key points across the posters included transparent decision-making, active family-led decision-making, meeting families where they are at, fostering cultural connections, and engaging in critically reflective practice. Rich discussion by participants was particularly noted during this session.

Session 3: Applying a scenario

The way the Wise Counsel was conceptualised varied. One conceptualisation of the model was an overarching framework with minimum standards that could then be adapted to different communities and services. Another was a Wise Counsel facilitator, who advocates for parents and seeks to improve accountability and transparency in pre-birth processes. It was agreed that a Wise Counsel should be enacted sooner during pregnancy (as opposed to late in pregnancy) and, have more frequent contact with families. Additionally, the service should be flexible. Featuring an advocacy role, being independent from other organisations, and strengthening professional pathways were also discussed.

Session 4: Barriers and anticipated challenges

Many challenges were identified. Some of the key barriers for Aboriginal and Torres Strait Islander parents, family, and community included fear of child protection services, lack of trust, feelings of shame, power imbalances, service overload, and confidentiality concerns. Challenges for service providers and funders included lack of communication across services, inadequate supervision, understaffing, burnout, and high staff turnover. The discussion highlighted the need for ongoing, adaptive funding and a Wise Counsel model to address the complex issues facing families and communities. Achieving system and policy change was noted as particularly challenging due to the entrenched nature of challenges within complex service systems, such as child protection, health, and welfare sectors.

Session 5: Facilitators and enablers

Participants discussed a range of facilitators and enablers for successfully implementing a Wise Counsel model. Participants discussed prioritising community and culture as a crucial enabler, and the need for Aboriginal and Torres Strait Islander community involvement and ownership over the model was particularly emphasised. Participants also emphasised the importance of a collaborative approach between all parties involved in a Wise Counsel model, the importance of ongoing training and education, resources, and funding to enable sustainability of the model in practice, accountability as a cornerstone of the Wise Counsel model, empowerment of First Nations communities and parents as central to the model and embedding First Nations leadership and culture into the model. A place-based, flexible approach to deliver the Wise Counsel model – tailored to the needs of local Aboriginal and Torres Strait Islander communities – was also discussed as critical to its success, as was the importance of building on existing resources and services, rather than attempting to ‘reinvent the wheel’.

Session 6: Implementation and evaluation

The discussions outlined key factors for program success, what works and does not work when implementing a new model of care, and where implementation can go wrong. This session emphasised the need for community ownership, sustainability, and upskilling. It also highlighted the importance of recognising and respecting the dignity and agency of parents and the need for decolonisation in service systems.

The discussions also suggested evaluating community-based programs using individualised plans and multi-layered methods. Recommendations included mixed methods and longitudinal evaluations. Data sovereignty and ensuring Aboriginal and Torres Strait Islander families are involved in developing a Wise Counsel model (community co-design) were also deemed critical to implementation success.

Next steps

- Invite all workshop participants to co-author a paper detailing the discussions and learnings of the workshop.
- Complete a re-search of the scoping review (initially done in 2022) to include sources published over the last two years.
- The SAFeST Start Leadership Group to explore the feasibility of further refining, and then implementing a Wise Counsel model in the *RBT* Project.
- If a Wise Counsel was implemented, the team would need to clearly define what a Wise Counsel model is - the scope, parameters, decision-making pathways, and service delivery. Parent co-design and community co-design would be necessary if a Wise Counsel model of care was to progress to implementation.

Replanting the Birthing Trees: Wise Counsel Service Provider Co-Design Workshop.

Developing program materials.

Overview of workshop

This workshop marks the first in a series of co-design workshops for the Replanting the Birthing Trees project and the first workshop specific to developing a Wise Counsel model. Approximately 36 participants (including 13 project staff) attended the workshop across two days in February 2024. Participants included Aboriginal Liaison Officers, health workers (e.g., Aboriginal health nurses), mental health professionals, practitioners with lived experience in child protection removal, researchers, and social workers.

The workshop aimed to build on what is known from the literature and address the gaps in thinking. To do this, Dr Jacynta Krakouer, lead of the SAFeST Start Coalition, presented an introduction section that outlined relevant findings from HPNF and preliminary findings from the SAFeST Start scoping review (review question focused on integrated models of care regarding the risk of child protection involvement in the perinatal period). The Workshop was then divided into six sessions. The workshop program is included (Appendix B).

In summary, participants were divided into 4-5 groups per session, consisting of approximately 4-6 people in each group, as well as one facilitator and one note-taker. Participants worked in groups for the bulk of the session. Then, in the last 15-20 minutes of the sessions, each group would share their key discussion points with the larger group. Note-takers typed or wrote notes based on personal preference and group comfort. Some facilitators also took individual notes. This report is based on the discussions held in the six sessions.

Day One: Setting the scene and building on what is known

Acknowledgement of Country

To open the workshop, Professor Cath Chamberlain acknowledged the Wurundjeri Peoples of the Kulin Nations, where the workshop was held and extended this acknowledgement to all the Lands participants were from.



Creating safety

Prior to the workshop, participants were emailed the program, 'Information Pack', and consent forms to be informed of its content. At arrival, participants were required to sign the consent form and were provided with packs. The packs included a printed-out 'Information Pack', an RBT t-shirt, First Nations teas, mindfulness colouring in, and a thank you and support document. The latter contained information and contact details for two private psychologists available across the two workshop days, as well as additional psychological contacts (e.g., 13YARN) if further support was needed after the workshop.

Participants were encouraged to contact the psychologists during the workshop for immediate support, particularly if any discussions raised issues for them. During the workshop, music by Aboriginal and Torres Strait Islander artists was played during the breaks, a short mindfulness session at the start of both days was undertaken, there was an acknowledgement that the content can be difficult, facilitators prompted regular breaks and stretching and reminded people to stay hydrated.

Facilitators endeavoured to foster cultural safety during the workshop. This included having Aboriginal facilitators throughout the workshop, establishing a safe space through collaborative discussion of the parameters for the workshop, and enabling relationality throughout discussions. In addition, physical efforts were made to embed cultural safety further, which included displaying two possum skin cloaks, Aboriginal and Torres Strait Islander flags, native flowers, gum leaves, and gum nuts throughout the venue, as well as establishing spaces where participants could have 'time out' from the discussion.

Each table contained diversionary activities, including mindfulness colouring/drawing, modelling clay, and weaving materials. Participants were encouraged to use the diversionary activities throughout the workshop to help with self-regulation. A facilitator was allocated to each table, and culturally grounded activities, including Wayapa and weaving facilitation, were booked to assist with regulation throughout the workshop.

Associate Professor Carlie Atkinson also facilitated a session with participants to establish the guiding principles for the workshop to foster a safe space for participation. These included the importance of:

- Confidentiality—to ensure that participants felt comfortable speaking freely and that the content discussed was not to be shared outside the workshop.
- Being respectful – recognition and acknowledgement that there are different ways of doing things.



- Being brave – participants were encouraged to share their thoughts and feelings to facilitate discussion.
- Being kind – the importance of care for ourselves and each other was highlighted.

Each table also wrote its own rules of participation.

Introduction and overview of a Wise Counsel model

Dr Jacynta Krakouer, lead of the SAFeST Start stream, provided an overview of the Wise Counsel model and the work conducted to inform its thinking (Figure 2). Before the workshop, participants were sent an 'Information Pack' containing a synthesis of findings. The 'Information Pack' included preliminary findings from the SAFeST Start scoping review and definitions relevant to the Wise Counsel workshop (see Appendix A). The Information Pack also included a structured outline of past findings (HPNF workshop 3, HPNF workshop 4, literature included in the scoping review), aligned to the six sessions for the Wise Counsel workshop (see Figure 2 below and Appendix A).

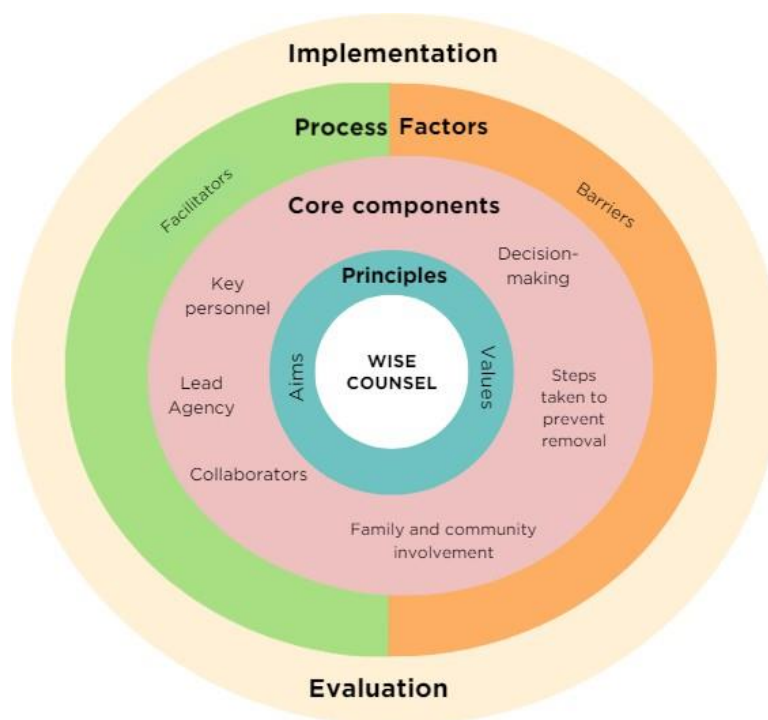


Figure 2 Overview of the Wise Counsel workshop

Dr Jacynta Krakouer discussed that pregnancy, birth, and the transition to becoming a parent is a particularly critical time when both risk and protective factors for trauma-related distress and recovery converge with unique life-course opportunities.

Past research has investigated the characteristics of women who have been subject to unborn reporting and infant removals by child protection (Broadhurst et al., 2015; Taplin,

2017; Marsh et al., 2017; Wieler et al., 2018). Due to this research, we know that mothers who have experienced a range of adverse life experiences – such as family and domestic violence (DFV), homelessness, mental ill-health, substance use and prior child protection involvement (either for themselves or for previous children) – are more likely to have contact with child protection systems prenatally, and to experience the forced removal of their infant by child protection after birth (O'Donnell et al., 2019; Taplin, 2017; Marsh et al., 2017; Wieler et al., 2018)."

In this research evidence base, Indigeneity has been identified as a unique risk factor for infant removals. Research has found that Indigenous parents experience the child protection system differently to non-Indigenous parents, and that when controlled for all other factors, Indigeneity has accounted for almost double the risk of infant removals in some states. However, the experiences of Indigenous women and families involved with child protection involvement prenatally represent a gap in the research literature.

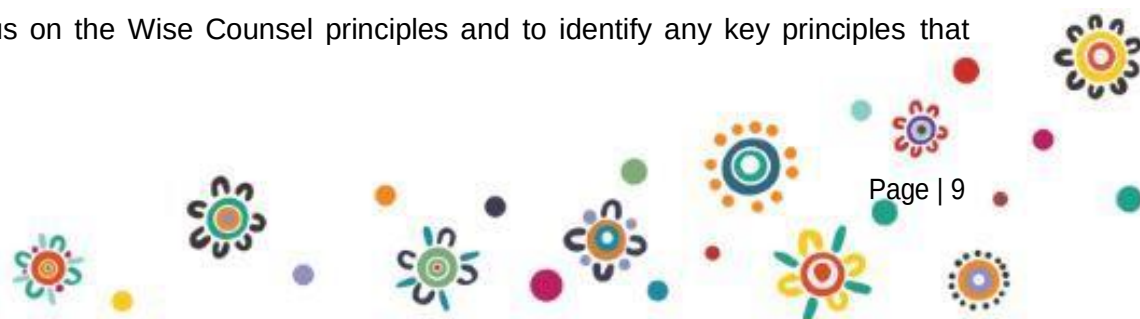
An overview of the sessions for the workshop was then provided, as shown below in Table 2.

Table 1 Six sessions of the Wise Counsel workshop

Session (1)	Refining the Wise Counsel Principles, Aims and Values
Session (2)	Refining the Wise Counsel Core Components. Poster station (1): Key Personnel Poster station (2a): Lead Agency (2b): Collaborators Poster station (3a): Decision-making (3b): Family and community involvement Poster station (4): Steps taken to prevent removal
Session (3)	Applying a Wise Counsel to a Scenario
Session (4)	Barriers and Anticipated Challenges (Process Factors)
Session (5)	Facilitators and Enablers (Process Factors)
Session (6)	Implementation and Evaluation (Process Factors)

Session 1: Refining the Wise Counsel Principles, Aims and Values

A Wise Counsel model – Vision, Purpose, and Values Statement has been developed by the SAFeST Start Coalition (Appendix C). Participants were sent Wise Counsel Vision, Purpose, and Values Statement prior to the Workshop. However, at the start of the session, Dr Jacynta Krakouer read through each dot point in the statement. This session aimed to reach a consensus on the Wise Counsel principles and to identify any key principles that were missing.



Summary of workshop discussions on the Wise Counsel Principles

All five groups had consensus regarding the Wise Counsel Vision, Purpose and Values Statement. However, the groups found it challenging to prioritise values as they recognised their interdependence. Despite this, 'strengths-based', 'family-centred' and 'place-based'/a tailored approach were noted as particularly important. Central discussions from the preliminary review of the discussions are below.

The use and importance of language

The meanings conveyed by the use of language were noted throughout the groups, and the importance of using the most appropriate language was emphasised. For instance, "shared ownership" as opposed to "shared power". The term "shared power" raised the most discussion among the groups (e.g., what does this mean, preference for shared ownership, shared responsibility, and accountability).

Also discussed:

- Moving away from trauma-informed. Safety should be the baseline. Moving towards healing integrated/informed.
- Elevating Indigeneity into the Wise Counsel Vision, Purpose and Values Statement by embedding more 'doing/action' words.

"Culture is a protective factor"

- Elevating Indigenous ways of being, doing and knowing into the Wise Counsel Vision, Purpose and Values Statement. Integrating Aboriginal knowledge - "valuing the wisdom is one thing"... how is it actually being enacted?
- Key terms discussed here: kinship, wisdom, community, relationality, collectivist, eldership, belonging and identity.
- Grandmother's Lore. "Pulling them back in", "we call our children home, it doesn't matter how old the children are. That our Grandmother Lore" – Elder.
- "You can go to any community. There will be someone, if not a group, that has the capacity to hold people". "Empowering someone to do that work. Finding the healers, we can walk alongside".

Additional principles identified:

- Transparency with families (key terms also discussed here: honesty, communication with families). Importance of trust and the time it takes to build trust in relationships.
- Collaboration with families and between service providers.
- Curiosity.



- Two-way learning (terms also discussed: ongoing learning, embedding deep listening).
- Respect.
- Transformation (terms also discussed: change, regenerative, revitalising).
 - “To take something from this place and bring it to this place. Lends itself to a circular process. People grow and evolve.” – Elder.
- Culture as foundational. Grandmother’s Lore.
- Requirement of ongoing evaluation for the model.
- Community consultation and involvement is essential.
- Advocacy.

Additional discussion points:

- Challenges of implementing the principles into practice (discussed by each group)
- The need for practitioners to be able to have difficult conversations.
- Importance of advocacy and education.
- Importance of responsibility and accountability (re: for organisations/the systems).

Session 2: Refining the Wise Counsel Core Components

Aim. The purpose of this session was to start conceptualising how a Wise Counsel could function. Some of the questions asked included:

- Who are the key personnel that would be on a Wise Counsel model?
- Would a Wise Counsel have set collaborators, or would it be dependent on each family? If so, how could this be done?

At the start of this session, we acknowledged that the questions being asked were big conceptual questions, and as a result, we were unlikely to generate definite answers in one session. However, rather than attain set answers, our aim was to generate discussions and gain insight into what the participants valued.

Activity. Participants were asked to complete the MoSCoW (Must Have, Should Have, Could Have, and Won’t Have) activity on six posters, separated into four poster stations. The posters contained some pre-entered data that emerged from the synthesis of findings and that were also provided in the participant’s information pack. Some posters also contained some questions to generate discussion. An example of a poster is shown in Appendix C.



Preliminary Summary of the Core Components

Poster station (1): Key Personnel

- Assumption that parents are the lead.
- Need for frameworks that are invested in by community. What level is the Wise Counsel operating at? (e.g., national, regional, local). Who is the Wise Counsel?
- Having small number of members to not overwhelm families, a suggestion for 5 people on each Wise Counsel.
- Strong support (all green dots = Must Have) for having formal supports and a mixture of formal/informal support.
- Overall support (mostly green, some blue = Should Have) for having informal support, people with lived experience/cultural mentors.
- Need to recognise men, picture of babies having more than one parent, all genders.
- Suggestion to use terminology 'relevant community supports' rather than 'informal supports'.
- Comment that young people bring knowledge, which is often disregarded. However, mixed consensus (3 red dots = Won't Have, 2 green dots = Must Have).

Poster station (2a): Lead Agency (2b): Collaborators

- Strong preference for collaborators to be determined by the family/led by the families but acknowledged that it can be a lot to ask families to choose. Supporting families through the process required.
- Consensus (7 and 6 green dots) that legal services and mental health services should be on board as collaborators.
- "Allies needed so mob not overloaded".
- Consensus (12 red dots) that child protection should not be the lead agency.
- Flexibility required.

Poster station(3a): Decision-making (3b): Family and community involvement

- Consensus for following pre-identified strategies of decision-making poster: 'transparency around decision-making', 'active and consistent family-led decision-making'.
- Consensus for following pre-identified strategies on family and community involvement poster: 'meeting families where they are at', taking 'time to get to know the family', 'fostering cultural connections/identity', 'practitioners engaging in critically reflective practice'.
- Noted that emphasis should be on 'informed participation' rather than 'voluntary participation'.
- Easy to be disheartened in this space. Reflectivity can help to "keep the fire alive".
- "We need to turn lived experience into a strength rather than risk".

- Mostly consensus for 'place-based/localised', noted that it is important to consider that people have families in different places and mob move around a lot, so need flexibility. Links to "meeting families where they're at".
- Important to consider if parents do not have family/community around them.
- Mostly consensus that it should not be practitioner-led. A comment notes that if it is practitioner-led, it must be an Aboriginal practitioner but family-led would be preferred. Also noted that practitioner support is still required, "help and guidance needed but family-led".
- 'Power' is problematic. Too binary, ownership/identity is preferred.
- "Mum and dad lead the process is lacking from all decisions". Family must be central to decision-making pathways.
- "Mum will tell you who is safe person".

Poster station (4): Steps taken to prevent removal

- Does the Wise Counsel have a service delivery component?

Is the Wise Counsel in this instance ...

- Supporting best practice?
- Advocating/educating/applying pressure holding CPS and other services/agencies **accountable**. What does that accountability look like?
- An overseer? Support in the working together collaboration, not in silos.
- Contributing and supporting evidence-based care.
- Representing family and cultural ways of knowing, being and doing. Protecting cultural ways, family and community as strength and protective. Relationship-based.

Improving collaboration in child protection services

- Is it more "improving child protection to collaborate with families".
- Child protection services is the wrong framework. Embrace community authority and models.
- Consistency.

Transparent conversations and info-sharing

- Transparent but trauma informed. Strengths-based.
- Is Wise Counsel to help organisations develop service models. Idea of "champions" to build capacity in organisations and implement training/education, staff capabilities to change and improve practice.

Additional notes

- Wise Counsel can't do everything.

- “Advocating and educating and applying pressure and holding child protection accountable.”
- More questions than answers.

Session 3: Applying a Wise Counsel to a scenario

AIM. This session aimed to transition from abstract thinking to practical implementation and identify potential design issues.

Activity. Participants were provided with a scenario about ‘Jack and Sarah’. The scenario contained background information about the couple and their pregnancy journey described at the 12-week, 18-week, and 7-month checkpoints of their first pregnancy. Participants were asked to apply how they envisioned a Wise Counsel working in a provided scenario. Each group discussed barriers and facilitators to implementing a Wise Counsel model. These points will be transferred into Section 4 (Barriers and Anticipated Challenges) and Section 5 (Facilitation and Enablers) to avoid duplication in the report.

Participants were asked prompt questions such as:

- How often is the Wise Counsel meeting?
- Who is facilitating the Wise Counsel? Is there a Wise Counsel worker/role?
- How does the Wise Counsel facilitate decision-making when it convenes?

Summary of workshop discussions about applying a Wise Counsel to a scenario.

How a Wise Counsel was envisioned.

‘High/structural-level’ – an overarching framework, teaching, training at an institutional level,

- A framework of minimum standards that can then be adapted to different communities and services.
- Ability to be flexible and tailored to individual services.
- Providing oversight for care team meetings.
- Accountability mechanism.
- A framework of excellence.
- “Watch-dog over child protection system” (Group 4).

On the ground: a reflective practice tool for practitioners; a Wise Counsel facilitator who acts as an advocate/mediator for parents/oversees that stakeholders are accountable.

- Complimentary service.

- Paid role, paid as consultants (e.g., Elders).
- The service or individual can call Wise Counsel whenever and at whatever point to be able to get an ally/advocate/critical friend.
- Families/parents having the power to call a meeting through the Wise Counsel to be able to convene meetings – empowers parents to call a meeting and provides them a place or power where their voice can be heard.
- Preventative work. The Wise Counsel is not a child protection context but a family support context.

When a Wise Counsel should be activated.

There was consensus that a Wise Counsel should be activated sooner rather than later (i.e., earlier in pregnancy, as opposed to in the third trimester) and should be more frequent rather than less (i.e., occurring more than once, instead of a one-off meeting). Suggestions for activating a Wise Counsel were at the first appointment visit and/or once a narrative of risk was developed about the family. If a family is informed at the first appointment, it was suggested this is done directly and indirectly.

- Directly: a conversation initiated by practitioner/representative with appropriate cultural training.
- Indirectly: brochures, posters on the wall in antenatal care, visibility, accessible information provided with other resources.

Flexibility and timing with antenatal/other standard appointments were also discussed.

Other discussion points.

- Importance of accountability. The need for 'high-level' organisational commitment (e.g., buy-in from an executive level).
- Mum and dad lead.
- Importance of engaging with Aboriginal Liaison Officers.
- A Wise Counsel featuring some advocacy role was consistent throughout the groups.
- Independency from other organisations.
- A need for shared language amongst service providers and Wise Counsel noted.



Day Two: Making it happen

Acknowledgement of Country

To open Day Two, Dr Jacynta Krakouer acknowledged the Wurundjeri peoples of the Kulin Nations, where the workshop was held, and extended this acknowledgment to all the Lands participants were from.

Reminder about our safe space

A/Prof. Carlie Atkinson summarised the safe space processes discussed on Day One and showed Miriam-Rose Ungunmerr-Baumann's *Dadirri* video.

Recap of the previous day and outline of the purpose of the day

Dr Jacynta Krakouer provided a recap of the content discussed on Day One and an outline for the day. Day Two focused on implementing and evaluating the model, including the barriers, anticipated challenges, facilitators, and enablers.

Session 4: Barriers and Anticipated Challenges

Aim. The objective of this session was to identify and discuss any obstacles that may hinder the achievement of a Wise Counsel.

Activity. The groups received five A3 posters, each containing pre-identified barriers from five perspectives: (1) mums/parents, (2) Aboriginal and/or Torres Strait Islander extended family, (3) Aboriginal and/or Torres Strait Islander communities, (4) service providers, and (5) funders. The pre-identified data on the poster came from the synthesis of findings. Participants were asked to review the pre-identified barriers, add comments, and identify any additional barriers that were not listed. They were also asked to share practical examples of where the barriers had been mitigated well.

Naturally, the groups began to discuss facilitators to the identified barriers. These discussions are in the next section, Session 5 (Facilitators and Enablers). The posters were designed to encourage discussion. Some groups wrote directly onto the posters (an example is shown in Appendix D), while others discussed aloud. Discussions about barriers and anticipated challenges in other sessions have also been merged into this section.

Preliminary overview of discussions about barriers and anticipated challenges.

Barriers across multiple perspectives.

- Fear of child protection services by proxy.
- Distrust of services (especially with historical context).
- Feelings of shame.

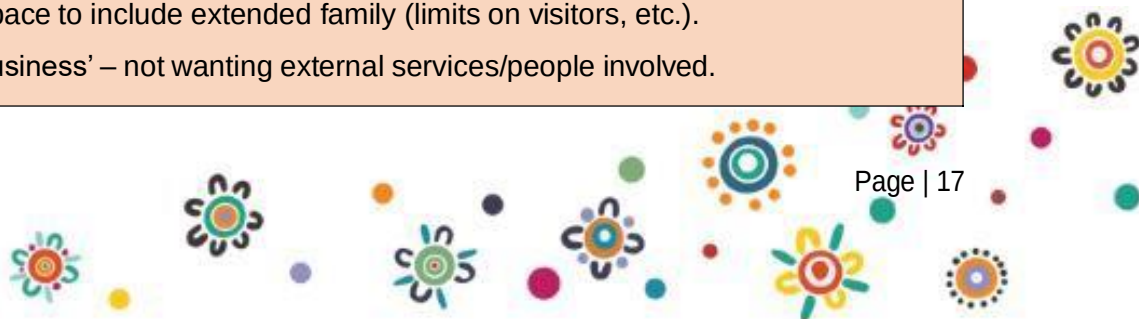
- Power imbalances.
- Service overload, fatigue, and confusion.
- Developing awareness of a Wise Counsel model when service overload exists.
- Healing families/community politics. Family relationships can be complex, in large part due to the impacts of past and current policies.
- Cultural taboos.
- Confidentiality concerns.
- Lack of accountability and transparency. Complexities of governance and accountability.
- Funding and funding requirements.
- Sustainability of funding and programs.
- Reactive rather than proactive/preventative response. Difficult conversations are not occurring in the preventative stage.
- Risk-averse culture.
- Working in silos.
- The time it takes to develop relationships.
- Homelessness and/or domestic violence can mean that women have to move around constantly, have different numbers, home visits aren't appropriate.
- High staff turnover and the effect on continuity of care (women losing the ability to have the same midwife as a previous birth).
- Culturally unsafe spaces.
- Published research is largely from the perspective of the service provider, not the family or community.
- Services that are working well can be defunded. The government may stop funding existing models when bringing in a new model.
- Simplicity thinking – “one-size-fits-all”.

Perspective of mum/parents

- Access barriers (e.g., transport, appointment times).
- Not enough communication prior to the appointments.
- Assumptions made rather than working with individual families.
- Inability to access some supports without a child protection referral.
- Having to repeat stories over and over.

Perspective of family

- Lack of space to include extended family (limits on visitors, etc.).
- ‘Family business’ – not wanting external services/people involved.



- Environment where meetings are held (not culturally appropriate if held in places of power imbalance between Aboriginal families and professionals, i.e., in government offices).

Perspective of community

- Western qualifications to practice. Often ignores the lived experience of First Nations people who are culturally qualified.
- Cultural load.
- Challenges for remote communities (may have limited services, going to a metropolitan hospital and being separated from their community).

Perspective of service providers

- Burnout, inadequate supervision, understaffing, compassion fatigue.
- Lack of capacity/time.
- Cultural training is not prioritised due to the overwhelm of services and high demands. Yet a specialised skill set is required to provide appropriate support.
- Data security infrastructure. Funding is often insufficient to maintain good security and storage.
- People are scared of losing their jobs – (i.e. risk-adverse culture rather than strengths-based; workers may offset perceived risk to child protection authorities rather than having difficult conversations with families).
- Individual co-design work with parents/families can be challenging (e.g., frequent moving, changing numbers).
- Outreach can be a challenge.
- Getting the evidence-based to convince funder buy-in. There can be a preference to stick with the status quo.

Perspective of funders

- Funding not being utilised properly.
- Philanthropic funders don't want to fund stuff that's not already shown to work, yet with government funding the KPIs and parameters are strict.
- Funding needs to be ongoing, adaptive.

Other discussion points

- "It's hard to define. What is the Wise Counsel?" (group 3).
- If we are going down the accreditation route. A Wise Counsel could become another thing to tick a box to.
- Framing of parents experiences (e.g., a failure to support and provide is a bigger issue than failure to attend).

- Wise Counsel needs some ‘teeth’.
- Some service provider/s may say we don’t need this new model of care.
- The diffusion of responsibility. If you say everyone needs to be responsible can become no one’s responsibility.

Session 5: Facilitators and Enablers

Aim. The purpose of this session was to identify and discuss potential factors that could help overcome the barriers and challenges identified in the previous session. Our aim was to identify the strengths that we can utilise so that Wise Counsel can come to fruition and achieve its objectives.

Activity. Participants were given an Impact and Feasibility Matrix on an A1 page. They were also provided with some pre-identified barriers and facilitators derived from the data synthesis. Participants were asked to map the facilitators on the Impact and Feasibility Matrix using Velcro tabs to assist with prioritising. Additionally, blank tabs were provided to allow the participants to write their own answers. Due to the slightly smaller number of attendees on day two, the participants merged into four groups.

Participants were encouraged to consider holistic solutions that address multiple perspectives. Questions such as “what is working well for families and children in the community?” were asked to prompt discussion.

Preliminary review of facilitations and enablers discussions

- Developing shared language to ensure a knowledgeable, skilful workforce.
- Importance of ‘buy-in’ at an organisational, executive, and at a policy level, in order for the model to have authority and sustainability. ‘Buy-in’ selling points: burnout rates, imagine you did not have to carry all of this risk/dissemination of risks, you have the support of Elders, making it attractive, practitioners feeling supported.
- Obtaining philanthropic funding, diversifying the funding options.
- Allies are needed to help drive things forward.
- Going into homes and doing outreach.
- Communication, transparency, and clear parameters are needed.
- Utilising existing models and frameworks (e.g., SEWB model).
- The onus should be on institutions, not individuals, to make healthcare accessible and non-discriminatory.

Community-centred

- Elders as a form of governance.

- “Preference for experience and knowledge and connections over qualifications” (group 4). Interns/champions, supporting individuals who may not have tertiary qualifications but are essentially already doing the work in community.

Preventing practitioner burnout

- A potential ‘quick win’ is ensuring practitioners receive adequate and appropriate supervision. As well as reframing supervision to reflective practice - ongoing learning, upskilling, not a deficit.
- Potential ‘major project’ – improving policy guidelines to provide more support for practitioners (e.g., leave cover).

Common responses marked in the ‘Do First. High priority’ category

- Prioritising community and culture.
- Burnout, staff turnover.
- Elders as a form of governance.
- Utilising existing models and structures.

Session 6: Implementation and Evaluation

Implementation

Members from an Aboriginal Community Controlled Organisation presented, sharing their learnings and insights. The goal was to draw on the expertise in the room and generate discussion from a real-life example. After the presentation, the four groups were asked prompt questions and had a short discussion, which was then fed back to the wider group. The prompt questions and a preliminary review of the discussions are included below.

1. Are there key factors underpinning program success?

- Community-led and driven, community ownership.
- Building on the success of existing programs/services/infrastructure.
- Having the right people at the table.
- Right governance structure in place – review process.
- Needs to be sustainable.
- Flexibility/agility = sustainability.
- Needs to be legislated to give it “teeth”, authority and decision-making abilities.
- Drive the upskilling of community.

2. What does and doesn’t work when implementing a new model of care?

- *What does work:* Need to recognise the dignity and agency of parents.

- *What doesn't work:* Outsiders coming in for only a short time before leaving again.
- *What doesn't work:* Evaluation is always decided by Western system.
- *Consideration:* We need to look at who is already being paid to do a service and hold them accountable to actually do that well rather than creating new things to be managed.

3. What are some of the things that are unspoken or ignored in design and delivery?

- *What doesn't work:* Still within Western system/culture + adding Aboriginal and Torres Strait Islander culture on top. Decolonisation needed.

4. Where does implementation 'go wrong'?

- Assumptions
- Not with community but to, must be community co-designed.
- Agencies can't admit they "don't know".
- Ignoring localised strengths → coming in from the outside, 'top-down' approach.
- Realistic timeframes.
- Generational outcomes – outcomes not income.
- Funding outputs – quantity focus not quality focused.
- Rushing it.

Evaluation

Participants were then asked three questions relating to evaluation and asked to briefly discuss them with their group before sharing them with the broader group. The prompt questions and a summary of the discussions are included below.

1. What are important outcomes we should evaluate?

- Every community to decide what should be evaluated – what outcomes should be measured. What does success look like for community?
- Do the parents think it's helped. Quality of the plans developed – this is family dependent.
- Evaluating all along the way.
- Multi-layered evaluation.
- Individualised plans.
- Avoid over-evaluating, use data that's already being collected.

- Need to show the system how much money will be saved in the long term.
- Can only evaluate the model for what it is responsible for.

2. Any suggestions about evaluating the model?

- Mixed methods evaluation.
- Longitudinal evaluation.
- Look at the informal services/people who are already championing this kind of work.
- Evaluation needs to be safe.
- Data sovereignty.
- What is the purpose of the evaluation? Is it to 'judge' the program, or is it to support community in their governance to continuously improve the supports available for their communities? It can't be a process of fund/don't fund, which keeps having communities go back to the start – an external judgement that this didn't work.

3. Any questions people are still unsure about that we should try to answer?

- The identity of a Wise Counsel model. What is it? Where does it sit? What is its purpose?
- Service providers – are we reliant on their outcomes, data, etc?
- Families being involved in the development of a Wise Counsel.

Evaluation forms

Participants were then asked to complete two paper evaluation forms: one for the co-design workshop and the other for the Wise Counsel model. In total, 25 evaluation forms were received.

Co-design evaluation. Participants were asked to respond to 14 questionnaire items; items 1 – 11 used a Likert 5-point scale from 1 = strongly disagree to 5 = strongly agree. Items 12 – 14 were open-ended questions.

Thirteen co-design evaluation forms were received from the 23 workshop attendees, representing approximately 57% of the total participants. Overall, the feedback was positive. A summary of the feedback is provided below:

Scaled questions 1 – 11. From the 13 responses, 86% of participants 'strongly agreed' that "facilitators were well prepared", while the remaining 14% 'agreed'.

Responses to open questions 12 – 14



Is there anything you particularly liked about the workshop? If so, what was it?

- “Connected”.
- “Shared of ideas”.
- “Respect shown”.
- “Expansive time to think”.
- “Participants were knowledgeable, great discussions and reflections”
- “Culturally safe environment, our mob leading”.
- “Good size group for workshop”.
- “Inclusive. Open”.

Is there anything you particularly didn’t like about the workshop, or felt could be improved? If so, what was it?

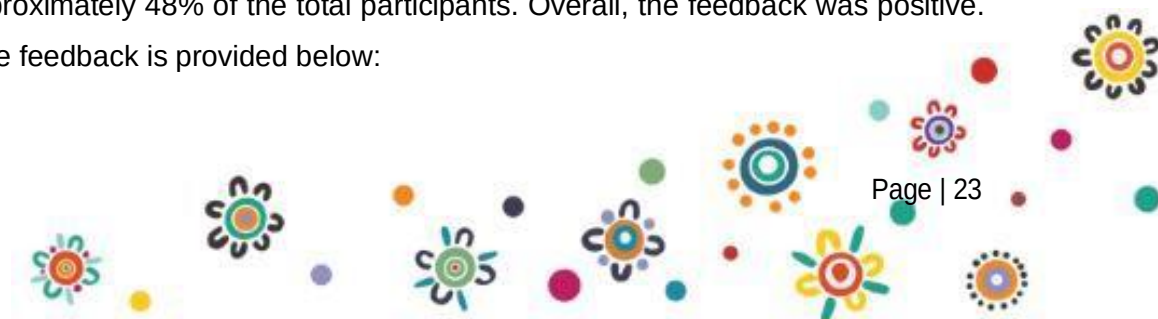
- “No. It is always challenging to break down a big problem (or a specific issue in a broader system), and I think was done well”.
- “Everything was positive”.
- “Consider seeking out more mothers/fathers in the future”.
- “A little intense however, much needed. Important discussions/work”.

Are there any other comments or suggestions you would like to make?

- “Loved it. Thanks for the opportunity”.
- “Nice job team”.
- “Thanks – really enjoyed it”.
- “More mothers with lived experience would be of great value”.
- “Perhaps some suggested models of what Wise Counsel could look like/function”.
- “Grateful for beautiful reflection session at the end”.

Wise Counsel evaluation. Participants were asked to respond to nine questionnaire items; items 1 – 6 used a Likert 5-point scale from 1 = strongly disagree to 5 = strongly agree. Items 7 – 9 were open-ended questions.

Eleven Wise Counsel evaluation forms were received from the 23 workshop attendees, representing approximately 48% of the total participants. Overall, the feedback was positive. A summary of the feedback is provided below:



Scaled questions 1 – 6. From the 11 responses,

Overall, how would you rate this model? 64% of respondents rated the model 'good', and the remaining 36% rated the model 'excellent'.

Responses to open questions 7 – 9.

Is there anything you particularly like about the model? If so, what was it?

- "Strengths-based-trauma informed".
- "Challenges the (illegitimate) authority of CP [child protection], and seeks to reposition support for children/mothers/families as a network for children. It reclaims that network as the responsibility to families".
- "Body needs to be legislated".
- "Like the elements of self-determination, oversight and ownership by Aboriginal and/or Torres Strait Islander person!"

Are there any concerns you have about the model or something you felt could be improved? If so, what was it?

- "We have to be clear about self-determination and define the policy exercising it properly. This is not to diminish the importance of dignity and agency, but to liberate for [illegible] systems for families. Clarity on the distribution between oversight and/or service delivery, to position the model clearly".
- "No concerns. Buy-in will be challenging but not unrealistic".
- "Make sure community, mum/parent lead the processes. Inspire hope as key to improve outcomes, inspire hope is key".
- "Concerned about being something new – is there anything that already exists that can be scaled up?"
- "Worried the model doesn't impact systems practiced. Needs to educate, train current health and CP staff in practice. Needs to lean into existing stuff and elevate/empower positions to hold more authority".



Are there any other comments or suggestions you would like to make?

- “Thanks I really enjoyed being part of this”.
- “Neutral in self-determination as people are confined by a system. They can have self-determination but minimal influence/control in decision making”.
- “Don’t think too big, too fast. This model could be great with thoughtful thinking”.

Elder’s Circle Reflection

The Elder’s Circle by We Al-li was the closing activity. All attendees (including facilitators and note-takers) participated. Everyone contributed to the reflections, but only one person spoke at a time. One facilitator took notes; a summary of the reflections is below.

Summary of Insights from Elder’s Circle Reflection

- Really complex to implement.
- Curious, hopeful but wondering how is it different to other advisory?
- There’s a lot – feelings of exhaustion but grateful for wisdom and passion in room.
- No more band aids – but staying hopeful but big emotions.
- So important to come to come together in person-exchange of energy.
- Not alone in struggle, same levels of motivation.
- Collective wisdom... hearing stories to hold onto, be strengthened...
- Feel strong because a group holding hope and vision despite everything that could know it down.
- We are sovereign, we are strong – long wisdom and knowledge that exists in our DNA.
- Anxious that this co-design may mean it is rolled out in the wrong way – “values held tightly, but ideas held loosely”.
- Need to safeguard the model from being changed, diluted.
- Big emotions, big work.

Thank you and close

Prof Cath Chamberlain and Dr Jacyntha Krakouer thanked all participants for their contributions and closed the workshop. A culturally grounded performance was scheduled to conclude the workshop, but unexpected circumstances arose at the last minute, and unfortunately, this did not occur.



Next steps

- Invite all workshop participants to co-author a paper detailing the discussions and learnings of the workshop.
- Complete a re-search of the scoping review (initially done in 2022) to include sources published over the last two years.
- The SAFeST Start Leadership Group to explore the feasibility of further refining, and then implementing a Wise Counsel model in the *RBT* Project.
- If a Wise Counsel was implemented, the team would need to clearly define what a Wise Counsel model is - the scope, parameters, decision-making pathways, and service delivery. Parent co-design and community co-design would be necessary if a Wise Counsel model of care was to progress to implementation.



References

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Appendices

Appendix A: Wise Counsel Workshop Information Pack

BACKGROUND

A lot of research, generating action, has taken place in the lead up to the Wise Counsel workshop. This information pack has been put together to provide you with background reading that may assist you during the Wise Counsel workshop. This information pack contains the following information:

- A preliminary synthesis of our past research findings relating to child protection involvement during pregnancy and post-birth.
- Definitions relevant to the Wise Counsel model
- A structured outline of past findings, synthesised from a range of sources, aligned to the sessions you will be taking part in for the Wise Counsel workshop. These sessions are:
 - o Session 1: Refining the Wise Counsel Principles, Aims and Values
 - o Session 2: Refining the Wise Counsel Core Components, including:
 - Key personnel
 - Collaborators
 - Lead agency
 - Decision-making
 - Family and community involvement
 - Steps taken to prevent removal
 - o Session 3: Applying the Wise Counsel to a scenario (not included in this pack)
 - o Session 4: Barriers and Anticipated Challenges (Process Factors)
 - o Session 5: Enablers and Facilitators (Process Factors)
 - o Session 6: Implementation and Evaluation (Process Factors)



PAST RESEARCH FINDINGS RELATING TO CHILD PROTECTION INVOLVEMENT DURING PREGNANCY AND POST-BIRTH

Pregnancy, birth, and the transition to becoming a parent is a particularly critical time when both risk and protective factors for trauma-related distress and recovery converge with unique life-course opportunities.

Past research has investigated the characteristics of women subject to unborn reporting and infant removals by child protection. Due to this research, we know that mothers who have experienced a range of adverse life experiences – such as family and domestic violence, homelessness, mental ill-health, intellectual disability, substance use and prior child protection involvement (either for themselves, or for previous children) – are more likely to have contact with child protection systems prenatally, and to experience removal of their infant by child protection after birth.

In this research evidence base, Indigeneity has been identified as a unique risk factor for infant removals. Research has found that Indigenous parents experience the child protection system



differently to non-Indigenous parents, and that when controlled for all other factors, Indigeneity has accounted for almost double the risk of infant removals in some states. But the experiences of Indigenous women and families involved with child protection involvement prenatally represent a gap in the research literature.

DEFINITIONS RELEVANT TO THE WISE COUNSEL MODEL

There is a lot of jargon and overlapping definitions used that refer to similar concepts. We have provided a list of definitions below that we are using in the Wise Counsel workshop.

Principles	The overarching values that influence and guide the model of care. Includes: the aims and values of a Wise Counsel model.
Core Components	The elements or aspects of care within a Wise Counsel model of care. The structural elements, the 'nuts' and 'bolts'. Includes: key personnel, collaborators, lead agency, decision-making, family and community involvement and steps taken to prevent removal.
Key personnel	We differentiate between 'formal' and 'informal' personnel. 'Formal' personnel refers to an individual who has completed formal qualifications and/or is in a paid role. These individuals have a professional, working relationship with families (e.g., midwife, social worker). 'Informal' personnel refers to individuals who may have a personal relationship with the family (e.g., a friend, family members). We recognise that dividing individuals into 'formal' or 'informal' categories reflects binary thinking, which is not always in line with Indigenous ways of thinking. For instance, based on the above definitions, an Elder may be categorised as 'informal' personnel despite holding a formal cultural position in the community. We plan to continue to reflect on appropriate terminology/categorising as the development of the model progresses. Any comments or feedback is appreciated.
Process Factors	Aspects for implementing and evaluating the model of care. Practical elements. Includes: funding source, barriers, facilitators, implementation and evaluation.

Over the page, we have provided some additional definitions that may be useful and are relevant to the Wise Counsel model.



Additional definitions

Integrated model of care: Defined as a model of care in which decisions about what services are needed, who should provide those services, and how families can access services are reached through a shared and transparent process (e.g., achieved via collaboration and cooperation between health service providers, community members (Elders), child protection services and/or families to enable seamless, coordinated, efficient and effective care that responds to all of a families' health and wellbeing needs.

Interagency collaboration: Similar to an integrated model of care, interagency collaboration refers to practitioners from different organisations working as a multidisciplinary team with one primary care plan.

Place-based/localisation: Responding to the unique needs and requests of the local community to enable a tailored approach to service delivery.

Wraparound care: Various definitions exist across the literature. Some describe wraparound care as a 'one-stop-shop' whereby multiple services are offered in one location^{9,10,13,14}. Others describe wraparound care not as a service per se but rather "a process of team-based planning and collaboration"¹⁵. Ultimately, the definitions describe wrapping around the family through integrated care and collaboration (whether with one service or multiple) to improve outcomes.



STRUCTURED OUTLINE OF PAST FINDINGS ALIGNED TO WISE COUNSEL WORKSHOP SESSIONS

We have undertaken a lot of work over the years that has highlighted community concerns about child protection involvement with our families during pregnancy and post-birth. The diagram below provides a visual overview of the work we have undertaken in this area to date.



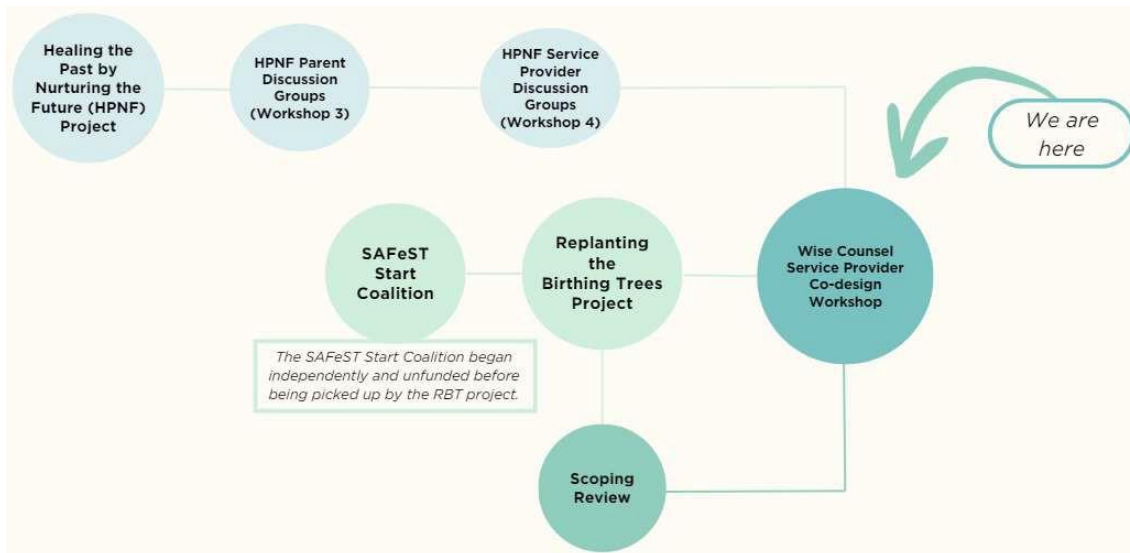


Figure 3 Work undertaken on the Wise Counsel to date

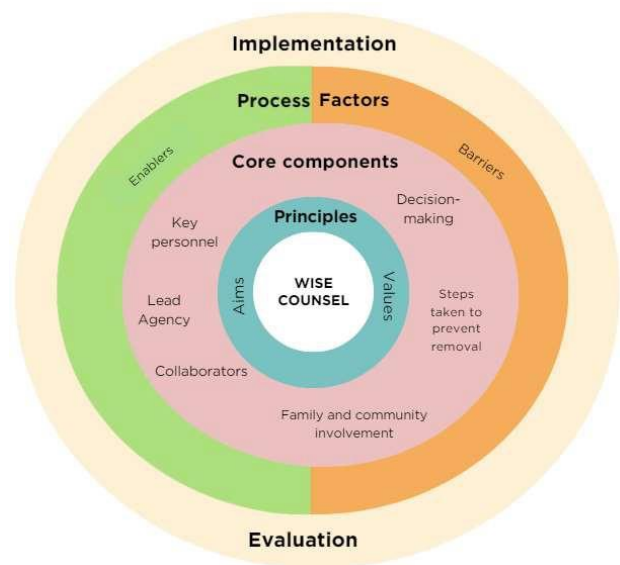
To assist your thinking during the Wise Counsel workshop, the team has undertaken a synthesis of our past research findings to identify what is already known from the research literature.

We have included the following sources in our synthesis of findings over the next few pages:

- ¹Healing the Past by Nurturing the Future Parent Discussion Groups (Workshop 3)
- ² Healing the Past by Nurturing the Future Service Provider Discussion Groups (Workshop 4)
- Healing the Past by Nurturing the Future Workshop 3 and 4 Reports
- Literature included in the Wise Counsel scoping review (review question: focus on integrated models of care regarding risk of child protection involvement in the perinatal period.)

The synthesis of findings is aligned with the Wise Counsel workshop sessions you will be taking part in. These are visually depicted, with colour coding, below.

- Session 1: Refining the Wise Counsel principles
- Session 2: Refining the Wise Counsel core Components
- Session 4: Barriers and anticipated challenges
(Process Factors)
- Session 5: Enablers and facilitators
(Process Factors)
- Session 6: Implementation and evaluation



SESSION 1: REFINING THE WISE COUNSEL PRINCIPLES

Our scoping review sought to identify integrated models of care aimed at reducing child protection involvement during pregnancy.

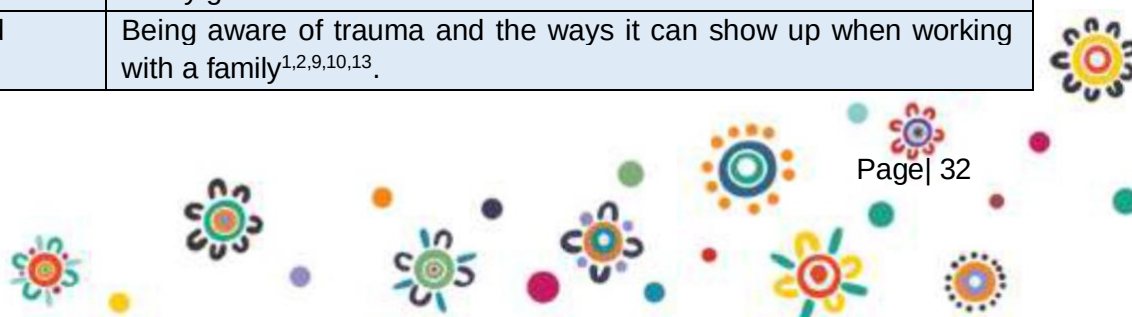
Regarding the AIMS of included studies however, only two models of care specifically aimed to reduce child protection involvement and/or prevent infant removal by child protection. ^{4, 14} Another aimed to reduce rates of child abuse⁷.

For most studies (n=11), child protection concerns during the perinatal period were addressed as a by-product of a model of care that primarily aimed to address the 'complex needs' of their clients ^{3,6,12} or were specific to women in the perinatal period experiencing substance use ^{4,5,8,9,10,11,13,15}.

The values identified in our past HPNF workshops, and in the models reviewed as part of our scoping review, are outlined below.



VALUES	DEFINITION AND SOURCE
Integrated care. Holistic, wraparound support	Integrated care was discussed in each of the reviewed papers, yet the way integrated care was described utilised different terminology. For example, the Waminda model ¹⁴ reviewed described the importance providing "integrated and coordinated pathways of care", while a (primarily) substance abuse model ⁴ described how interagency collaboration could be achieved to provide clients with holistic, integrated care. In one way or another, every article reviewed in our scoping review described the importance of wrapping care around the family and interagency collaboration as a method to achieve this.
Interagency collaboration	Interagency collaboration refers to practitioners from different organisations working as a multidisciplinary team with one primary care plan.
Person-centredness/ Strengths-based	Strengths-based, relationship-based intervention is a broad concept, and reflectively, the HPNF co-design workshops and most of the literature included in the scoping review used similar but varying terms and sets of values that align with this.
Family-led decision-making	The degree of family involvement ranged across the sources from allowing families to determine their own goals to active and consistent family-led decision-making throughout the model of care ¹⁴ .
Culture	Culturally appropriate and considered responses as a core aspect of models of care ^{1,2,14} .
Harm-reduction approaches	A harm reduction approach promotes a non-judgemental response from practitioners, particularly if there is perceived regression or if the family goals are not achieved ^{4,8,13} .
Trauma-informed practice	Being aware of trauma and the ways it can show up when working with a family ^{1,2,9,10,13} .



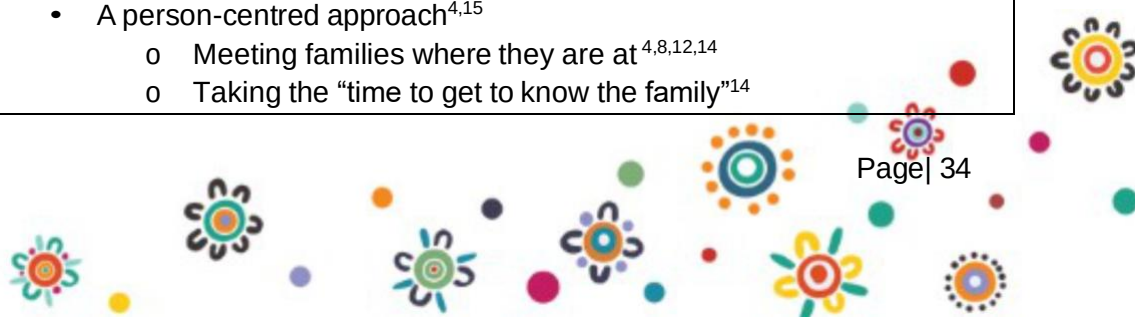
Transparency	Openness, clarity, and accessibility of information about decisions made ^{1,2,4} .
Trust and confidentiality	Trust and confidentiality were identified as important principles in several sources we reviewed ^{1,2,8} .

SESSION 2: REFINING THE WISE COUNSEL CORE COMPONENTS

Below is a synthesis of past findings from our reviewed sources, aligned with the 'core components' that we will be discussing in our Wise Counsel workshop on Day 1.

Key personnel	HPNF Parent Discussion Groups and HPNF Service Provider Discussion Groups: • Age and gender balance. Elders, but also young people • A mix of 'formal'/'informal' • Mixture of cultural knowledge and knowledge of professionals • Individualising based on circumstances and situation • Starting with the family – who is already there? • Professionals – culturally appropriate and skilled professionals (e.g., Aboriginal Liaison Officers) • Someone with authority is needed – someone to oversee the program • Community members who have integrity in the community (good standing, not so traumatised that they can't participate), recognised by other Aboriginal people (i.e. Elders, senior members of the community who are Aunties, people who are called upon for advice by communities) • Family, wellbeing champion – family to choose from guidelines for personnel, and families to be empowered to make the decision – and respect that families may need support to decide. Scoping review: Most of the sources in the review discussed having formal personnel involved in the model of care^{3,4,5,6,8,10,11,12,13}. Three sources discussed informal personnel, as well as, formal personnel in the model of care^{7,14,15} and one source did not discuss key personnel involved¹⁰.
Collaborators	Collaborators mentioned in HPNF Service Provider Discussion Groups: • Mental health – The importance of engaging key services, i.e. Orygen youth mental health service, people as advisory staff – in a framework led by community members (trusted members) • Dardi Munwarro, a holistic Aboriginal men's healing service – The importance of tapping into organisations that have intersections with child protection and therefore lots of resources. Collaborators mentioned in the scoping review: • Child protection, local community partnerships (e.g., housing services, substance use providers) and hospitals/health practitioners^{3,4,6,9,10,13} • Peer mentors with lived experience of substance use and abstinence¹¹ (NB. most of the models reviewed in our scoping review related to substance use)
Lead agency	HPNF Service Provider Discussion Groups:

	Discussion included an acknowledgement that the model of care should not be led by child protection, but no alternative lead was identified. Lead agency identified in our scoping review: • Child welfare led¹¹ • Child welfare and juvenile justice systems⁷ • A ‘one-stop-shop’ lead agency^{9,10,13,14}. One source, Waminda is an Aboriginal Community Controlled Health (and Wellbeing) Organisation¹⁴.
Decision-making	HPNF Parent Discussion Groups: • Discussion included a need for transparency about who is making decisions and when decisions are made. This does not always occur in current practice. • A need to change the dynamic of power – to shift power back in the hands of community. • Recognition of community politics. There needs to be someone on the Wise Counsel who is knowledgeable about a family’s dynamics. HPNF Service Provider Discussion Groups: • Empowering families to make decisions (self-determination). • Place-based relationships and decision-making. Decision-making likely dependent on circumstances. • Family to identify their champions. Scoping review: Articles included in our scoping review featured differing levels of decision-making. Some articles did not specify who was responsible for decision-making or it was unclear^{5,6,7,9}. While one model of care was practitioner-led¹¹, some articles appeared to have both practitioner and family input^{3,4,8,15} while others appeared to have family-led decision-making with practitioner support^{10, 12,13,14}.
Family and community involvement	HPNF Parent Discussion Groups: • Building parent capacity to promote self-determination for parents. • “The family always knows”. Families are the experts in their care. HPNF Service Provider Discussion Groups: • Included discussion that models should be centred on self-determination for the birthing parent (family decision-making) – then have people (e.g., practitioners) to support. • Discussion included an acknowledgement that at times families may need support in decision-making, but they are still the expert in their care. Scoping review: Articles included in the review featured differing levels of family involvement, ranging from unspecified^{5,6} to person-centred care^{3,7,8,10,13} (e.g., being guided by the family) to active and consistent family-led decision-making (e.g., Waminda model¹⁴). Examples of strategies to involve families and communities included: • A person-centred approach^{4,15} - o Meeting families where they are at^{4,8,12,14} - o Taking the “time to get to know the family”¹⁴

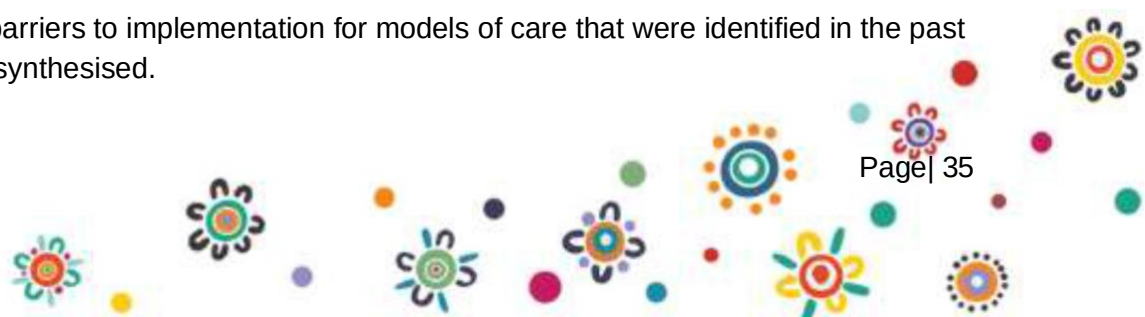


	- o Forming trusting relationships⁸ - o Exploring the family's strengths^{11,14} • Voluntary participation^{7,12,14} • Fostering cultural connections/cultural identity¹⁴ • Wraparound/ 'no wrong door approach' / 'one-stop-shop'¹⁴ • Strong community reputation^{13,14}
Steps taken to prevent removal	HPNF Parent Discussion Groups and HPNF Service Provider Discussion Groups: In these discussion groups, a Wise Counsel model was discussed as a model of care to prevent child protection removal. The decision-making powers of a Wise Counsel model were not discussed. However, strategies such as working alongside child protection (interagency collaboration), clarifying roles and effective communication, were discussed, as well as focusing on prevention rather than intervention and transparent decision-making with active family involvement. Scoping review: Two sources in our scoping review specifically aimed to reduce child protection involvement and/or prevent infant removal by child protection. Both models are delivered in New South Wales, Australia. (1) The Nabu program at Waminda is a specialist team that focuses on family preservation and restoration¹⁴. The Nabu program also offers intensive support through a wraparound approach at the 'one-stop-shop' ACCHO, Waminda¹⁴. (2) The other program that included reduction of child protection involvement and/or prevention of infant removal was the Substance Use in Pregnancy and Parenting Services (SUPPS) which is a specialist program that provides support in the perinatal period⁴ for those experiencing substance use concerns. Child protection concerns during the perinatal period were addressed as a by-product of a model of care for most of the included sources (n= 11). Strategies included: • Developing an individualised case plan⁸. • Improving collaboration across services (interagency collaboration)⁷. • Improving collaboration with child protection services in particular¹⁴. • Integrated planning process (case plan team made up of formal and informal supports)⁴. • Specific practitioner teams. Family facilitators in the JIGSO team¹². Pairing a social worker and family mentor together, with a maximum caseload of 15 families¹¹.



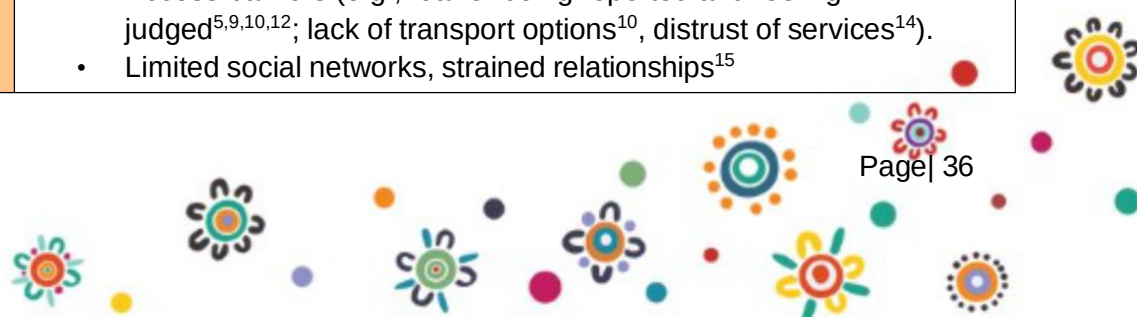
SESSION 4: BARRIERS AND ANTICIPATED CHALLENGES (PROCESS FACTORS)

Below is a list of barriers to implementation for models of care that were identified in the past research that we synthesised.



Please note that these are aligned with the ‘barriers and anticipated challenges’ that we will be discussing in our Wise Counsel workshop on Day 2.

Barriers to implementation	Mentioned in HPNF Parent Discussion Groups, HPNF Service Provider Discussion Groups and some of the included review sources: • Lack of flexibility in service delivery (e.g., appointment times) • Lack of liaising between services involved with the family (limited information sharing, over-servicing/doubling up on work) • E.g., Different professional perspectives and priorities⁴ • E.g. Varying bureaucratic processes and organisational values^{4,11,13} • Funding constraints • Current practice (systemic). E.g., CPS not acknowledging capacity for change, automatic notifications/ ‘ticking boxes’ • Lack of transparency in decision-making (e.g., parents not notified of notifications)^{1,2,4} • Time it takes to achieve systemic change^{1,2,11} • Power dynamics (e.g., community voice overlooked)^{1,2,4,14} • Constantly changing landscape (e.g., reshaping of the Department)^{1,2,11,14} HPNF Parent Discussion Groups: • Political, community dynamics, family dynamics, conflict within families. • Inconsistency in practitioner responses • Could potentially place an additional burden on First Nations services HPNF Service Provider Discussion Groups: • Challenge to successfully implement a model of care from theory into practice (Quotes: “[There are] already models around...how well they are practiced, and collaborative practice [is another story]. We all talk about it, but it’s not facilitated very well”; “All of those frameworks are there, they’re just not working for us for some reason”). • Challenges in collective decision-making (facilitating decision-making once convened if there is no consensus/ “too many people/overwhelming”). • Risk-adverse culture • Lack of knowledge about diversity in child rearing (Collective child rearing vs Western-Anglo (nuclear family, individualised) parenting). • Limited resources • Lack of cultural safety/awareness in practice Scoping review: • Access barriers (e.g., fear of being reported and feeling judged^{5,9,10,12}; lack of transport options¹⁰, distrust of services¹⁴). • Limited social networks, strained relationships¹⁵
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	• Burnout, staff turnover^{4,9} • Limited referrals generated to service¹⁵
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SESSION 5: ENABLERS AND FACILITATORS (PROCESS FACTORS)

Below is a list of enablers and facilitators for models of care that have been identified in the past research we synthesised.

Please note that these are aligned with the ‘enablers and facilitators’ that we will be discussing in our Wise Counsel workshop on Day 2.

Enablers/ Strengths	HPNF Parent Discussion Groups and HPNF Service Provider Discussion Groups: • Quote: “Might not take as long as what we think to get off the ground because I know – well our child protection services in South Australia are not coping the number of referrals”. If the Wise Counsel works as intended, it could promote relationship-building with child protection colleagues, as they will see the value in the program, and it reduces their workload. • Shifting it back to a joint decision (relates to accountability and risk-averse culture, dispersing accountability and anxiety – more likely to sit in risk). • Shared responsibility – reducing burden on child protection system, health staff, front line workers. • Wise Counsel could talk up the strengths of Aboriginal families (shift from deficit lens). • Greater support from child protection when different/additional service providers are involved. • Putting the power back in the hands of the community – changing the dynamic of power. • “I think it’s feasible because all of these things in one way, shape or form is already there” (Quote, HPNF Service Provider Discussion Groups) • “You have your Elders group, you have different organisations that provide certain things, especially with Aboriginal organisations, they’re like one-stop shops now, super clinics with all sorts of departments in them” (Quote, HPNF Service Provider Discussion Groups) • “We also have children’s outreach which is doing really, really well” (Quote, HPNF Parent Discussion Groups) • Parents have a right to be involved and be informed about what is happening. Education: • Quote: “I think more explanation of the harm done, and to how obviously Child Protection Services could be more supportive and less punitive. But at a universal health level, yeah really helping
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Facilitators to successful implementation (Solution - generating)	people understanding the history that makes referral to Child Protection really harmful”. • Develop up practice guidelines². • Place-based/localised responses (i.e., a framework that honours place-based decision-making, not pan Aboriginality)². • “Collaboration with child protection. Being very clear on our roles, and how we work together” (Quote, HPNF Service Provider Discussion Groups) • Power: political support needed – ACCHOs, ACCOs². Scoping review: • Shared governance structure^{4,13} • Elders as a form of governance¹⁴ • Prioritising community and culture¹⁴ • Shared organisational values and practice approaches amongst different service providers (interagency collaboration)^{4,7,9,13} • Strategies discussed to improve interagency collaboration: regular communication and meetings, having a team-based approach⁸, co-locating staff at each other’s offices^{9,14}, sharing staff⁹, mutual referrals/ joint case responsibility and decision-making^{9,14}, information sharing⁹, offering/attending joint training^{9,14} and allocating time to building relationships^{9,13}. • Enhancing policies and practices to improve workforce sustainability and avoid practitioner burnout⁴. • Continuity of care as a key to retaining family engagement⁴. Strategies identified to increase family engagement included offering the same practitioner throughout care⁴, offering flexible appointment times.
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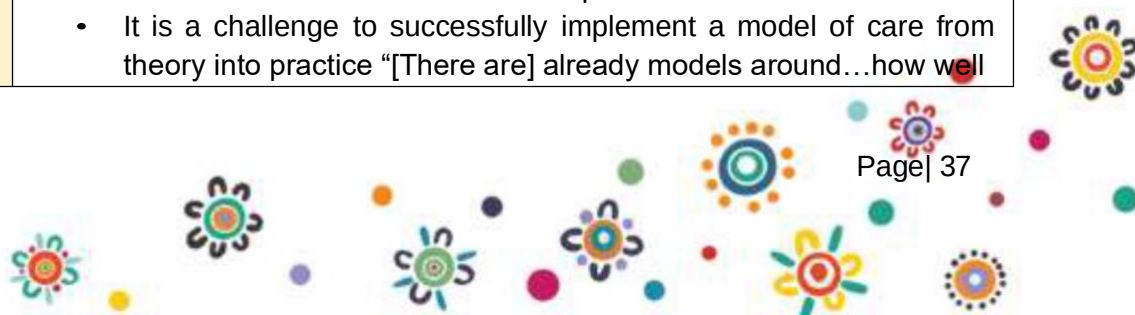


SESSION 6: IMPLEMENTATION AND EVALUATION (PROCESS FACTORS)

Below is a list of considerations for implementation and evaluation of models of care that have been identified in the past research we synthesised.

Please note that these are aligned with the ‘implementation and evaluation’ session in our Wise Counsel workshop on Day 2.

Implementation and evaluation	HPNF Parent Discussion Groups: • The importance of evaluation was discussed. There was acknowledgement that many programs with lots of funding do not have Key Performance Indicators (KPIs) and are not evaluated. Quote: “Where’s the outcome?” HPNF Service Provider Discussion Groups: • It is a challenge to successfully implement a model of care from theory into practice “[There are] already models around...how well
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	they are practiced, and collaborative practice [is another story]. We all talk about it, but it's not facilitated very well"; "All of those frameworks are there, they're just not working for us for some reason" (Quote, HPNF Service Provider Discussion). • The importance of addressing families' fears and concerns was discussed: "There's a lot of nervousness about bringing new people around who are the right people. But also, there's that, before you get into that Child Protection space, is the family wanting this to happen, and do they want those, and who do they want to have involved." (Quote, HPNF Service Provider Discussion). • The importance of involving child protection for implementation to be successful was discussed: "Child protection need to really be in this with us" (Quote, HPNF Service Provider Discussion). Scoping Review: Limited findings were available from the scoping review regarding implementation and evaluation. Predominantly, the models of care reviewed had not been evaluated, and included articles did not describe implementation in enough depth for it to be included here.
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Appendix B: Workshop Program

Wise Counsel service-provider co-design workshop 15 – 16 February 2024



Replanting the
Birthing Trees

Location: Treacy Function Room,
Treacy Centre

126 The Avenue,
Parkville, VIC, 3052

DAY ONE, Thursday 15th February

Setting the scene and building on what is known

9.30 am	Arrival and registration
10 am	Welcome <i>Welcome to Country, creating our safe space and getting to know each other</i>
10.30 am	Overview of the Wise Counsel model and findings
11.10 am	Refining our aims and objectives
11.40 am	Morning Tea <i>Weaving with Renna Gayde</i>
12pm	Refining the core components of the Wise Counsel mode
1 pm	Lunch
1.45 pm	Sharing the trends and themes - Core components
2 pm	Applying the Wise Counsel to a scenario
3.30 pm	Afternoon Tea
3.45 pm	Reflection and feedback
4.30 pm	CLOSE
OPTIONAL:	
4.30 pm	Yoga
7 pm	Group Dinner

Wise Counsel
service-provider co-design
workshop
15 – 16 February 2024



Location: Treacy Function Room,
Treacy Centre

126 The Avenue,
Parkville, VIC, 3052

DAY TWO, Friday 16th February



Making it happen

8.30 am	Arrival and registration
9 am	Start <i>Acknowledgement of Country, creating our safe space and recap of yesterday</i>
9.20 am	Barriers and anticipated challenges
10.20 am	Morning Tea
10.40 am	Strengths and enablers <i>Brainstorming and solution-generating</i>
11.40 am	Implementation and Evaluation
12.40 pm	Lunch
1.15 pm	Final reflections
1.45 pm	Performances
2 pm	CLOSE



Appendix C: Wise Counsel – Vision, Purpose and Value statement.

Vision: To create a safe, self-determining space in order to provide meaningful, family-centered, trauma-informed support to Aboriginal and Torres Strait Islander parents and families at risk of child protection involvement during pregnancy and post-birth.

Purpose: To generate solutions to provide nurturing support to Aboriginal and Torres Strait Islander parents and families, with the aim to ensure children grow up safe and thriving, and where possible, prevent child protection from removing an Aboriginal and/or Torres Strait Islander baby at birth by drawing on the collective wisdom of a Wise Counsel of wellbeing champions selected by the family to support the parent/family during pregnancy and post-birth.

Value Statement:

- We all agree that the safety of babies and children is paramount. This requires proactive steps to promote their holistic social and emotional wellbeing as a developmental process across the life course. This is best achieved through prevention, partnership, and holistic wraparound support to families, provided through services, organisations, family and community, to ensure the safe nurturing of children that enables ongoing connection to family, community, Country and culture.
- Access to culturally-safe and appropriate services, tailored for the needs of Aboriginal and Torres Strait Islander families, is essential to enable optimal outcomes for babies, mothers, parents and families. This means that services need to be responsive to and flexible in meeting family's needs.
- The agency and empowerment of families is important in making good decisions that are more likely to be implemented and achieved. This can only occur within a safe and trusting environment – there must be mutual trust and confidentiality respected between parents/families and Wise Counsel members to ensure optimal outcomes for all.
- In line with the principles of Indigenous self-determination, we value the right of communities to shape the support systems needed for Indigenous families, and the right of families to act with agency, with nurturing support from the Wise Counsel.
- Pro-active planning with everyone involved is essential. Families are best placed to decide who should support them on their Wise Counsel, with support, advocacy, and assistance to do so, during pregnancy concerning child protection involvement – a strengths-based, family centered, place-based and tailored approach is paramount.
- We value the wisdom of Aboriginal and Torres Strait Islander people from a wide variety of backgrounds, ages, genders and locations – a Wise Counsel should consist of a mixture of informal and formal support people, of varying ages, either Aboriginal and/or Torres Strait Islander or non-Indigenous, as decided on by the family.
- Parents and families who experience child protection involvement during pregnancy may carry significant trauma and complexity in their lives – supporting parents and families in diverse circumstances and situations requires a culturally safe and trauma-informed approach, where the complexities of human rights and 'best interests' are taken into account.
- Shared power in decision-making is paramount – we value the importance of working in partnership with child protection professionals to create transparent goals, actions and plans to ensure the safety and wellbeing of Aboriginal and Torres Strait Islander babies, parents and families.
- We value the right to culture for Aboriginal and Torres Strait Islander babies, children, families and communities, understanding culture as an individual experience enjoyed in community with other members of one's cultural group. We recognise these processes of culturally connecting in the context of ongoing resistance and survival of Aboriginal and Torres Strait Islander peoples.



Appendix D: Blank Key Personnel Poster (Session 2)



Session 2: How does a Wise Counsel function? (core components)

Key personnel

Who should be on the Wise Counsel?

Any practical examples where this is done well? And/or comments?	Strategies	Consensus (Dot) Vote
	^{1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13} Formal supports (e.g., social worker)	
	^{1, 2} Informal supports (e.g., family, community members)	
	¹¹ People with lived experience (e.g. peer mentor with lived experience of substance use and abstinence)	
	^{1, 2, 7, 14, 15} Mixture of 'formal' and 'informal' supports	
	A set number of members on each Wise Counsel?	
	² Individualised members on each Wise Counsel determined by the family	
	^{1, 2} Gender balance	
	^{1, 2} Age balance	

Other comments/suggestions?

¹ HPNF Parent Discussion Groups; ² HPNF Service Provider Discussion Groups; ³ Ayerle et al., 2012; ⁴ Coupland et al., 2021; ⁵ Crane et al., 2019; ⁶ Derbyshire, D.a., 2020; ⁷ Dodge et al., 2004
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Appendix E: Blank Barriers and Anticipated Challenges Poster (Session 5)



Session 4: Barriers and anticipated challenges

Identified barriers	Comments and/or any practical examples where this is addressed well?
^{1, 2, 3, 4, 5, 6, 7} Access barriers (e.g. Fear of CPS referral, lack of flexibility in appointment time, lack of transport, mental health, limited finances, distrust of services, sham/fear of being judged).	
² Additional 'burden' of responsibility placed on First Nation services	
^{4, 8} Burnout, staff turnover	
^{2, 9} Challenges with collective decision-making/differing perspectives (interagency collaboration) E.g., Disagreements with case plans, conflict, restrictive information sharing, interagency blaming.	
¹ Community dynamics/politics	
^{1, 2, 7, 9} Constantly changing landscape (e.g., reshaping of the Department)	
^{1, 2, 10} Funding constraints	
^{1, 2, 7, 8, 9} Lack of liaising between services involved with the family	
⁹ Length of time to develop interagency collaboration (the process of storming, norming and forming a group)	

¹ HPNF parent discussion groups; ² HPNF service provider discussion groups; ³ Crane et al., 2019; ⁴ Hubberstey et al., 2022; ⁵ Hubberstey & Rutman, 2020; ⁶ Jones et al., 2021; ⁷ SNAICC, 2022; ⁸ Coupland et al., 2021; ⁹ Huebner et al., 2015; ¹⁰ Teel, 2014