trauma care

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Trauma-Informed Care and Equity in Group Pregnancy Care for Women of Refugee Background: Reflections from the Workforce

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Abstract: For women and families of refugee background having a baby in Australia, trauma-related experiences contribute to maternal and neonatal health inequities. Group Pregnancy Care for women of refugee background is a new model of care that was codesigned with communities of refugee background, to incorporate a trauma-informed approach to care. The aim of this paper is to explore how trauma-informed care is understood by Group Pregnancy Care professional staff. An exploratory descriptive qualitative study involving twenty-three semi-structured interviews with past and present professional staff was conducted. Data were analysed using reflexive thematic analysis. The results reported in this paper include five themes: acknowledging the universal potential for trauma; accountability to community; practising in trauma-informed ways; how can we determine whether trauma-informed care is happening?; and understanding equity. The analysis showed that GPC staff aimed to practise in trauma-informed ways and understood that their ability to integrate trauma-informed care could improve over time. However, there were times when participants perceived organisation- or structural-level barriers that were incongruous with their understanding of health equity, which created tension and led to feelings for some of being in a 'battle against the system'. Key individual- and organisation-level factors were identified that assisted with integrating trauma-informed care, including a safe and accessible space to hold the program, strategies to minimise the risk of retraumatisation and burnout, and adequate time to facilitate group processes and support staff to participate in team reflective practises. Understanding trauma-informed care and equity were seen to have important implications for workforce wellbeing and the promotion of refugee maternal and child health.

Keywords: trauma-informed care; health equity; health professionals; refugee populations; group pregnancy care; qualitative study

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1. Introduction

1.1. Trauma and Health Equity

Trauma is a major public health issue [1–3] that contributes to adverse mental, physical, social, and emotional health inequities [3–6]. In Australia and other high-income countries, trauma-related experiences contribute to the inequitable burden of adverse maternal and neonatal health outcomes experienced by women and families of refugee background, compared to their locally born counterparts—including stillbirth, preterm birth, low birthweight, and mental health or social health concerns [7–9]. For women and families of refugee background, trauma can be individual or collective, resulting from human rights violations or other events experienced as seriously harmful or life threatening [3–5]. The effects of trauma are often complex, long-lasting, and intergenerational [3–6]. Concerningly, there is mounting evidence that racism and discrimination also contribute to trauma, are

ubiquitous in health care, and perpetuate inequitable health outcomes by consciously or unconsciously influencing perceptions of need and the kind or quality of care provided [8,10]. Marmot and others have identified that meaningful changes to the way health care is provided are necessary to achieve health equity [7,11]. For example, reorienting health service funding and priorities to account for structural power imbalances that affect health and wellbeing, such as finances, housing, and other resources [7,11].

1.2. Trauma-Informed Care

For women and families of refugee background, maternity care that does not acknowledge the enduring impact of trauma can be unsafe and difficult to engage with [2,4,9,12–15]. Universal health care settings in high-income countries like Australia must learn to provide trauma-informed care. As defined by the Stronger Futures Centre of Research Excellence [16], trauma-informed care is "grounded in principles of personal and cultural safety, justice, and dignity. Services implementing trauma-informed approaches provide a safe environment for people impacted by trauma, integrate knowledge about trauma into their policies and procedures and organisational culture, and promote strengths-based healing and recovery" [5]. Research demonstrates that trauma-informed care promotes better access to services, and improves engagement and satisfaction with care [10,17]. Although trauma-informed approaches are increasingly recommended in health care [2,18], the concept remains not well-understood in Australian maternity care settings. Furthermore, few trauma-informed models of care have been developed or evaluated in maternity care settings worldwide, and research that contributes to this evidence base is needed [2,19]. Integrating a trauma-informed approach in universal health care settings requires organisation- and system-level adaptations to ensure that policy, practise, and workplace culture actively avoid retraumatisation by building the capacity of professional staff to understand the signs, symptoms, and impacts of trauma, and pathways to recovery [3,4,20]. When trauma-informed care is structurally embedded, women and families do not need to repeatedly disclose trauma to receive safe and accessible care, professional interpreters are consistently provided as part of the care experience, and staff demonstrate a high level of awareness, inclusivity, and respect.

1.3. Group Pregnancy Care

Group Pregnancy Care (GPC) for women of refugee background is a model of collaborative community-based maternity care that offers potential benefits for women and families, by enabling trust and improving engagement between the community and health care services [21–27]. Between 2014 and 2020, two GPC programs for women of refugee background were codesigned, implemented, and evaluated with Assyrian Chaldean and Karen communities of refugee background in the northern and western suburbs of Melbourne, Australia. This project was facilitated by the Intergenerational Health group at the Murdoch Children's Research Institute (MCRI) and the Victorian Foundation for Survivors of Torture (Foundation House), in partnership with two public hospitals, two maternal child health services, and a refugee support agency. GPC for women of refugee background was codesigned to incorporate a trauma-informed approach to care, and brought together a multidisciplinary team of professional staff, including a bicultural family mentor and an interpreter so that women and families could consistently access information, care, and support in their own language [27]. Other key elements of GPC included access to continuity of care and caregiver antenatally and up to four months postnatally and the opportunity to make social connections, share experiences, and participate in additional education on a range of topics determined by attending women [26,27]. GPC was provided by a midwife, maternal child health nurse, and bicultural family mentor, who cofacilitated two-hour, fortnightly group information sessions. One-to-one antenatal appointments were provided as per the hospital guidelines, by a second midwife and interpreter at the same time as the group. These appointments were held in an adjacent room to the group to ensure women had the opportunity to discuss anything privately.

1.4. The 'Refugee Recovery Framework'—An Approach to Trauma-Informed Care

All professional staff from both GPC programs attended professional development provided by Foundation House, to support the practical integration of trauma-informed care. The training was contextualised to include refugee experiences of motherhood, prearrival and settlement, important considerations when planning and providing trauma-informed pregnancy and postnatal care, and the Foundation House 'Refugee Recovery Framework' (as pictured below in Figure 1). This framework is adaptational and locates the experience and impact of torture and other traumatic events associated within the greater socio-political context in which they occurred [4]. The persecution, oppression, marginalisation, and human rights violations inflicted upon refugee survivors are not hidden or glossed over. Instead, participants are invited to engage with this material from a humanistic perspective and to consider their unique position to counter these abuses through being a part of the recovery process for survivors [4]. Understanding and engaging with the horrific realities of these events is paramount to being able to create an environment of healing and recovery. The four core recovery goals [4] are:

- Restore safety and enhance agency and control.
- Restore secure attachments, connections to others, and sense of belonging.
- Restore meaning and purpose to life, rebuild identity, and promote justice.
- Restore dignity and value and reduce excessive shame and guilt.

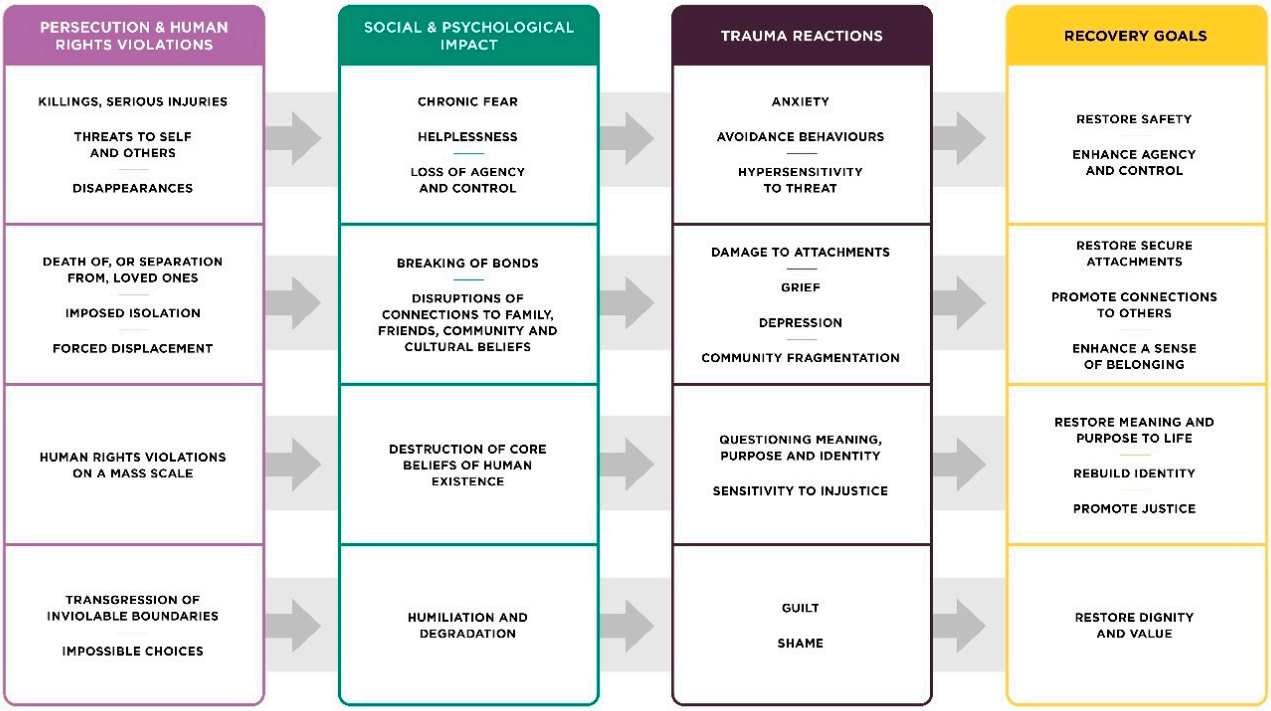

Figure 1. The 'Refugee Recovery Framework'—reproduced with permission from Foundation House, 2020.

The professional development was built around the recovery goals and the way in which individuals (and organisations or systems) can contribute to them. The participants were encouraged to reflect upon their power to enact these goals in whatever role they have. The sharing of practise-based knowledge was also prioritised, given the multidisciplinary nature of GPC teams. This provided an opportunity for peer-to-peer learning by acknowledging and drawing on the knowledge and skills of the multidisciplinary team members in caring for families of refugee background [28]. The professional development also aimed to support staff wellbeing by generating discussion and strategies for preventing burnout, and recognising the impact of vicarious trauma.

1.5. Research Aims

This paper reports findings from the qualitative process evaluation of GPC for women of refugee background, which constitutes one part of the broader formative evaluation. Papers about women's experiences of attending GPC, the codesigned multimethod evaluation protocol, and staff experiences of implementing and facilitating GPC—including the role of bicultural family mentors—have been published in detail elsewhere [26,28,29]. The formative evaluation report is also available via the study website [30]. GPC for women of refugee background is the first model of its kind in Australia and one of the first worldwide [31]. In the context of the unique nature of this model and the small staff teams at each site, and to prevent participant identities from being deduced by local readers of this paper, we use the language 'professional staff' to refer to the range of clinical and social care staff, stakeholders, and leaders involved in the implementation, facilitation, or oversight of GPC for women of refugee background. For this component of the qualitative process evaluation, we asked the professional staff to reflect on their involvement with GPC, including understanding and experiences of providing trauma-informed care. This paper aims to (i) explore how trauma-informed care is understood by GPC professional staff; (ii) explore how equity is understood by GPC professional staff; (iii), and understand what can be learned about implementing trauma-informed care.

2. Materials and Methods

2.1. Study Design and Participants

This exploratory descriptive qualitative study [32] was theoretically underpinned by constructivism—a research paradigm that acknowledges the role of lived experience, culture, and other factors on our perceptions and understandings of reality [33,34]. Constructivism supports researchers to see, hear, read, and think openly [35], and to be able to hold multiple concurrent complex understandings of the same program. The Foundation House 'Refugee Recovery Framework' [4] was also used to inform researcher positionality throughout all stages of the research process. The framework provided a supportive infrastructure for researchers, aiming to provide a physically, emotionally, and culturally safe space for participants working with women and families of refugee background. Bringing a trauma-informed approach to research encouraged healthy workplace and self-care practises for the researchers. For example, no more than two interviews were conducted per day, and the team came together to debrief and reflect regularly.

We recruited eligible participants using purposive sampling within a known and finite cohort [36]. A total of twenty-nine past and present professional staff from partnered organisations were invited to this evaluation. Recruitment was facilitated using Research Electronic Data Capture (REDCap) [37]. Personalised emails that included a REDCap survey hyperlink were delivered, so participants could register their interest and nominate their preferred date, time, and mode of contact for follow-up discussion. This study obtained ethics approval from the Royal Children's Hospital Human Research Ethics Committee (HREC/17/RCHM/66). Informed e-consent was obtained prior to each interview.

2.2. Data Collection

Between January and March in 2021, we conducted semi-structured interviews in English that lasted 30–90 min, over the phone or via Zoom, as per participant preference (COVID-19 safety precautions meant that interviews could not be conducted in person). REDCap was used to facilitate secure storage of the data. An interview guide and spontaneous lines of questioning were used in each conversation. The aim was to contain ourselves to relevant topics, while allowing for new insights to be incorporated as the study progressed. Before undertaking field work, the interview guide was piloted with one person from the study team familiar with GPC, and no changes were recommended. Twenty-one interviews were audio recorded with consent. Two interviewees preferred that detailed notes be taken in lieu of audio recording. Professional services transcribed the

audio data. Transcripts were then checked for accuracy and corrected where required by the interviewers (FH, AK).

2.3. Data Analysis

The data were analysed using reflexive thematic analysis [38,39]. This method is theoretically congruent with a constructivist worldview and acknowledges the role of researcher subjectivity and interpretation in research processes [40]. Braun and Clark recommend that good practise includes a clear theoretical and reflexive position [41,42]. We found the process of interpretive analysis to be cyclical and repetitive. The transcripts were read multiple times while listening to the audio recordings to encourage immersion (FH). Reflexive field notes were taken after each interview (FH, AK), and then continuously throughout the analysis (FH). The transcripts were coded and categorised iteratively (FH), with visual mapping and reflexive supervision occurring simultaneously (FH, LB, and ER). Themes, or 'meaning-united stories' [41], were developed in the context of the study aims using a combination of writing, rewriting, and team discussion (FH, LB, SB, AK, JS, and ER) [43].

2.4. Reflexivity

The research team undertaking this evaluation facilitated the codesign and implementation of the model. Several strategies were embedded into the research protocol from the study outset to support team-based reflexivity, including regular attendance at project meetings, group reflection, and critical enquiry, and contemporaneous feedback processes to progress thinking, analysis, and writing. The authors of this paper (FH, LB, SB, AK, JS, and ER) always aimed to be sensitive and accountable to the needs of the participants and partner organisations. With regard to the lead author, FH is a midwife currently working on public health and maternity care research projects. In addition to these group practises, FH maintained a reflexive and self-inquiring practise through regular reflective supervision and journaling.

3. Results

3.1. Participant Demographics

Interviews were completed with twenty-three (23/29, 79%) professional staff involved in the implementation, facilitation, or oversight of two GPC programs for women of refugee background in the northern and western suburbs of Melbourne, Australia. Of the twenty-nine prospective participants invited to take part in an interview, twenty-three registered their interest, two declined to participate, and four did not respond to the invitation (23/29, 79%). It is important to note that two staff members from the same professional group did not participate, citing stress related to the COVID-19 pandemic. These interviews were conducted at a time when the Australian healthcare system was in the midst of adapting to the pandemic [44], local lockdowns were occurring, and international travel was limited—meaning that people with international families were separated from their loved ones for an indefinite period of time [45]. Please see the 'limitations' section of this paper for further details. As stated in the introduction, professional roles, names, and organisations are not explicitly described anywhere in this paper to protect the anonymity of participants, and potentially identifying interview quotes included in the results are reported in the third person for the same reason.

The results reported below include five themes: acknowledging the universal potential for trauma; accountability to community; practising in trauma-informed ways; how can we determine whether trauma-informed care is happening?; and understanding equity.

3.2. Theme 1: Acknowledging the Universal Potential for Trauma

Many participants emphasised the impact of attending professional development with Foundation House—in terms of aligning an understanding of trauma-informed care, and why it is important to remain cognisant of the universal potential for trauma in a person's background. Participants were mindful that whether an event is experienced as traumatic varies according to the individual. Also, that potentially traumatic events can include refugee prearrival experiences, the challenges for women associated with settlement, as well as other adverse life experiences. For example, miscarriage, stillbirth, family violence, isolation, and loneliness.

> *So, I mean, the refugee experience isn't the only sort of trauma that women have. Somebody that might have had domestic violence or mental health issues or some other sorts of things that . . . that's relevant, the whole idea of that trauma and what people might need in a setting, to feel safe.* (202)

Participants reflected that when professional staff possess the capacity to acknowledge the potential impacts of adversity and trauma for women and families, the need to plan and provide care in ways that promote equitable outcomes for women of refugee background becomes clear. Furthermore, this recognition also needs to occur at an organisation-level, and be translated into policies and practises that embed a trauma-informed approach.

> *It's just a refresher* [the professional development] *in your mind and offers skills on what our focus is and why. You know, the lead up to why these women are here and why we feel they need that additional support and encouragement through the journey of their pregnancy. And how just putting them in a basket with all mainstream general public of women . . . these women need that additional support and knowledge and perhaps just an insight on how things are done in the Australian medical system and why.* (108)

There was concern expressed by some that attending professional development with Foundation House could potentially retraumatise staff with lived experiences of trauma. These interview participants emphasised that acknowledging the universal potential for trauma needs to include consideration of professional staff (along with the women and families receiving care), highlighting the connection between trauma-informed care and emotional and cultural safety in the workplace.

> *. . .similar training has caused distress to other* [professional staff] *who have lived through trauma.* (203)

3.3. Theme 2: Accountability to Community

Many participants explicitly acknowledged that the bicultural family mentors and interpreters in GPC worked directly with their own communities, and that this connection carried with it a different level of accountability to women and families attending the group.

> *. . .it's more than a job because it's working with your community, and you feel a responsibility for your community.* (203)

> *. . .the women knew her* [the bicultural family mentor], *they trusted her.* (101)

> *. . .women knew they could contact* [the interpreter] *and just have that direct line.* (305)

Participants were mindful that bicultural family mentors and interpreters were possibly connected with women and families outside of GPC (in the community). Also, along with shared language(s) and culture, the professional staff working in these roles potentially shared lived experiences with community members, including refugee or refugee-like experiences. The corresponding effort required to maintain healthy boundaries was perceived to have possible implications for professional wellbeing and workforce sustainability.

> *But we do set the ground rules. Like we can talk, but we don't mention the names* [of the people we are discussing], *and as soon as you leave, whatever* [happens] *outside* [the group] *it's not my responsibility. . . if any of you* [group attendees] *heard any gossiping or any story retelling from the group it's definitely not* [coming from staff in the group]. (103)

> *So, they're* [women and families] *constantly contacting* [the bicultural family mentor] *and there's an expectation that she is able to help them. . . often it's totally not even related to the pregnancy program, but* [the bicultural family mentor] *will feel, well, she may feel obligated. . . feel it's her role, her duty and her commitment to her community, to assist them.* (108)

Some participants felt that explicitly embedding supportive trauma-informed workplace infrastructure for these professional roles was necessary to overtly acknowledge what it takes to work well with your own community, and to encourage emotionally healthy, long-term professional practises.

> *That is a, not a barrier* [to sustainability], *but a challenge. . . we have to put strategies in place to help manage* [the bicultural family mentor's] *time and also her workload.* (108)

3.4. Theme 3: Practising in Trauma-Informed Ways

Staff who facilitated GPC aimed to practise in trauma-informed ways. They understood that their ability to integrate trauma-informed approaches to care could improve over time, and that this ability could be impacted positively and negatively by organisation-level factors. Key organisation-level factors that could support staff to deliver trauma-informed care include a safe space, adequate time, and team reflective practise processes.

Participants understood a 'safe space' to mean somewhere that feels warm, welcoming, and is geographically convenient to access (community-based and typically not the maternity ward or outpatient clinic of a hospital). The women and families are familiar with the building, can bring along other children, and can walk, carpool, or catch public transport if required. Women showed participants that they felt safe when they proactively engaged in their care and attended appointments and the group regularly. In a safe space, it could also feel easier for staff to respond well to disclosures and challenges as they arose.

> *. . .physically, geographically, at the right location where all of these newly arrived people, refugees, are coming and settling.* (101)

> *. . .the venue was really—it made people relax, families were happy to come there.* (110)

> *. . .mothers would come even when they didn't have appointments because they knew they could.* (111)

GPC staff expressed the need for adequate time to be allocated by their employers in order to provide a service able to meet the needs of women and families. They emphasised that it takes time to provide appropriate information and clinical care that is tailored to the context of individual women, to establish trusting and respectful relationships, and to follow up on important issues raised during appointments and group time. Participants also perceived that women and families need adequate time to be able to understand and engage with their care and the information being provided.

> *. . .there's all these other additional things and questions and work that comes from those two hours that* [the staff member is] *with the women.* (108)

Formal and informal team reflective practise processes helped participants to recognise how their own life experiences, beliefs, and values could shape the way care was provided, for example, having the opportunity to attend professional development or to debrief after facilitating GPC. The aim of practicing reflectively was to become self-aware, learn how to let go of preconceived judgements, and how to be open to new information and challenges.

Practicing reflectively helped staff show up to the group in the right frame of mind—feeling present, settled, and ready to listen.

> *. . .an open mind and a bit of an open heart as well.* (109)

> *. . .if I listen to where they've come from, walk with them* [women and families] *rather than telling them what to do—I think that's really important.* (102)

3.5. Theme 4: How Can We Determine Whether Trauma-Informed Care Is Happening?

Some interview participants felt unsure if Group Pregnancy Care was successful in bringing a trauma-informed approach to life. In contrast, others believed that only the women and families could determine whether their experiences of the model were trauma-informed—meaning the perspectives of professional staff and organisations are less important when looking to understand success.

> *. . .even if we're talking about trauma-informed care and all of those things, how do we know that it's happening? . . .it would be very interesting to see what women have said about the program.* (305)

Overall, engagement and trust were identified as important elements of trauma-informed care that could indicate a level of success to the interview participants. GPC was seen to be working well when participants could observe signs that women and families were engaged, and that community trust in the model was established. For example, when women would refer other pregnant friends and community members to GPC; openly share their challenges with staff; seek out capacity-building opportunities to increase their knowledge and understanding of important topics to do with pregnancy, early parenting, or health literacy; and initiate lifestyle changes based on information and advice received.

> *. . .we've seen women really, really take on the advice and implement that into their life, and for their babies and their pregnancies, and we've just seen a really lovely transformation that happens. And then carry their babies to full term, and know exactly what . . . who to call, when to go to hospital, you know, signs and symptoms of labour, how to manage it, and you know they've had some really, really wonderful outcomes.* (201)

3.6. Theme 5: Understanding Equity

Health equity is a concept integral to trauma-informed care, and an intention embedded in the codesign of GPC for women of refugee background [27]. However, there were important differences in how equity was understood between interview participants.

Although the participants realised that each GPC program was run for a specific community group to meet the language and cultural needs of the women and families attending, some felt this was unfair to others that were ineligible for and unable to access GPC (due to belonging to a different cultural group).

> *I just feel like there's a bit of favouritism you know, that this particular group get all the expertise and all our attention, and that there's many, many groups out there that are not getting this same care, and this same attention. So, I would like to see a more equitable, more, what do you call it, a better capacity to provide this same quality of care to all families. . .* (201)

Because each GPC program was run for a specific community, some participants felt the number of women accessing the group was too small to be sustainable for their health service and recommended that GPC be provided in a less culturally specific way so that a larger number of women at risk of poorer health outcomes would be able to be seen by staff.

> *I would expand it to other vulnerable groups. That's the thing I would change.* (204)

In contrast, the interview participants who reported having more experience working in equity-oriented ways sometimes felt that it was necessary to go above and beyond—to increase the understanding and capacity of their colleagues by providing education, informal mentorship, and advocating for the GPC model. In accommodation of the fact that the professional staff were coming to the project with individual learning requirements and different experiences, it was observed that some GPC staff would have benefited from increased opportunities to engage with further trauma-informed professional development. It was also recommended that the professional development be offered broadly to staff working outside the model.

> *But for the other staff that are new, one session is not enough. . . to get the whole knowledge and understanding.* (107)

> *For me, one of the things we could've done better in our hospital is to have brought that* [trauma-informed] *training in for the broader staff.* (305)

When equity was not understood or embedded at an organisation-level, tensions arose for professional staff with a strong understanding of, and commitment to, equity—who could feel that they were battling against the system. These tensions had important implications for workforce wellbeing and longevity. Many interview participants reported regularly working beyond their remunerated hours to complete the work they felt was required for GPC to function equitably, and for women and families to receive necessary care.

> *. . .I guess it's an ongoing battle. It* [GPC] *needs that strong advocacy. . .* (305)

> *. . .the* [staff] *can burn out quite easily and get a bit disgruntled or feel like they're forever fighting battles against the establishment. . .* (301)

> *We're ending up putting more hours into that program than we actually are being sort of rewarded for or acknowledged for.* (201)

4. Discussion

4.1. A Need for Ongoing Professional Development

The results of this study highlight the need for professional staff working with women and families of refugee background to be able to learn by doing, and reflect on their skills, knowledge, and capacity to provide trauma-informed care. Becoming a parent offers a unique life-course opportunity for trauma recovery, and the potential for preventing intergenerational trauma [46]. Trauma-informed care in the refugee context requires comprehension of the reality of violence, horror, and powerlessness that many people have experienced (and may continue to experience), and to recognise how this can impact on a person's life, including physical, social, and mental health outcomes [3,4,47]. The tailored professional development with Foundation House provided a platform for staff to cultivate a shared understanding and approach. However, these results demonstrate a clear need for ongoing access to professional development supporting trauma-informed practises for teams to collectively achieve these goals. One session was not enough to facilitate an understanding of trauma-informed care for health professionals who had less experienced working in this way.

The results from this study also indicate that access to professional development would have been beneficial for staff and management working outside of GPC, taking a 'whole of organisation' approach, to ensure the wider workforce was also operating with a trauma-informed lens. At times, GPC professional staff perceived a lack of understanding and support from colleagues and management in their organisation and felt this inhibited the group's capacity to provide trauma-informed care. This finding is consistent with other research, which reports that meaningful change, such as the integration of trauma-informed care, requires intervention and understanding at a policy-, organisation-, and systems-level [48,49]. For example, in a mixed methods study that aimed to reduce racism, discrimination, and stigma by reorienting services to health equity, Varcoe et al. [49]

described individual-level professional development as an important, but inadequate, element of change. Education, action, and accountability need to be embraced by the whole organisation for a culture shift to occur [49,50]. A qualitative study on the micropolitics of implementation by Rogers et al. [48] also observed several organisation-level factors that constrain change by perpetuating unequal power dynamics including traditional forms of authority, an unsupportive workplace culture, and working in an environmental or cultural 'silo'.

As stated in the introduction, trauma-informed care is generally not well understood in Australian maternity care settings [2,19]. In comparison to other health and mental health care fields, the trauma-informed maternity care literature is sparse. There are numerous distinct bodies of trauma-informed research that focus on specific experiences of trauma, recovery, and healing, including but not limited to refugee and refugee-like experiences [4,47], First Nations and Indigenous experiences [46,51], and adverse childhood experiences [20]. Certain definitions of trauma are well known and regularly cited, for example, the seminal definition provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is referenced in this paper [3,52]. However, across the broader evidence base, there can be a lack of consensus defining what trauma-informed care looks like in practise [2,18]. For professional groups who are new to trauma-informed care, inconsistent or ambiguous information and approaches have the potential to create ideological confusion or conflict and could pose a barrier to the effective integration of trauma-informed care in maternity services [53]. For example, an integrative review was recently published that explored trauma-informed education and care in midwifery [19]. This paper approached the topic with a narrow lens, in context of the effects and relevance of perinatal and birth trauma [19]. The effects of birth trauma for women, their families, and health care professionals such as midwives are significant and are known to contribute to workforce secondary traumatic stress, burnout, and attrition [54,55]. Without minimising the implications of birth-related trauma, introducing trauma-informed care in such a limited context is problematic, as this framing does not facilitate acknowledgement of the intersection and effects of other experiences of trauma outside the perinatal period. The results from our study indicate that professional staff working with women and families of refugee background need clear and consistent information about trauma-informed approaches to care that are congruous with their organisation's values and mission, and that safely and respectfully acknowledge a person's whole self and life experiences—including the potential for trauma in all contexts.

4.2. The Health and Safety of Professional Staff

Trauma-informed care includes respect for safety and the belief that recovery is possible [1,3,4]. The findings reported in this paper indicate that professional staff cannot sustain a commitment to these beliefs in practise without consideration of their own needs. Trauma-informed care therefore includes accounting for the health, wellbeing, and potential for experiences of trauma for professional staff (as well as women and families). For the health care workforce, poor mental health outcomes such as secondary traumatic stress, retraumatisation, and burnout are strongly associated with trauma, present a significant problem, and contribute to attrition, workforce shortages, and diminished quality of care [55,56]. Integrating trauma-informed care at an organisation-level challenges staff and managers to reflect upon and potentially transform workplace culture, practises, and priorities to restore safety, promote recovery, and positively contribute to improved professional satisfaction and longevity [1,20,56,57]. The results from this study show that, in practise, this includes a safe work environment for staff that minimises the risk of poor mental health outcomes by providing adequate support, remuneration, and resources, and a safe space and protected time for team reflective practise as issues arise. Professional staff need supportive organisational infrastructure to be able to role model a healthy sense of self-care and care for others.

The multidisciplinary team of professional staff that facilitated GPC included bicultural family mentors and hospital-employed interpreters. In recognition of the unique nature of these professional roles, understanding what it takes to implement trauma-informed organisational infrastructure to support wellbeing requires additional consideration. The findings reported in this paper acknowledge that there was a different level of accountability to community experienced by these members of the team, who potentially shared language(s), culture, and lived experiences with the women and families attending the group. While there is no evidence available specifically addressing the professional wellbeing of bicultural family mentors working in perinatal services, our findings are relevant to other research concerning the potential health and mental health implications for interpreters [58] and other workforces with 'lived experiences' [59]. For instance, a scoping review by Fennig and Denov [58] about interpreters working with people of refugee background in mental health care settings reported that interpreters who themselves have a refugee background can experience heightened distress and other negative emotional impacts when engaging with refugee stories of trauma over the course of their work. The labour required to maintain healthy boundaries and manage expectations with community and employers may also contribute to work-related stress [60]. Furthermore, it is important to note that although workplace culture can differ between practise settings, health care systems and hospitals are historically founded upon colonial, hierarchical, and institutional traditions [61]. At an organisation- or systems-level, the recognition of any professional implications associated with an increased sense of accountability to community may be inhibited by structural power dynamics [62] when service priorities do not align with such issues. For future work in this area, we recommend embedding collaborative feedback processes to inform the development of trauma-informed organisational infrastructure that encourages knowledge and power sharing, such as codesign and group supervision [63,64].

4.3. Understanding the Connection between Health Equity and Trauma-Informed Care

Achieving health equity means that everyone can reach their full potential for wellbeing without "unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality" [65]. Trauma-informed care is an important component of equitable health care delivery, given that its aims are to improve the physical, emotional, social, and cultural safety, and accessibility of services—particularly for groups who are inequitably impacted by trauma [4,10,66]. In this study, a lack of understanding was apparent among some interviewees with regard to concepts like 'equity', 'equality', 'fairness', and how equity and trauma-informed care intersect. For example, some participants felt that providing GPC in a less culturally specific way would make the model more sustainable for their organisation. However, enacting this recommendation would limit the capacity of GPC to be facilitated in community language(s), and exclusion from health care services for women and families who do not speak English fluently is known to be a settlement stressor linked with dissatisfaction and retraumatisation [67]. The participants also felt that when colleagues and managers did not understand equity, they themselves lacked the power required to influence change at an organisation-level, to promote equity.

Power imbalance is a root cause of health inequity [4,10,49,50,68]. Those who benefit from and perpetuate the inequitable status quo have power, while communities who live in marginalised conditions lack power [4,68,69]. To advance health equity, health and social care professionals must be able to recognise and analyse power imbalances, deploy strategies to build community power, and limit the power of those who benefit from inequity [10,49,50,57,70]. However, systems and organisations have a corresponding and overarching responsibility to facilitate the right kind of working environment for staff to learn to enact these skills, by targeting care improvements to people most structurally disadvantaged by poverty, racism, and other forms of discrimination and stigma [68,71]. Trauma- and violence-informed care is a universal approach that extends upon the foundations of trauma informed care by explicitly acknowledging the presence and ongoing impact of all

forms of structural violence—and that wellbeing is determined by the interplay of structural determinants, including social, economic, cultural, and geographical factors [57,72,73]. There is a need for trauma- and violence-informed research to be generated, specifically in context of maternity services, to address the evidence gaps and improve individual- and organisation-level understanding for this sector. While this paper has focused on the perspectives of the professional staff involved with GPC, there is a broader need for research that examines what trauma-informed care means to women and families of refugee background. For those seeking to undertake similar work in future, we recommend that trauma- and violence-informed professional development be provided at an individual- and organisation-level. Specifically, facilitating consideration of systemic power dynamics may better support professional staff and managers to understand equity, and to transform care by reorienting services towards equity—meaning that care is then more likely to be trauma-informed with respect to the workforce, women, and families.

5. Strengths and Limitations

To the best of our knowledge, this is the first study to explore how trauma-informed care and health equity are understood by professional staff implementing and facilitating a model of GPC for women of refugee background. The methodology and methods used are a strength of this paper. These interviews took place across a number of cultural boundaries and the theoretical positioning facilitated by a constructivist worldview and the 'Refugee Recovery Framework' enabled the lead author to hold a different complex understanding of the same program. Conducting a reflexive thematic analysis incorporated a high level of reflexivity throughout the research processes and potentially improved the rigour of study findings. Semi-structured interviews were conducted over a three-month period, which allowed sufficient time for researchers to identify new understandings and to bring these into the interviews, by pursuing new lines of questioning. Although most professional staff involved in GPC for women of refugee background chose to take part in an interview, it is a limitation of this paper that two people from the same professional group did not participate. The views of those who did not participate were unable to be included in the analysis, and unfortunately the professional group cannot be disclosed to readers to protect the anonymity of other study participants. Additionally, although this is an Australian piece of research, much of the literature cited in this paper has been generated overseas, and more Australian work in this field is needed.

6. Conclusions

Trauma-informed care offers an opportunity to support health, healing, and recovery for women and families of refugee background—as well as for professional staff. The findings reported in this paper are congruent with the existing literature and demonstrate that trauma-informed infrastructure and care need to be embedded at a 'whole of organisation' and health system-level. This includes ongoing access to professional development supporting trauma-informed approaches to care for staff working in multiple roles across entire organisations. Trauma-informed care and equity are inherently linked, and the health and social care workforce need to be supported to understand the relevance for reorienting perinatal care in this way, to improve maternal and child health outcomes, and address inequities.

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