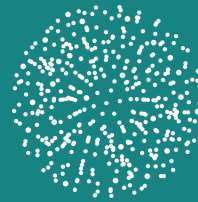




**Pregnancy
to Parenthood**
Parent & Infant Mental Health Service
Early Connections Endless Impact



STAN PERRON
*CHARITABLE
FOUNDATION*

Building Stronger Foundations

**Empowering the Geraldton
Perinatal & Infant Mental Health Workforce**

**Geraldton Workforce Development
Training Project: Phase Two**

**Evaluation Report
April 2026**

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Acknowledgement of Country

Pregnancy to Parenthood acknowledges that we live, work, and create together on Whadjuk Boodjar. We pay our respects to the sovereign Noongar nation, the custodians of this Boodjar. We also pay respects to the custodians of all First Nations lands, which always was, and always will be Aboriginal land, and which holds the stories and histories of the world's oldest continuous cultures.

We would also like to respectfully acknowledge the Yamatji Peoples who are the Traditional Owners and First People of the Midwest land, The Nhanhagardi, Wilunyu, Naaguja. We pay our respects to the Elders past, present and future for they hold the memories, the traditions, the culture and hopes of the Yamatji Peoples.



Project Details

Name of Organisation: Pregnancy to Parenthood Clinic, 420 Bagot Rd, Subiaco, WA 6008 Australia

Australian Business Number: 54 659 775 90

Project Title: *Building Stronger Foundations: Empowering the Geraldton Perinatal and Infant Mental Health Workforce*

This project aims to establish a foundational workforce development model for Perinatal and Infant Mental Health (PIMH) Training specifically tailored to regional areas of Western Australia, starting in Geraldton. In phase one, we recruited ten multidisciplinary practitioners from local mental health and health sectors to participate in a 9-month training program. The training combined face-to-face workshops and online /in-person reflective supervision and aligned with the international PIMH Competency and Endorsement Framework (The Alliance). Outcomes indicated high levels of engagement, increased practitioner competence, and the ability to deliver targeted PIMH interventions to support Geraldton's youngest children and their families.

Phase two focused on sustaining and expanding this initiative, addressing systemic barriers identified in phase one, and building a shared understanding of PIMH across the broader Geraldton community.

Primary Objective Areas: Paediatric/Children's Health; Health and Wellbeing of Australian Citizens; Health Service/Hospital; Education Program/Initiative.

Primary Areas of Focus:

- Community Development - Place-based interventions
- Education-Vocational education and training - Vocational post- secondary education
- Health - Healthcare access
- Health - Healthcare quality
- Human Rights - Diversity and intergroup relations- Social inclusion

Start Date of Project: 1st January 2025

Completion Date of Project: 31st Dec 2025

Contact Names for Report: Rochelle Matacz, Chief Executive Officer and Karen Griffin, PIMH Supervisor

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Report Date: February 2026 Report

Due Date: February 2026

Report Sent to: The Stan Perron Charitable Foundation

Contact Names: Elizabeth Perron and Suzanne Sweeney

Foreword

It is with deep appreciation and a strong sense of responsibility that I present the *Phase Two Evaluation Report* of the *Geraldton Workforce Development Training Project*.

This Project was born from a simple but powerful conviction: that babies' mental health matters, and the wellbeing of infants and very young children is inseparable from the wellbeing of the caregivers and communities who surround them. In Geraldton and across the Midwest, we have listened carefully to local practitioners, leaders and families who are committed to doing better for their youngest community members.

Phase One demonstrated that when we invest in workforce capability, reflective practice and a shared language, meaningful change begins to take root. Phase Two has deepened that work, expanding the reach of Perinatal and Infant Mental Health (PIMH) knowledge across the Continuum of Care, from promotion and prevention through to clinical intervention, and strengthening a relationship-based, culturally responsive community of practice.

The findings are both encouraging and instructive. Fifty-seven additional multidisciplinary professionals engaged in Phase Two training, reporting increased knowledge, confidence and competence in embedding PIMH principles into daily practice. Ongoing reflective supervision further strengthened clinical depth and reflective capacity. Importantly, this work has extended beyond individuals, influencing teams, strengthening referral pathways and contributing to a more integrated PIMH system in Geraldton.

The 2024 AEDC data reminds us why sustained effort is essential. Rising developmental vulnerability signals the need for responses that are place-based, culturally safe and collaborative. Workforce development is not a short-term initiative, it is infrastructure and the foundation upon which prevention, early intervention and therapeutic services stand.

Our approach has focused on “scaling deep” through embedding knowledge, shifting culture and strengthening relationships across sectors. True systems change occurs not only when services expand, but when mindsets shift and practices evolve. We are seeing early evidence of this transformation in Geraldton.

I extend sincere thanks to the Stan Perron Charitable Foundation for their continued partnership and vision. I also acknowledge P2P staff Karen Griffin, Brooke Maddestra, Jenna Thornton, Kaoru Nosaka, Angharad Titlestad and Jodie Naismith, whose expertise, dedication and relational leadership brought Phase Two to life in such a meaningful way. My thanks also to the practitioners, supervisors, local leaders and organisations who have committed their time, trust and collaboration to this initiative.

The *Geraldton Workforce Development Project* now stands as a blueprint for strengthening regional PIMH systems across Western Australia. With continued partnership and investment, we can consolidate the Geraldton Hub as a regional centre of excellence and extend this model to other communities equally committed to supporting infants, young children and families.

Babies cannot advocate for themselves. It is our collective responsibility to ensure the systems surrounding them are capable, reflective and responsive and this Project is one important step toward that vision.

Rochelle Matacz
Chief Executive Officer
Pregnancy to Parenthood

Key Findings

Pregnancy to Parenthood recognises that ongoing embedding of Perinatal and Infant Mental Health (PIMH) principles across the Continuum of Care in the Midwest is critical.

To achieve this, P2P proposed that the Pilot Project delivered in 2024 was scaled up and a second phase of the Geraldton Workforce Development Project be delivered throughout 2025, underpinned by the goals of the *National Mental Health Workforce Strategy 2022-2032*.

The second phase focused on sustaining and expanding this initiative, addressing systemic barriers previously identified in Phase One and continuing to build a shared understanding of PIMH across the broader Geraldton community.

Continued investment in building the PIMH workforce in the Midwest is essential, given the latest Australian Early Development Census data (2024), which shows rising developmental vulnerabilities across key early childhood domains.

The main objective of this second phase was to deepen the reach of the training to further embed PIMH principles into the broader Midwest community, thus supporting an appropriately trained and reflective workforce with the ability to consider the mental health needs of infants, very young children and their families.

Increased awareness amongst a locally trained workforce of emerging emotional disturbances in infants and young children supports earlier access to vital specialised services to address infant mental health and family wellbeing. Positive impacts to intervening early include strengthening parent/infant relationships and promoting healthy family functioning in the local community.

Delivered by our PIMH Training Team of Internationally Endorsed Infant Mental Health Practitioners®, the Phase Two Training Program was underpinned by recommendations from Phase One of the Workforce Development Project delivered in 2024 and was developed in conjunction with local stakeholders as part of a co-design process.

Identified issues impacting local families included homelessness, adult mental health, family and domestic violence (FDV), and alcohol and other drugs. Local stakeholders expressed concerns regarding the effects of these issues on parent/infant relationships, family functioning and developmental outcomes for infants and young children.

Key themes of PIMH promotion, prevention and treatment/intervention emerged from the consultation process which supported the subsequent training development. The training directly aligned with an international endorsement framework, the Australian Association for Infant Mental Health's (AAIMH) Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

Over a 12-month period, a total of **57 additional multidisciplinary professionals participated in the training**, delivered through four in-person workshops and four online sessions.

Furthermore, **12 practitioners** who completed the initial nine-month intensive interdisciplinary Training Program in Phase One **were invited to continue with monthly group reflective supervision sessions in Phase Two** of the Workforce Development Project.

The Project evaluation examined the Training Program's impact on the participants and included pre-and post-training surveys, content analysis of participants' training feedback and thematic analysis of individual interviews. Spanning all workshops, high levels of engagement, a positive perception of the training and satisfaction with the training material were evident.

Additionally, **an overall trend emerged across all workshops towards positive ratings at post-test in terms of knowledge of PIMH and confidence in promoting PIMH within the local community**.

Three main themes emerged from individual participant interviews:

- **Perception of PIMH training;**
- **Training impact across the Continuum of Care;** and
- **Continuing to embed PIMH in the local community.**

Additionally, trends which emerged from post-training responses by trainees from Phase One who attended ongoing reflective supervision opportunities included greater perceived importance of reflective supervision and improvement in reflective capacity.

In summary, social impacts of the training included:

- **Direct increased PIMH competency for 57 local multidisciplinary professionals** (and indirectly by a minimum of an additional 57 team members who benefit from the shared learnings).
- Practitioners reported **improved wellbeing outcomes for local families** as a result of increased PIMH workforce capability.
- **Enhanced service delivery**; provision of culturally safe interventions.
- **Increased access to services** and **greater awareness of PIMH, reducing waitlists** for specialised services.
- **Sustainable capacity building** fosters leadership in PIMH locally.
- **Professional endorsement opportunities to support building workforce capacity** across the PIMH Continuum of Care.

Priority recommendations for Phase Three of the Project arising from the evaluation are outlined below:

- Geraldton's PIMH Hub is in its second year, with a locally engaged workforce undertaking foundational training and reflective supervision. **Continued investment is required to embed skills, extend service reach, and sustain the workforce**, particularly given the 2024 AEDC findings and the complex needs of local families.
- A **stepped, place-based approach is recommended to establish a culturally safe, self-sustaining hub-and-spoke model aligned with international best practice**. This includes re-orienting the Geraldton Clinic as a regional PIMH Hub providing AAIMH-aligned training, PREPP training, ongoing reflective supervision, and targeted workshops. Cultural consultancy and dedicated pathways for Aboriginal and CALD practitioners are essential factors.
- A **pilot IECMHC initiative (16 hours/week) within ECEC and Child Protection Services** is also recommended to address barriers to PIMH training participation due to challenges associated with job requirements that require early childhood staff to remain on site with children. This pilot opportunity draws on strong international evidence to strengthen early childhood systems and outcomes across the region.

Chapter One: Project Introduction

In 2024, P2P established and successfully delivered a nine-month intensive interdisciplinary pilot training program for 12 trainees located in Geraldton. The Training Program consisted of six days of face-to-face group training sessions and three days of reflective supervision complemented by ongoing online small group supervision throughout.

Delivered by our PIMH Training Team of Internationally Endorsed Infant Mental Health Practitioners® and Infant Mental Health Clinical Mentors®, this Training Program was developed as part of a co-design process to directly align with an international endorsement framework, the Australian Association for Infant Mental Health (AAIMH)'s Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

The evaluation of this pilot examined the Training Program's impact on participants' PIMH competencies and their capacity to apply PIMH strategies in practice. It also identified barriers and enablers for ongoing implementation in the Midwest and proposed improvements for future training that could be replicated in other regional locations.

The evaluation involved pre- and post-training surveys, content analysis of participants' training feedback, and thematic analysis of focus groups with facilitators and participants. Participants demonstrated through their reflections and practice examples that they are integrating PIMH principles into practice following participation in the Training Program.

In summary, key findings underpinned the following recommendations for subsequent phases of the Training Program's delivery:

- 1) Establishing a shared community response
- 2) Continue provision of reflective supervision for Phase One participants
- 3) Support practitioners to become endorsed as Infant Mental Health Practitioners
- 4) Establish a local PIMH Advisory Group for sustainable, community-led services
- 5) Secure additional PIMH funding, resourcing and specialist PIMH services
- 6) Deliver a scalable PIMH training model to other regional locations

The evaluation confirmed a clear commitment and passion for PIMH existed amongst training participants and facilitators, with a strong desire to continue to work collaboratively as part of a shared community response to embed PIMH across the Continuum of Care in the Midwest.

To achieve this, P2P proposed scaling up the pilot and delivering a second phase of the Geraldton Workforce Development Project in 2025, aligned with the *National Mental Health Workforce Strategy 2022-2032* and focused on sustainability, addressing systemic barriers identified in Phase One, and strengthening shared understanding of PIMH across the Geraldton Community.

Stakeholder Consultation

Following on from the consultation and relationships developed over the course of the Phase One training, P2P continued to intentionally put the local community at the centre of the change process through inclusive involvement of a broad spectrum of professionals (who each represented diverse system stakeholders) to disrupt and attempt to change the local PIMH system where needed, in line with Phase One recommendations.

Developing the Phase Two PIMH Training Program for Geraldton's multidisciplinary practitioners involved deep engagement with a broad range of local stakeholders and organisations supporting infants, young children, and their families, underpinned by co-design principles.

Meetings were conducted both in person and online with managers, representatives, and teams from Health, Government, and Not-for-Profit organisations, including Health Communication Resources, the Department for Child Protection and Family Support (CPFS), Ngala, and Centacare. These organisations provide services with multidisciplinary staff supporting families within the Early Years sector.

The enquiry revealed:

- A need to raise broad community awareness of PIMH across the primary prevention sector, at the whole population level. This reflection was underpinned by the following themes:
 - the impact of the transition into parenthood;
 - distinguishing the baby blues from more serious concerns;
 - the experience, needs and inclusion of dads;
 - normalising help seeking;
 - provision of “good enough” parenting;
 - building connections; and
 - raising awareness of available supports.
- Demonstrated demand for a practical, hands-on learning opportunity for a range of community professionals across different sectors and agencies, where everyday PIMH intervention skills could be understood and strengthened. This was underpinned by themes related to:
 - signs that someone may be experiencing mental health challenges or indicators of mental health concerns;
 - ways to talk with parents in the moment about PIMH;
 - ways to help parents engage with their babies and young children;
 - raising awareness about the impact of FDV on child development; and
 - the challenges and impact of homelessness on families.

- Support for clinicians in therapeutic roles was essential to further develop and embed PIMH clinical intervention skills into practice, particularly through use of case examples related to complex mental health and trauma presentations, alongside a deeper exploration of PIMH interventions.
- A motivation to focus on the needs of the local Aboriginal community. For example, a community-based prevention workshop with a cultural lens would be an important consideration, possibly led or co-facilitated by a local Aboriginal professional.
- A concern that caregiver psycho-education sessions whilst valued might not result in high levels of engagement. Important considerations would include oversight of the sessions and the provision of referrals/support pathways following the sessions, if required. Partnership with a local agency may be a more effective strategy to ensure engagement.
- FDV was an important focus that could be presented as a stand-alone session, within the PIMH frame. Possible topics could include opening conversations, informal risk assessment processes, safety planning and developing wrap around supports.

Following stakeholder consultation, it was determined that the first three workshops would be designed to span the PIMH Continuum of Care across promotion, prevention and intervention. The fourth workshop content would remain open to consideration and would be developed in response to community needs and relationships that emerge throughout the first three workshops. The Phase Two training would focus on building and enhancing knowledge, skills and competence in PIMH, incorporating these into existing roles, teams and organisations so PIMH could be further integrated across the Continuum of Care and embedded more broadly within the Geraldton community.

Building a PIMH Collective Impact Across the Continuum of Care in the Geraldton Community

Introduction

Deriving from the Geraldton Workforce Development Training Project (2024) Phase One Evaluation Report, this section seeks to broaden the PIMH lens and orientate the reader to consideration of a whole-of-community approach to PIMH.

A macro-level view encourages reflection upon different community needs, services, supports and ways of working. Furthermore, including consideration of how individuals, organisations and communities can enhance their work in promoting the social and emotional wellbeing needs of infants, young children and their caregivers.

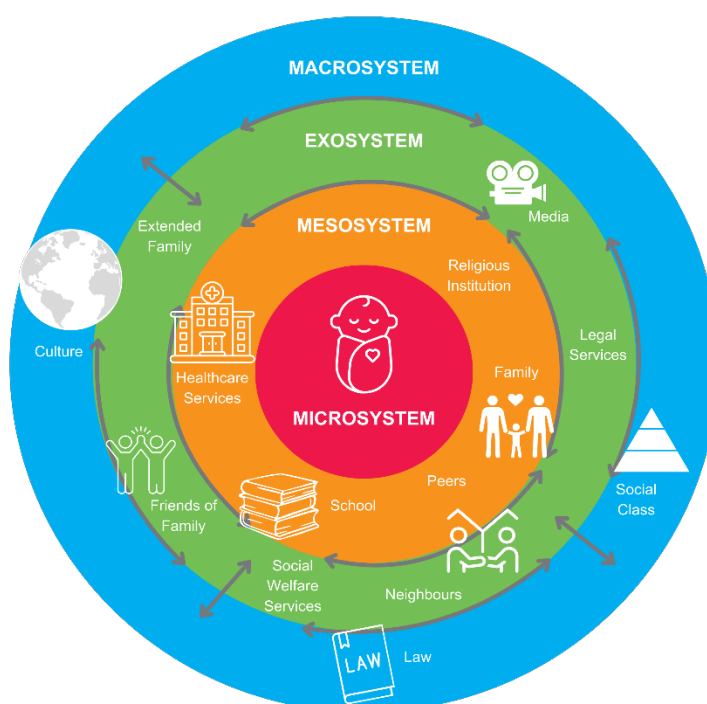
In this context, several theories, models and frameworks are discussed, all of which serve to highlight the interconnectedness of different aspects of the PIMH field and PIMH promotion principles.

The Importance of a Whole-of-Community Approach in Perinatal and Infant Mental Health

When applied to PIMH, an ecological perspective highlights how the wellbeing of infants and their caregivers is shaped not only by what happens within the family, but by the broader relational, social, and service environments that surround them during pregnancy and early parenthood.

Bronfenbrenner's Ecological Systems Theory (EST) (1979) views the child as developing within a complex system of relationships affected by multiple levels of the surrounding environment. The model envisions the environment as a set of nested structures, including but also extending beyond the home, school and neighbourhood settings in which children spend their everyday lives. Each layer of the environment is viewed as having a powerful impact on development.

Figure 1: Bronfenbrenner's Ecological Systems Theory (EST) (1979), Berk (2008)



A Community-Based Approach to Perinatal and Infant Mental Health Promotion

A health promotion approach to PIMH focuses on strengthening protective factors, building caregiver capacity, and creating supportive community environments that promote emotional wellbeing from pregnancy through early infancy.

This approach emphasises prevention and early intervention, reduces stigma through education and awareness, and supports collaboration across health, social, and community services to ensure families can access timely, culturally safe, and appropriate support.

This approach is grounded in the understanding that the perinatal period (pregnancy to three years postpartum) is a critical time for infant development and caregiver wellbeing, with lasting impacts across the lifespan. By focusing on prevention, early support, and strengthening protective factors within families and communities, this approach aims to promote positive mental health outcomes and reduce the risk and impact of later onset of mental health challenges.

Health promotion seeks to reduce “differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential” (WHO, 2025).

In line with Bronfenbrenner’s EST (1979), health promotion as defined by the WHO recognises the wider system influences on health. Health promotion is underpinned by six interrelated actions:

- Build healthy public policy
- Create supportive environments
- Strengthen community actions
- Develop personal skills
- Reorient health services
- Moving into the future

(WHO, 2025)

Promotion, Prevention and Treatment/Intervention

According to Zeanah & Zeanah (2018, p.14):

“Promotion activities aimed at the general population, do not require professional guidance or involvement, and are useful adjuncts to all levels of prevention and intervention. In infant mental health, promotion includes general parenting education about early social and emotional development, early relationship building, language and literacy development, family relationships and so forth. Promotion also may include advocacy; raising awareness; and collaborations with parents, professionals, and communities to develop networks and resources to support optimal development.”

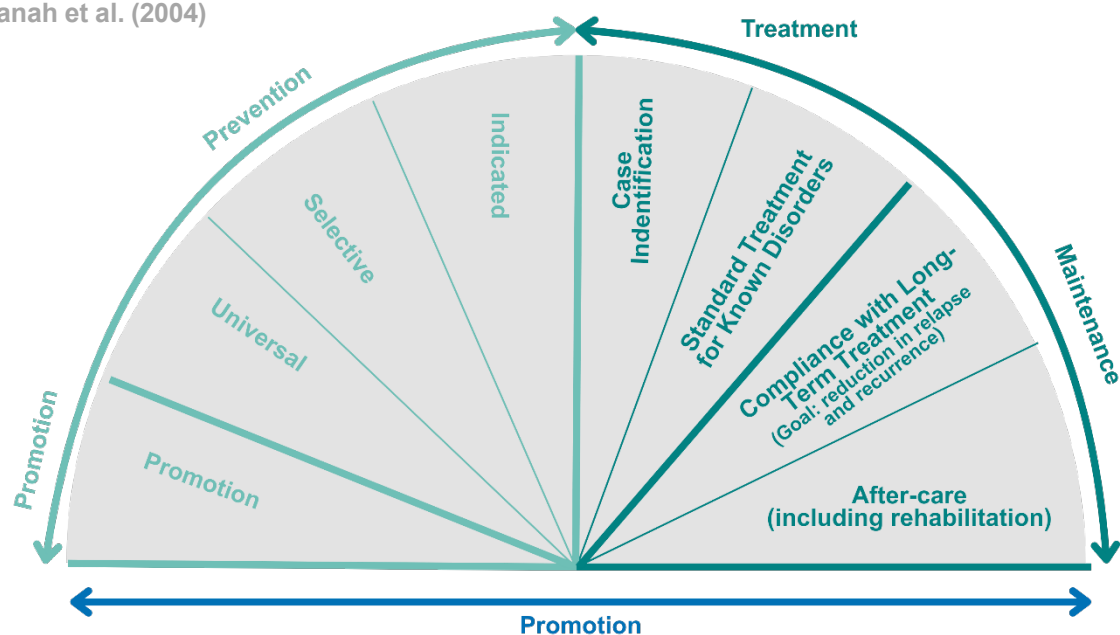
Prevention interventions can be divided into Universal, Selected or

Indicated and “aim to prevent or decrease risk or causal factors before problems become apparent, to increase protective factors, and/or to decrease the severity or duration of a disorder” (Zeanah & Zeanah, 2018, p.14).

Infant mental health interventions focus on improving infant and parent behaviours and family dynamics to support typical development and promote healthy parent–infant relationships. “Treatment of existing disorders is the highest level of intervention in this conceptualisation. For young children who already have identifiable disorders, psychotherapy aimed at alleviating suffering or repairing or remediating functioning is necessary. Most often these services are provided by mental health professionals trained in specific infant mental health assessment and intervention techniques” (Zeanah & Zeanah, 2018, p.18).

In consideration of the continuum of PIMH services required to support infants, young children and their carers across the Continuum of Care and the cross-system collaboration required to support their needs, it is important to focus on reviewing different elements of systemic change.

Figure 2: The mental health intervention spectrum across the Continuum of Care, as per Zeanah et al. (2004)



Mapping Specific Issues Relevant to the Local Context

Broad Australian Bureau of Statistics (ABS) figures relevant to the Geraldton region were previously reported in P2P's Phase One Report. In addition to newly released child development data, further context and statistics are presented below relevant to key local issues that stakeholders identified in Phase Two relating to:

- Homelessness
- Family domestic violence
- Alcohol and other drugs

These local issues were incorporated into the training workshops, specifically in Workshop Two (Prevention) and Workshop Four (Consolidation).

Community Profile – Australian Early Development Census (AEDC)

The Australian Early Development Census (AEDC) cites ABS 2021 Census data in describing the Greater Geraldton Community as being 378kms from Perth, covering an area of 9,922 km². The area has a residential population of 42,138 with 2,832 children aged 0 to 5 years.

The 2024 AEDC results for the Greater Geraldton Community are stark. As shown in Table 1:

- The number of children who are **developmentally vulnerable** on one or two (or more domains) has **increased significantly since 2021**.
- The number of children whose **development is on track** across the five domains has **decreased significantly since 2021**.

Table 1: A broad comparison of 2021 & 2024 AEDC results for the Greater Geraldton Community

	2021		2024		Significant change 2021 vs 2024
	n	%	n	%	
Vulnerable on one or more domains	118	22.1	177	34.7	Increase
Vulnerable on two or more domains	68	12.7	103	20.1	Increase
On track on five domains	302	56.6	221	43.2	Decrease

As shown below in Table 2, in 2024, there were significant decreases across all five AEDC domains in the number of children who were deemed 'on track' compared to 2021 data. Equally, there were significant increases in 2024 across all five AEDC domains in the number of children who were deemed 'vulnerable' compared to 2021 data.

Whilst there were increases in the number of children classed as 'at risk' in four of the five 2024 AEDC domains, these changes were not colour coded to represent significant change when compared to 2021 AEDC domains.

Table 2: 2021 & 2024 AEDC domain level results for the Greater Geraldton Community

		2021		2024		Significant change	
		n	%	n	%	2021 vs 2024	
	Physical health and wellbeing	On track	434	81.3	365	71.0	Decrease
		At risk	42	7.9	62	12.1	Increase
		Vulnerable	58	10.9	87	16.9	Increase
	Social competence	On track	411	77.0	351	68.3	Decrease
		At risk	79	14.8	90	17.5	No change
		Vulnerable	44	8.2	73	14.2	Increase
	Emotional maturity	On track	415	77.7	340	66.4	Decrease
		At risk	69	12.9	90	17.6	Increase
		Vulnerable	50	9.4	82	16.0	Increase
	Language and cognitive skills (school-based)	On track	422	79.0	343	67.3	Decrease
		At risk	52	9.7	70	13.7	Increase
		Vulnerable	60	11.2	97	19.0	Increase
	Communication skills and general knowledge	On track	434	81.3	362	70.4	Decrease
		At risk	53	9.9	81	15.8	Increase
		Vulnerable	47	8.8	71	13.8	Increase

Overall, comparisons between the 2021 and 2024 AEDC survey results for the Greater Geraldton Community are concerning, with the number of children developmentally on track in the five AEDC domains having significantly decreased and the level of developmental vulnerability in children having significantly increased.

Homelessness

Homelessness has been identified as a local issue by stakeholders. A recent report on child homelessness has been published by Homelessness Australia (2024). The impact of homelessness on children's development, wellbeing and social connections is significant:

"It is widely recognised that homelessness has a detrimental effect on children's health and wellbeing that can persist beyond the period of homelessness. Babies and toddlers may have delays in physical and mental development while older children can experience high levels of stress, anxiety, loss and grief, high rates of mental health problems and behavioural disorders." (Eldridge et al., 2012, as cited in Bland & Shallcross, 2015, p.7)

This highlights the importance of prevention and early intervention in the homelessness space.

Illuminating the impact of homelessness in the PIMH context, a Commissioner for Children and Young People WA (CCYP WA) Report (Bland & Shallcross, 2015) states that homelessness impacts children's relationships with immediate and wider family and friends, including the parent-child relationship and connectedness to the community.

Family and Domestic Violence

Family Domestic Violence (FDV) has been identified as a local issue by stakeholders. As cited in the CCYP WA Report (Bland & Shallcross, 2015), one of the main reasons women with children are homeless is due to domestic violence.

As noted by the CCYP WA (2025):

“Living with family and domestic violence has short and long-term impacts on children’s health and wellbeing. These include mental health issues such as anxiety and depression, difficulties with learning, behavioural issues, a higher likelihood of future alcohol and drug misuse and greater risk of homelessness. Research also suggests that family and domestic violence can impact a parent’s ability to parent effectively.”

Experiencing FDV involves children and young people not only being *subject to* FDV but also *witnessing* FDV. The existence of violent behaviour in the home impacts:

- The likelihood of childhood trauma
- Negative child health and wellbeing outcomes
- Children’s coping mechanisms and sense of self
- A state of hypervigilance in children
- The potential for a diagnosis of Post Traumatic Stress Disorder (PTSD)

(cited from <https://www.ccyp.wa.gov.au>).

Alcohol and Other Drugs

The impact of alcohol and other drugs has been identified as a local issue by stakeholders. The WA Primary Health Alliance (WAPHA, 2025) states that “the use of alcohol, tobacco and other drugs, inclusive of prescribed medications and illicit substances, is having an increasing impact on the physical, mental and emotional health and wellbeing of individuals, families and communities in Western Australia.”

In the perinatal context, alcohol is a known teratogen which can impact the growing baby while it remains in utero. Drug use can lead to obstetric and medical complications and withdrawal symptoms in newborns.

Illicit drugs influence emotions, perceptions and behaviour. Parenting is also influenced by the effect of a particular drug on emotional interactions with the child; “a sedative drug, for example, will make it difficult for a parent to be appropriately responsive, while a stimulant drug may make the parent irritable, erratic and overstimulating” (Mares, Newman & Warren, 2011, p. 266), hence the infant-parent relationship is impacted by drug effects and changes.

The relational impact of drug use can occur in conjunction with the hazards of difficulty in prioritising infant needs, potential exposure to aggression and violence, infant-parent separations, adverse family functioning, disruptions to daily routines, social isolation, abuse and maltreatment, including poor nutrition, inadequate care and lack of supervision (Mares et al., 2011).

Summary

In the context of key issues at the local level that have been identified in Phase Two, the information reported in this Chapter highlights the importance of early intervention and prevention of associated risk factors and the need to enhance associated protective factors in order to support and enhance children's wellbeing and development in the short, medium and long term in the local Geraldton community, and beyond.

An appropriately trained and reflective multidisciplinary early childhood workforce working across the Continuum of Care, with the ability to keep the needs of the youngest and most vulnerable members of our society in mind, and the capacity to work effectively with caregivers to support and enhance the parent-child relationship, is vital.

Creating a community of practice that intertwines family resources, supports, and services is integral to ameliorating adverse developmental outcomes and promoting safety and wellbeing for babies, infants and children in the local Geraldton community.

Scaling Deep for Systemic Innovation and Social Impact in the Local Community

The identified issues impacting the local community reinforce the importance of early intervention and prevention to address risk factors and strengthen protective factors that support infants' and children's wellbeing and development in the Geraldton community.

A skilled, reflective multidisciplinary workforce and an integrated community of practice that connects families, supports, and services is essential to promoting positive outcomes for babies, infants, and children. These findings point to the need for a deliberate, place-based approach that moves beyond isolated initiatives to embed sustained, collaborative practice across the local system.

To maximise the impact and number of people that social innovation reaches, it is necessary to scale for impact with implementation of deliberate strategies to influence the social system and create systemic change (Moore, Riddell & Vocisano, 2015).

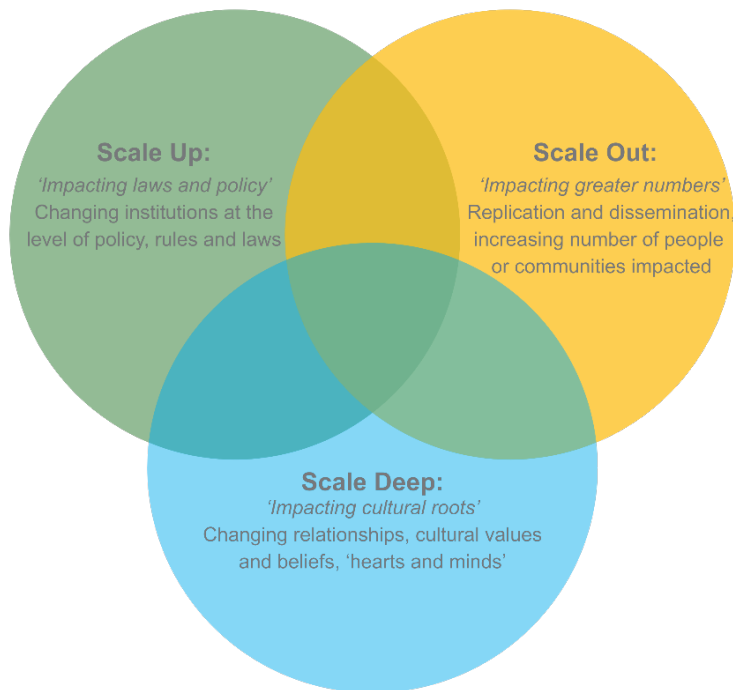
Westley et al. (2014) highlight the differences between different but intersecting scaling strategies.

- **Scaling Out** - attempting to cover a larger geographic area and different communities to support more people via replication and diffusion; and
- **Scaling Up** - impacting policies to support all people who need social innovation and/or address the broader systemic causes of a problem.

Moore et al. (2015, p.74) pose an additional strategy:

- **Scaling Deep** - described as "the notion that durable change has been achieved only when people's hearts and minds, their values and cultural practices, and the quality of relationships they have, are transformed."

Figure 3: Components of social innovation, as per Moore et al. (2015)



Moore et al. (2015, p.77) further explain that ‘Scaling Deep’ is “based on the recognition that culture plays a powerful role in shifting problem-domains, and change must be deeply rooted in people, relationships, communities and cultures”.

Key strategies for scaling deep include:

- Sharing big cultural ideas and reframing stories to change beliefs and norms
- Intensively sharing knowledge and new practices via learning communities, distributed learning platforms and participatory approaches
- Investing in transformative learning networks and communities of practice

(Moore et al. 2015, p.77).

In addition to ‘Scaling Up’ and ‘Scaling Out’, ‘Scaling Deep’ lies at the heart of the strategic focus and breadth of clinical and systemic initiatives at P2P, including the various components of the Geraldton Workforce Development Project (and in particular Phase Two of the Project), which seeks to foster broad community level and collective impacts across the Geraldton Continuum of Care.

Summary: Facilitating Systemic Change Across the Geraldton Continuum of Care

Supporting the mental health and emotional wellbeing of infants, young children, and their parents is a responsibility shared by a broad and diverse range of professionals and organisations. From health care to early education, these professionals come from different backgrounds but are united by the goal of ensuring children and families thrive.

Aligned with the *National Mental Health Workforce Strategy 2022-2032*, the focus of P2P is on overcoming systemic barriers and fostering a shared understanding of PIMH within the

community. Achieving these goals is essential to developing a skilled, committed, and resilient workforce to meet the evolving needs of Geraldton's future mental health system.

The Phase Two Workshop series described later in this Report builds on the recommendations from the *Geraldton Workforce Development Training Project (2024) Phase One Evaluation Report*, to strengthen the local workforce, expand capacity, and embed PIMH across the Continuum of Care (promotion, prevention & intervention) in Geraldton and the Midwest.

As noted by Zeanah & Zeanah (2018, p.20), "the complexity of the problems of infants and toddlers must be matched by the comprehensiveness of our efforts to minimise their suffering to enhance their competence."

Chapter Two: Evaluation

Introduction

Phase Two of the Project was grounded within an evaluation and reporting frame; mixed methods data was collected and analysed for the purposes of reporting the Project outcomes to Stan Perron Charitable Foundation and the broader WA community.

In this context, the Project Team developed several questions which were designed to inform the ongoing content development of the Training Program, understand trainees' perspectives and the potential impact of the training.

Pre/Post Survey

Trainees were invited to complete a pre-post forms survey at the beginning and end of each Workshop. In collecting this mixed methods data, the Project Team sought to explore:

1. Trainees' immediate perception of the training (both in relation to Workshop content and training resources)
2. The immediate impact of the training on trainees' self-reported PIMH professional competence (knowledge, relevance and perceived translation of learning into professional role); and,
3. Trainees' satisfaction/dissatisfaction with the training.

Data from five-point Likert scale questions were analysed descriptively, the frequencies of trainees' responses are presented in Appendices 1-4. Several quotes offering feedback about the training were collated and are displayed descriptively in the Report below, these quotes have not been interpreted or analysed using qualitative research methods.

Individual Interviews

Trainees were asked if they would be willing to take part in a de-identified interview to further explore their perceptions of the training. The Project Team sought to understand trainees' perceptions of the training experience, and the associated impact of the training at the professional and community level. In collecting this qualitative data via interview, the Project Team sought to explore:

1. How P2P could improve the training from trainees' perspectives (with topic suggestions incorporated into the content of subsequent training workshops)
2. The subsequent impact of the training on trainees' PIMH professional practice; and,
3. Trainees' perceptions of the impact of the training on the local community.

Reflective Practice Questionnaire

Trainees who completed the Phase Two Reflective Supervision (RS) series were also invited to complete an additional reflective practice questionnaire training survey. The survey included eight statements targeting reflective functioning in relation to professional practice when working with parents, infants, caregivers and PIMH Workers.

As the RS trainees were the same trainees who participated in the Phase One RS series, the questionnaire results were analysed in the context of the Phase One pre and post reflective practice questionnaire results.

The evaluation results from all data are discussed further below. Frequencies of the pre and post survey responses are included in Appendices 1-4. The online interview questions and a sample of the reflective practice questionnaire are also included in the Appendix.

Survey Results: Workshop One – Promotion

Data gathered from seven participants who attended the full-day Workshop and four participants who attended the online session is displayed in Appendix 1. The feedback indicates that all participants perceived they were engaged during the session (with four being highly engaged), most participants perceived the session went extremely well and that the training material was useful. This is reflected in participants' qualitative comments.

“Both facilitators were amazing, very engaging and knowledgeable – and down to earth! I really enjoyed the session, thank you.”

The frequencies for both the full-day Workshop and the online Workshop demonstrate a shift in participants' perceptions of their knowledge of PIMH after attending, with all participants agreeing they were knowledgeable about PIMH at post-test. This is reflected in qualitative comments shared by participants at post-test, which reveal their knowledge and understanding of key PIMH concepts.



“Understanding the importance of addressing parental and infant mental health together.”

Similarly, in terms of confidence in promoting PIMH in the community, there was a trend towards more positive ratings at post-test; participants who attended the Workshop agreed or strongly agreed that they perceived themselves to be confident in promoting PIMH to the local community. This is reflected in participants' qualitative comments, which suggest that with increased confidence, the knowledge gained from the training would likely be translated into real world practice.

“To build conversations about PIMH into every interaction with families.”

In summary, high levels of engagement and a subsequent desire to learn more about PIMH were indicated. The results are also indicative of a positive trend in participants' perceptions of their knowledge and confidence in promoting PIMH upon completing the Workshop.

In this way, the findings suggest that Workshop One goals were met, particularly in relation to influencing beyond the dyad at a community level: raising awareness of caregiver, infant and young child (0-3) relationships and development, and continuing to establish a shared community response (Phase One, Recommendation One).

Survey Results: Workshop Two – Prevention

Session feedback was gathered from nine participants who attended the Workshop, the data is displayed in Appendix 2. The feedback indicates all participants considered PIMH was relevant to their current professional roles, suggesting there was alignment between the focus of the Workshop and participants' work roles.

Participants perceived they were engaged or highly engaged during the session and most participants perceived the session went very well and the training material was very useful. This is reflected in participants' qualitative comments.

“The whole session has been really helpful, have only been focusing on the mum, now it will be really helpful to think about the child. Thank you.”

In line with Workshop One, the frequencies for the Workshop demonstrate a shift in participants' perceptions of their knowledge of PIMH after attending, with all participants agreeing they were knowledgeable about PIMH at post-test. This is noted in qualitative comments shared by participants at post-test, which highlight their knowledge and understanding of key PIMH concepts.



“The importance of infant mental health, observation of interactions between mothers and babies.”

Similarly, in terms of confidence in promoting PIMH in the community, there was a trend towards more positive ratings at post-test; participants who completed the post-survey agreed or strongly agreed that they perceived themselves to be confident in promoting PIMH to the local community. This is reflected in participants' comments, which suggest that with increased confidence, the knowledge gained from the training would likely be translated into real world practice within the local community.

“Take more opportunities to role model language from child's perspective.”

In summary, the results indicate the Workshop was well received, with high levels of engagement, a positive perception of the content and delivery and a positive trend in participants' perceptions of their knowledge of, and confidence in, promoting PIMH upon completion.

In this way, the findings suggest that Workshop Two goals were met, particularly in relation to focusing on early detection and intervention to reduce risk factors and to strengthen protective factors, as well as strengthening the caregiver-infant/child relationship and supporting child social emotional development and continuing to establish a shared community response (Phase One, Recommendation One).

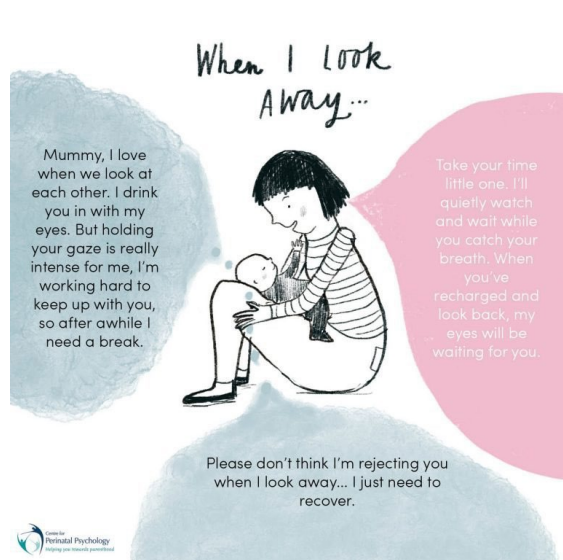
Survey Results: Workshop Three – Treatment/Intervention

Feedback was gathered from 13 participants who attended the Workshop, data is displayed in Appendix 3. The feedback indicates that all but one of the participants considered PIMH was relevant to their current professional roles, suggesting there was broad alignment between the focus of the Workshop and participants' work roles.

All participants perceived they were engaged or highly engaged during the session. All participants perceived the session went well or extremely well. Participants believed the training material was useful or very useful. This is reflected in participants' qualitative comments.

“Very informative and looking forward to the next session.”

In line with previous Workshops, the frequencies for the Workshop demonstrate a shift in participants' perceptions of their knowledge of PIMH after attending, with all participants agreeing they were knowledgeable about PIMH at post-test. This is mirrored in qualitative comments shared by participants at post-test which demonstrate their knowledge and understanding of key PIMH concepts.



“The many ways young children can tell you things without vocalising them.”

Similarly, in terms of confidence in promoting PIMH in the community, there was a trend towards more positive ratings at post-test; 12 participants who completed the post-survey agreed or strongly agreed that they perceived themselves to be confident in promoting PIMH to the local community. This is reflected in participants' comments, which suggest that with increased confidence, the knowledge gained from the training would likely be translated in a range of different ways into real world practice within the local community.

“Re-orientating to bringing baby's voice in therapy sessions.”

In summary, Workshop Three was the second most popular Workshop in the Phase Two series. The results indicate the Workshop was well received, with high levels of engagement and positive perception of the training Workshop.

The results are indicative of a positive trend in participants' perceptions of their knowledge of, and confidence in, promoting PIMH upon completing the Workshop. In this way, the findings suggest that Workshop Three goals were met, particularly in relation to developing clinical intervention skills, strengthening the caregiver-infant/child relationship and supporting child social emotional development.

Survey Results: Workshop Four – Consolidation of Learnings

Session feedback gathered from 15 participants who attended the Workshop is displayed in Appendix 4. The feedback indicates all participants considered PIMH was relevant to their current professional roles, suggesting there was strong alignment between the focus of the Workshop and participants' work roles.

All participants who answered the questions perceived they were engaged or highly engaged during the session. All participants perceived the session went well or extremely well. All participants believed the training material was very useful. This is reflected in participants' qualitative comments.

“Thank you! Very knowledgeable and engaging facilitators.”

In line with previous Workshops, the frequencies for the Workshop demonstrate a shift in participants' perceptions of their knowledge of PIMH after attending the Workshops, with all participants agreeing they were knowledgeable about PIMH at post-test. This is reflected in qualitative comments shared by participants at post-test which illuminate their knowledge and understanding of key PIMH concepts.

“Learning from Alicia re: Ghosts and Angels in the nursery.”

Similarly, in terms of confidence in promoting PIMH in the community, there was a trend towards more positive ratings at post-test; 14 participants who attended the whole-day Workshop agreed or strongly agreed they perceived themselves to be confident in promoting PIMH to the local community. This is supported by participants' qualitative comments, which suggest that with increased confidence, the knowledge gained from the training would likely be translated into practice within the local community.

“Promoting the importance of creating strong + positive relationships with youngsters.”

In summary, Workshop Four had the largest number of participants across the Phase Two Workshop series, which speaks to the importance of local connections, relationships and reputation which take time to emerge in the local community.

The results indicate that the full-day Workshop was well received, with high levels of engagement and positive perception of the training Workshop. The results are also indicative of a positive trend in participants' perceptions of their knowledge of, and confidence in, promoting PIMH upon completing the Workshop.

In this way, the findings suggest the Workshop Four goals were met, particularly in relation to consolidating prior learnings and continuing to establish a shared community response (Phase One, Recommendation One) that is contextualised to the needs and challenges of the local community.

Overall Summary of Workshop Surveys

Overall, 57 participants attended the Workshops across the Phase Two series. Across all Workshops, high levels of engagement, a positive perception of the training and satisfaction with the training material was evident.

There was an overall trend across all Phase Two Workshops towards more positive ratings at post-test both in terms of knowledge of PIMH and confidence in promoting PIMH to the local community.

Participants' positive perceptions and the value they placed on the training are implied through their endorsement and recommendation to others. From Workshop Two onwards, the Research Team incorporated a question into the post survey; "Would you recommend this training to someone else?"

From Workshop Two onwards, 34 out of 37 participants from the face-to-face Workshops chose to respond to this question (92% response rate). All 34 face-to-face participants who answered this question (100%) said yes, they would recommend the training to someone else. The three online participants who answered this question also said yes, they would recommend the training to someone else (100%).



High Levels
Engagement, Positivity, Satisfaction



Would you recommend this training to someone else?

100% of respondents said yes, they would recommend.

92% response rate
34 out of 37 participants

Semi-structured Interviews

Participants

Four trainees from multi-disciplinary backgrounds self-selected to take part in an individual interview with the Project Team; each interview focused on a specific training Workshop (i.e., Workshop One, Two, Three or Four).

Interviews and Analysis

Due to the regional nature of the Project, four individual interviews were completed online with trainees, using MS Teams to record the discussion. Thematic Analysis (TA) was selected as the data analysis method for this evaluation because TA is widely used for analysing qualitative data and offers a structured yet flexible framework for identifying, analysing, and interpreting patterns of meaning within data (Ahmed et al., 2025).

The TA indicated the data clustered around three main themes:

- Perception of PIMH training
- Training impact across the Continuum of Care
- Continuing to embed PIMH in the local community

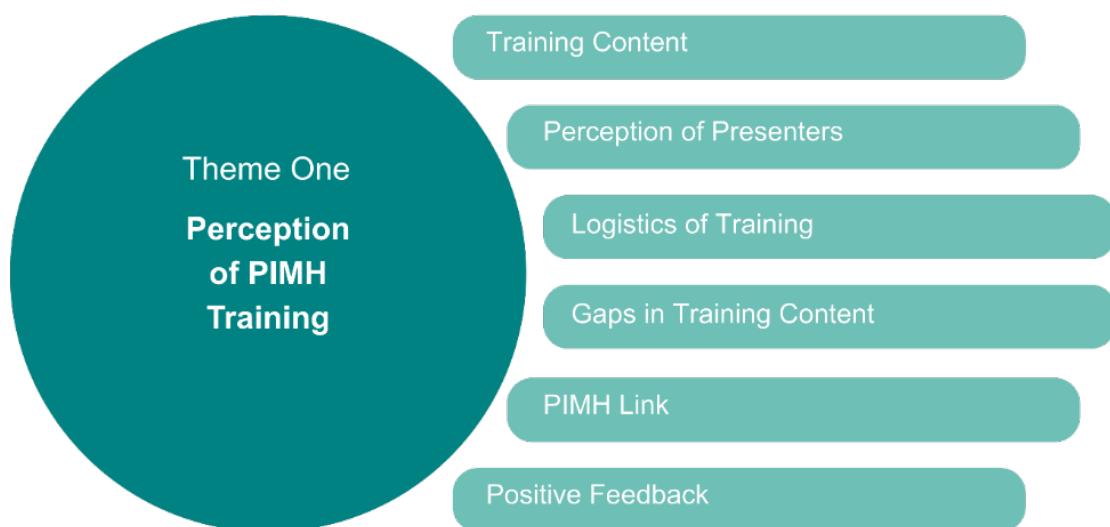
Fifteen codes were incorporated within the three themes. Each theme is discussed further below.

Theme One - Perception of PIMH Training

The Theme 'Perception of PIMH Training' captures trainees' comments about different elements of the Training Program and the presenters, including content, process, methods and improvements.

Some of the codes contained within this Theme helped to clarify how P2P might improve the training from the trainees' perspectives in the future. There were six codes attached to this theme as illustrated below in Figure 4.

Figure 4: Theme One – Perception of PIMH Training



Theme One: Perception of PIMH Training

Participants recognised training provided an opportunity to learn about PIMH - specifically the link between Perinatal and Infant Mental Health

"That's why perinatal mental health is so important, not just for the parents, but for the infant's mental health."



Logistics had no clear alignment of views



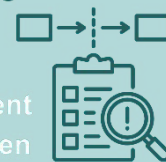
The training content was received positively
"Case studies... were absolutely fascinating. I really enjoyed those."



Participants' feedback about the training was positive

"I really liked it... I learned a lot."

Participants identified some gaps in training content, including neurodivergence, disorders of attachment and PIMH amongst men



Positive feedback for presenters



"I think your two presenters were very, very knowledgeable in their fields. They were very comfortable. Were speaking about any topic and they knew what they were speaking about. They could also hold space very well."

Participants identified some gaps in the training content including neurodivergence, disorders of attachment and PIMH amongst men.

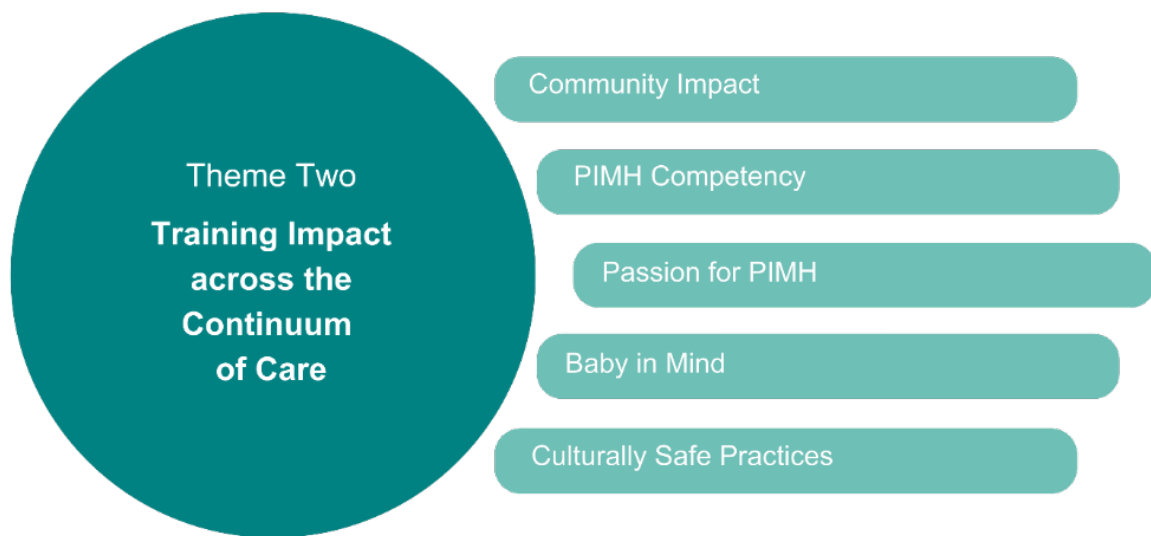
In terms of the logistics and methods of training delivery (e.g., times, format, duration), participants had mixed perceptions and feedback with no clear alignment of views.

Theme Two – Training Impact across the Continuum of Care

The Theme 'Training Impact across the Continuum of Care' captures participants' emerging PIMH competencies across self-described promotion, prevention and intervention activities in the local community, as well as trainees' perceptions of the impact of the Training Program at the local level.

The codes within this Theme help to offer insight into some of the subsequent impacts of the training on trainees' PIMH professional practice, and to understand some of the impacts of the training within the local community. There were five codes attached to this Theme as illustrated below in Figure 5.

Figure 5: Theme Two - Training impact across the Continuum of Care



Theme Two: Training Impact across the Continuum of Care

Participants expressed a passion for the training program and PIMH

"You sort of leave feeling inspired and motivated and wanting to make a difference in that area."



Keeping the baby in mind is a cornerstone of PIMH competency; this code is reflected by a participant:



"Just using that language of perinatal and infant mental health or even just infant mental health because I think, still, quite often you know, parents don't think of the infant as having mental health, and so just talking about it, and I guess planting that seed, that actually your infant does have its own [mental health]."

At the individual level, trainees also described the impact of the training in relation to their own PIMH competency, both in relation to knowledge and work practices

"...Actually being aware of what infant mental health looked like."

Community Level Impacts

"It's put perinatal and infant mental health on the agenda."



Culturally Safe Practices for the Aboriginal Community

"In terms of Aboriginal culture... the social and emotional wellbeing framework. That's a new one for me... I have implemented the social and emotional wellbeing that diagram in my work with Aboriginal culture... and... now bringing that into the case conference about the child has been amazing because it actually changes the model... it's amazing... and then the health professionals then speak differently about the child afterwards... so that has been so helpful."



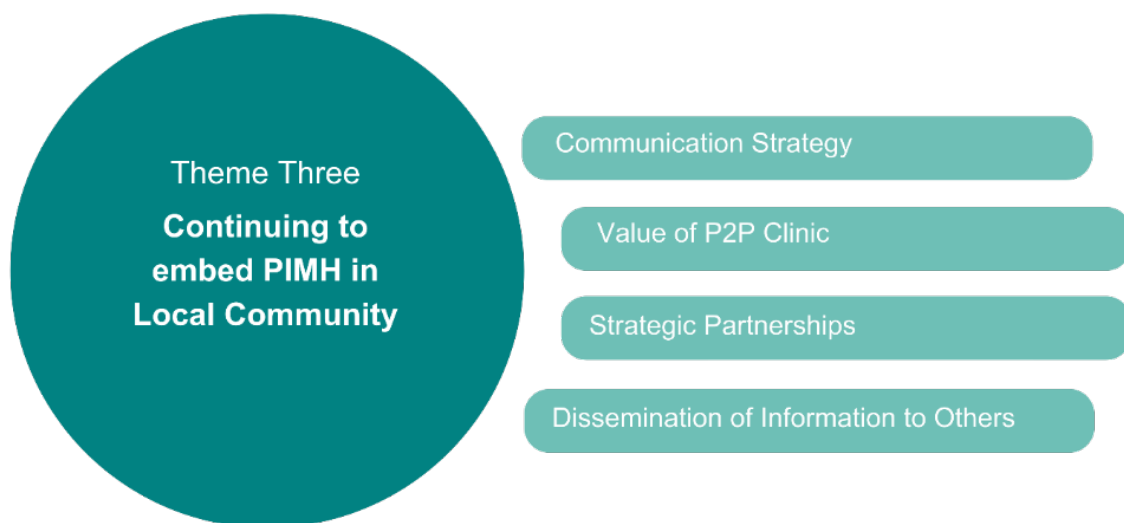
Theme Three - Continuing to embed PIMH in the Local Community

The Theme 'Continuing to embed PIMH in the Local Community' captures trainees' dissemination of their PIMH knowledge to personal and professional contacts within the local community.

Whilst having the P2P Clinic in Geraldton was valued, the Theme also reflects trainees' perspectives on how to maintain ongoing awareness of PIMH in the community in relation to further training, partnerships and communication strategies.

Overall, this Theme helps to illuminate trainees' perceptions of the impact of the training on the local community and ways this could be strengthened in the future. There were four codes attached to this Theme as illustrated below in Figure 6.

Figure 6: Theme Three - Continuing to embed PIMH in the local community



Theme Three: Continuing to embed PIMH in Local Community

Data suggested participants had been disseminating PIMH information to others upon completion of the training.

"At our staff meeting they asked me to speak about it and nobody there knew about it."



"I spoke to friends who are parents, and I told them about what I learned. And I spoke to a friend who's [a] psychiatrist... I told him about what I learned was, like, this has changed my life. You could kind of get some information out there."

"I would love every... child health nurse, every midwife, every GP... everybody who has any interaction with a parent to do this training... a lot of stuff falls through the cracks."

Recognition from participants of value of Geraldton P2P clinic

"Having... the service up here now is really, really valuable."

Need for a communication strategy



"We just need to get the word out more... so that more people know that their training is good."



Importance of building strategic partnerships to further embed a PIMH community of practice
"Working with the health promotion association and having infant mental health as part of the health promotion framework."

Discussion of Interview Data

The Project Team sought to understand trainees' perceptions of the training experience, and the associated impact of the training at the professional and community level via semi-structured interviews.

The data indicated trainees' positive perceptions of the training in relation to both content and process, and illuminated several ways in which trainees are applying their emerging PIMH competencies across the Continuum of Care at promotion, prevention and intervention levels within the local community.

The data demonstrates a number of important insights about how the Training Program and the work of P2P can be strengthened in the local community, to continue to further embed PIMH in the community, and continue to build a PIMH community of practice. The data from the qualitative interviews aligns with the Phase Two survey data.

Reflective Practice Questionnaire (RPQ)

For this Project, P2P used a modified RPQ consisting of eight questions adapted from Priddis and Rogers (2018). In our survey, reflective capacity refers to the ability, motivation, and tendency of healthcare professionals to engage in deliberate reflection during clinical practice.

Five participants completed both the pre- and post- training surveys. These matched responses were included in the comparative analysis of the pre- and post- training RPQ scores and the perceived importance of reflective supervision.

Whilst the results were not significant (possibly influenced by small numbers), some general trends were noted including:

- A trend toward greater perceived importance of reflective supervision in the post-training responses (72.7% at pre- test and 83.3% at post- test said that RS was extremely important).
- Across all statements, an improvement trend in reflective capacity was observed following the training.

Overall Summary of Evaluation Data

The mixed methods data gathered throughout Phase Two indicated:

- High levels of engagement with the training;
- A positive perception of, and endorsement of, the training; and
- Satisfaction with the training material.

Upon completion of the Workshops, there was an overall trend towards more positive ratings at post-test both in terms of knowledge of PIMH and confidence in promoting PIMH to the local community.

Following the training, there are currently several ways in which trainees are applying their emerging PIMH competencies across the Continuum of Care at promotion, prevention and intervention levels within the local community.

The training has provided an opportunity for trainees to enhance their competence in PIMH, as reflected in their understanding and perception of the importance of reflective supervision in this field.

The data also reinforces how the Training Program and the work of P2P can be strengthened in the local community, to continue to further embed PIMH in the community and continue to build a PIMH community of practice.

Social Impact

The Phase Two Workshops were developed in consultation with the local community to meet the professional needs of the local workforce, as part of a community development approach embedded across the Continuum of Care.

At its core, community development encourages us to widen the lens and facilitate collective action on important community issues by embedding change sustainably over the long term to achieve social impact.

This Project sought to widen the PIMH lens, with an intentional and community driven focus on the provision of PIMH multidisciplinary professional learning opportunities embedded across the local Continuum of Care. The Project aligns with the PIMH literature, which continually encourages us to incorporate the wider social and professional context when planning interventions to support the needs of infants and young children:

“Infant mental health focuses on early experiences of infants and young children and emphasizes the importance of caregiving relationships as having major effects on the young child’s social and emotional experience.

Healthy caregiving relationships, which are embedded within multiple social and cultural contexts, promote social competence in young children, and social competence is associated with adaptive behavioral, emotional, and cognitive outcomes.

The breadth of infant mental health includes clinical, research, and policy efforts, and encompasses the theoretical perspectives and knowledge base of multiple professional disciplines.

*The **complexity of the problems of infants and toddlers must be matched by the comprehensiveness of our efforts** to minimize their suffering to enhance their competence” (Zeanah & Zeanah, 2018, p.20).*

The findings emphasise the following social impacts:

1. **Increased PIMH competency amongst local practitioners:** an expanded number of practitioners (57 practitioners) across Geraldton gained enhanced knowledge, skills, and confidence in PIMH practice, strengthening their capacity to support local infants, young children and families.

Furthermore, these practitioners report having shared their experiences of the training with a minimum of one additional team member each, resulting in impacting at least a further 57 professionals.

2. **Improved outcomes for local families:** 57 practitioners engaged in PIMH training, therefore, families supported by these practitioners will benefit from high-quality, culturally safe services that foster healthier parent-child relationships, enable early intervention for mental health challenges, and promote overall wellbeing.
3. **Enhanced service delivery:** provision of increased practitioners with evidence-based PIMH training improves the quality of, and ability to, provide culturally safe interventions and accessibility to services, helping to mitigate the negative effects of disadvantage on young children and families.
4. **Increased access to services and greater awareness of how to deliver culturally safe PIMH services:** greater family access to PIMH services within local organisations will reduce waitlists for specialised services like Pregnancy to Parenthood, improving service reach.
5. **Strengthened collaboration:** strengthening referral pathways and service delivery across Geraldton will lead to increased collaboration, knowledge sharing, and professional development among practitioners, offering families a more seamless care experience.
6. **Sustainable capacity building:** ongoing reflective supervision for Phase One trainees ensured sustained practitioner growth, enabling them to continue supporting young children and families and fostering leadership in PIMH within the community.
7. **Professional endorsement:** by promoting PIMH professional endorsement opportunities with local practitioners, Geraldton may develop its own group of reflective supervisors and establish a PIMH Advisory Group, ensuring long-term sustainability of a PIMH model of care that supports the emotional wellbeing of infants and their families across the Continuum of Care.
8. **Long-term impacts:** continued capacity building will promote healthy child development and generate lasting positive effects on family wellbeing in the region for future generations.

Recommendations

Geraldton's Hub is in its second year of delivery, with a local cohort actively engaged in foundational PIMH training and reflective supervision.

Continued support is required to embed skills, expand service reach, and consolidate a sustainable local workforce. Continued support is particularly important in the context of the 2024 AEDC statistics for Geraldton (as reported above), as well as the complexities facing local families and the support needed to address these.

To continue to embed system-level workforce development that is place-based, culturally safe, and aligned with international best practice in the local Geraldton community, a stepped approach to implementation of recommendations is suggested, in line with the development of a locally embedded and self-sustaining hub and spoke model.

This approach will enable continued investment in the local workforce, embedding reflective and culturally responsive practice, and building durable infrastructure for cross-sector collaboration and professional growth.

In this context, key recommendations include re-orienting the Geraldton Clinic to become a regional hub – acting as a PIMH training and mentoring centre, offering;

- Intensive PIMH training aligned with AAIMH Competency Guidelines (including six-day foundational and four, one-day booster blocks).
- PREPP (Practical Resources for Effective Postpartum Parenting) training provided to 15 core cohort practitioners and 15 additional community practitioners.
- Ongoing reflective supervision (two hours per fortnight) delivered by P2P PIMH supervisors.
- In-person workshops and online seminars addressing place-based community needs.
- Cultural consultancy and dedicated places for Aboriginal and CALD practitioners to support inclusive, locally trusted care.
- A pilot project providing 16 hours per week of consultation in Early Childhood Education and Care (ECEC) to family day care, and/or child protection teams. This is essential to mitigate the barriers associated with engagement in attending PIMH training opportunities for ECEC professionals as evidenced by the feedback during the consultation process and by the lack of participation in Phase Two Training Workshops.

Despite their motivation to build skills in PIMH, barriers to attend professional development opportunities for ECEC professionals remain limited due to the commitments of their role, which frequently mean they are required to remain present and engaged onsite, or be readily available to address presenting crises in the community.

PIMH training is critical as the ECEC workforce supports infants, very young children and their families. Providing a training model that acknowledges these barriers by bringing training into the everyday practice of ECEC centres is invaluable.

- International evidence highlights that IECMHC leads to reduced early childhood expulsion, fewer mental health symptoms in children, and increased early educator competence.
- Piloting this approach in regional WA will demonstrate its value in strengthening infant and early childhood systems, reducing trauma, and embedding mental health promotion in child-facing services supporting infants, very young children and their parents.

These recommendations are designed to deliver both direct and indirect workforce impacts across the Geraldton area.

Cultural consultants will play a central role in ensuring that all training is inclusive, respectful, and culturally safe, building trust and engagement with Aboriginal families and communities.

Practitioners trained in core PIMH competencies will become local champions, embedding knowledge and skills within their services and influencing practice across teams.

Community-tailored workshops and seminars will promote cross-sector integration, increasing awareness of PIMH across early years' services, maternal and child health, child protection, and educational settings. Ongoing mentoring and reflective supervision strengthen practitioner capability, reduce isolation, and support workforce retention, creating a more stable, skilled, and responsive system of care.

Conclusion

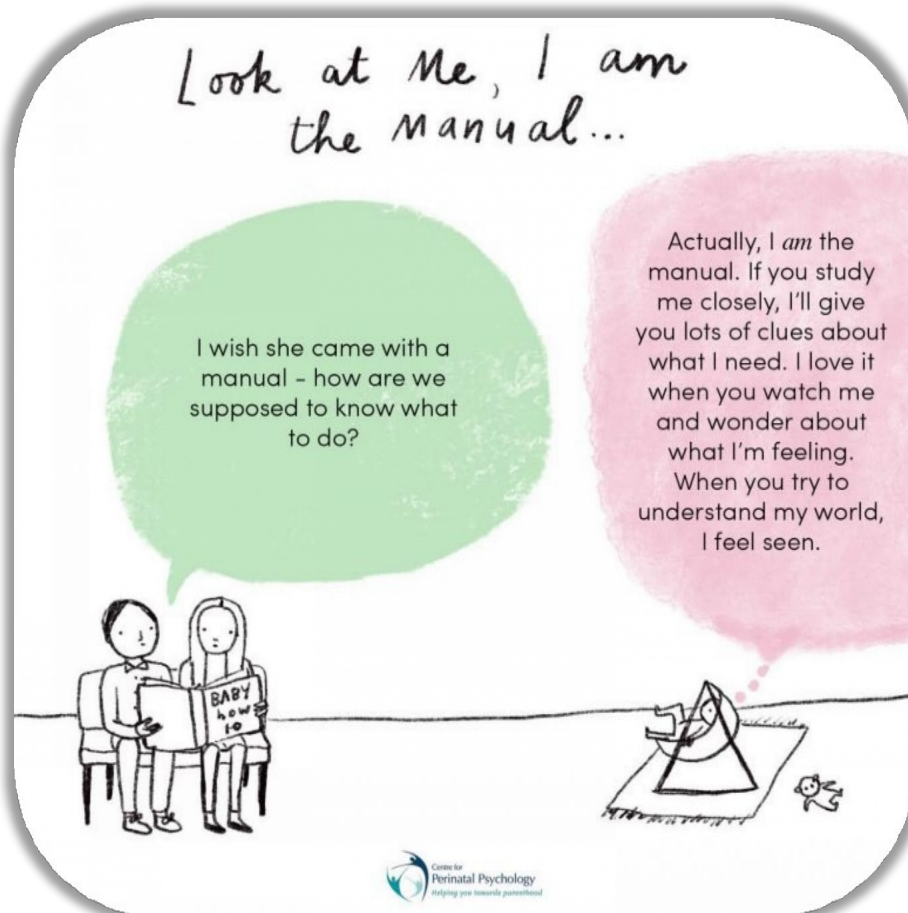
Data collected to date from the Geraldton Workforce Development and Training Project indicates that by combining foundational PIMH training and ongoing reflective supervision, the Project;

- Strengthens practitioner capability;
- Fosters cross-sector collaboration; and,
- Supports trauma-informed, culturally responsive care.

In doing so, the Project contributes to lasting improvements in the mental health and developmental outcomes of infants, young children and their parents, while reinforcing the foundations of a more connected, skilled, and sustainable infant early years ecosystem in the Geraldton area.

The outcomes of the Geraldton Project demonstrate how localised investment in workforce capacity can produce scalable, sustainable change in regional infant early childhood systems.

The Project can now be used as a blueprint and be replicated across the state in the service of the relational and developmental needs of infants, young children and their caregivers across WA.



Acknowledgements

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Centacare

Local organisations that supported their staff to attend

Trainees

Interviewees

Presenters

Reflective supervisors

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APPENDICES

Appendix 1 – Phase Two Workshop Series: An Overview

Following consultation with local stakeholders on March 5 and 6, 2025, as part of the Project's co-design process, four individual full-day training workshops were developed and delivered face-to-face in Geraldton, each complemented by a three-hour online condensed training session. This Training Program was created to directly align with an international endorsement framework, and training was delivered by a total of three IMH Practitioners® from our PIMH Training Team.

Workshop One – Promotion

The first Workshop in the Phase Two series was designed to focus on promotion/primary prevention of PIMH in the local community. The Workshop content was developed within the context of the research literature on community development, health promotion and the Continuum of Care (as discussed above). In designing the Workshop, several goals were held in mind, to:

- Influence beyond the dyad, at a community level;
- Raise awareness of caregiver, infant and young child (0-3) relationships and development;
- Raise awareness to prevent PIMH difficulties from occurring;
- Continue to establish a shared community response (Phase One, Recommendation One);
- Secure additional PIMH funding, resourcing and specialist PIMH services in the local area (Phase One, Recommendation Five); and,
- Raise awareness of P2P.

In this context, the content of Workshop One incorporated:

- Introduction to PIMH;
- Exploring why PIMH is important;
- Good enough parenting (and the associated impacts when this isn't present); and,
- Reflecting on points of entry and the collective impact at the community level.

Workshop Two - Prevention

The second Workshop in the Phase Two series was designed to focus on the detection and prevention of PIMH difficulties and challenges in the local community. It was aimed at a broad range of professionals in different community organisations: practitioners working directly with families in the community, although perhaps not in a clinical/therapeutic role.

Workshop Two content was developed within the context of the research literature on community development, health promotion, the Continuum of Care (as discussed in the Chapter above) and PIMH.

In designing the Workshop, several goals were held in mind, to:

- Focus on early detection and intervention to reduce risk factors and prevent the progression/worsening of PIMH difficulties once they have emerged;
- Strengthen protective factors;
- Strengthen the caregiver-infant/child relationship;
- Support parents in the transition to parenthood and in the development of their parenting identities;
- Support child social emotional development;
- Reflect on special topics highly relevant to the local context; and,
- Highlight local PIMH supports and pre-referral pathways.

In this context, the content of Workshop Two incorporated:

- Introduction to PIMH;
- Exploring why PIMH is important;
- The importance of observation in PIMH;
- Introducing the Tuned in Parenting Scale (TIP-RS);
- Reflections on the impact of FDV, homelessness, alcohol and other drugs in the PIMH context; and,
- Reflecting on points of entry and the collective impact at the community level.

Workshop Three – Treatment/Intervention

The third Workshop in the Phase Two series was designed to focus on clinical intervention of PIMH difficulties and challenges in the local community. This Workshop was aimed at professionals working directly with families in a clinical/therapeutic role who might provide intervention for PIMH difficulties and challenges.

The overall focus for the Workshop was to provide information and training that helped professionals to minimise the impact of existing psychological conditions (e.g., complex mental health and/or trauma presentations) and strengthen the caregiver-infant/child relationship, in a therapeutic setting.

Workshop Three content was developed within the context of the research literature on PIMH and specifically, clinical and intervention models and frameworks. In designing the workshop, several goals were held in mind, to:

- Lessen the impact of existing psychological conditions/challenges, to minimise potential co-morbidities and/or adverse longer term psychological, relational and developmental impacts;

- Develop clinical intervention skills;
- Unpack P2P clinical case studies e.g., CPP & ABC;
- Strengthen the caregiver-infant/child relationship;
- Support parents in the transition to parenthood and in the development of their parenting identities;
- Support child social emotional development; and,
- Highlight local PIMH supports and pre-referral pathways.

In this context, the content of Workshop Three incorporated:

- Pre-readings (as an introduction to PIMH, and to avoid duplication of content for previous trainees);
- The rights of infants in the context of the parent-infant relationship;
- The purpose and principles of assessment in PIMH;
- Different PIMH assessment types;
- Intervention in PIMH, including several frameworks;
- ABC intervention case study;
- Child Parent Psychotherapy (CPP) case study; and
- Reflecting on ports of entry and the collective impact at the community level.

Workshop Four – Consolidation of Learnings

The fourth and final Workshop in the Phase Two series was designed as a consolidation of prior learnings, based on ongoing stakeholder consultation and feedback at the local level. This Workshop, therefore, incorporated a blend of learning content drawn from the previous three Workshops, with the addition of some new content (e.g., a focus on fathers and neurodiversity), which stakeholders identified as important.

In this context, the content of Workshop Four incorporated:

- PIMH - A cultural lens;
- Defining IMH and Review of Core Principles;
- Early Relationships and IMH;
- Observation in IMH;
- Introduction to key IMH theorists;
- Fathers & PIMH;
- Neurodiversity & PIMH;
- Review of local issues affecting PIMH (local AEDC data, homelessness, FDV, alcohol and other drugs); and,
- Reflecting on ports of entry and the collective impact at the community level.

In total, across all four Phase Two Workshops:

- 47 people attended the full-day training workshops
- 10 people attended online follow-up training sessions
- Attendees were from a broad range of government (Health, Education & Communities) and NGOs spanning various roles within the early years sector.

The evaluation of the Phase Two Workshops is discussed further in the next Chapter.

Appendix 2 – Frequencies from Workshop One Pre/Post Survey Results

Table 3

Workshop One Promotion – Full Day – In Person (n = 7): Session Feedback

Question	Post	
How useful did you find this training material?	Useful	1
	Very useful	6
How well did you think this session went?	Very Well	2
	Extremely Well	5
How engaged were you in the training session?	Engaged	1
	Very Engaged	2
	Highly	4
	Engaged	

Table 4

Workshop One Promotion – Full Day – In Person (n = 7): Pre-Post questions relating to PIMH knowledge, relevance and confidence

Question	Frequency			
	Pre		Post	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Neutral	4	Agree	7
	Disagree	3		
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Agree	5	Agree	5
	Strongly Agree	2	Strongly Agree	2
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Disagree	1	Neutral	1
	Neutral	4	Agree	4
	Agree	2	Strongly Agree	2

Table 5

Workshop One Promotion – Condensed – three hour Online (n = 4): Pre-Post questions relating to PIMH knowledge, relevance and confidence

Question	Frequency			
	Pre		Post	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Disagree	1	Agree	4
	Neutral	3		
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Agree	1	Agree	2
	Strongly Agree	3	Strongly Agree	2
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Disagree	1	Agree	4
	Neutral	2		
	Agree	1		

Appendix 3 – Frequencies from Workshop Two Pre/Post Survey Results

Table 6

Workshop Two Prevention – Full Day – In Person (n = 9): Session Feedback

Question	Post	
How useful did you find this training material?	Useful	3
	Very useful	6
How well did you think this session went?	Well	1
	Very Well	5
	Extremely Well	3
How engaged were you in the training session?	Engaged	1
	Very Engaged	4
	Highly Engaged	4
Would you recommend this training to someone else?	Yes	9

Table 7

Workshop Two Prevention – Full Day – In Person (n = 9): Pre - Post questions relating to PIMH knowledge, relevance and confidence

Question	Frequency			
	Pre		Post	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Disagree	2	Agree	8
	Neutral	2	Strongly Agree	1
	Agree	5		
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Agree	5	Agree	3
	Strongly Agree	4	Strongly Agree	6
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Disagree	1	Agree	8
	Neutral	4	Strongly Agree	1
	Agree	4		

Table 8

Workshop Two Prevention – Condensed – three hour Online: Pre-Post questions relating to PIMH knowledge, relevance and confidence

Question	Frequency			
	Pre (n=4)		Post (n=3)	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Neutral	3	Agree	2
	Strongly Agree	1	Strongly Agree	1
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Neutral	1	Neutral	1
	Agree	1	Strongly Agree	2
	Strongly Agree	2		
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Neutral	1	Agree	1
	Agree	2	Strongly Agree	2
	Strongly Agree	1		
Would you recommend this training to someone else?			Yes	2
			No	1
			Response	

Appendix 4 – Frequencies from Workshop Three Pre/Post Survey Results

Table 9

Workshop Three Intervention – Full Day – In Person (n = 13): Session Feedback

Question	Post	
How useful did you find this training material?	Useful	2
	Very useful	11
How well did you think this session went?	Well	1
	Very Well	4
	Extremely Well	8
How engaged were you in the training session?	Engaged	3
	Very Engaged	5
	Highly Engaged	5
Would you recommend this training to someone else?	Yes	12
	No	0
	No Response	1

Table 10

Workshop Three Intervention – Full Day – In Person: Pre - Post questions relating to PIMH knowledge, relevance and confidence

Note that two people commenced the session late and so did not complete the pre-survey.

Question	Frequency			
	Pre (n=11)		Post (n=13)	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Disagree	1	Agree	10
	Neutral	4	Strongly Agree	3
	Agree	6		
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Neutral	1	Neutral	1
	Agree	5	Agree	6
	Strongly Agree	5	Strongly Agree	6
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Disagree	2	Neutral	1
	Neutral	5	Agree	10
	Agree	3	Strongly Agree	2
	Strongly Agree	1		

Workshop Three Intervention – Condensed – three hour Online

Three people registered for this workshop, one person cancelled their attendance and one person was a no show. Hence, only one person attended the Workshop Three condensed workshop, they did not choose to complete the pre-post surveys and so no data is available for this session.

Appendix 5 – Frequencies from Workshop Four Pre/Post Survey Results

Table 11

Workshop Four Consolidation of Learnings – Full Day – In Person (n = 15): Session Feedback

Question	Post	
How useful did you find this training material?	Very Useful	15
How well did you think this session went?	Well	1
	Very Well	1
	Extremely Well	13
How engaged were you in the training session?	Very Engaged	6
	Highly Engaged	7
	No Response	2
Would you recommend this training to someone else?	Yes	13
	No	0
	No Response	2

Table 12

Workshop Four Consolidation of Learnings – Full Day – In Person: Pre - Post questions relating to PIMH knowledge, relevance and confidence

Question	Frequency			
	Pre (n=15)		Post (n=15)	
I am knowledgeable about Perinatal & Infant Mental Health (PIMH)	Neutral	3	Agree	12
	Agree	10	Strongly Agree	3
	Strongly Agree	2		
Perinatal & Infant Mental Health (PIMH) is relevant to my current professional role	Agree	8	Agree	8
	Strongly Agree	7	Strongly Agree	7
I am confident in promoting Perinatal & Infant Mental Health (PIMH) within the local community	Neutral	6	Neutral	1
	Agree	6	Agree	8
	Strongly Agree	3	Strongly Agree	6

Appendix 6: Phase Two Reflective Supervision: A Personal Overview



Providing reflective supervision to training participants from Phase One during the second phase of this Workforce Development Project has been a unique opportunity. I appreciate the commitment to attending sessions by the supervisees, particularly given their busy professional roles and complexities of their caseloads. I have an increased and deepened understanding of both the exclusive challenges faced by regional clinicians and the profound value of creating intentional spaces for reflection.

As a supervisor working from a distance, I have come to appreciate how the geographical and professional isolation common in IMH practitioners located in regional WA, such as Geraldton, shapes their emotional

landscape. Supervisees described carrying a dual sense of responsibility: meeting the immediate needs of vulnerable infants and families, while simultaneously navigating limited local resources and services. This context makes reflective supervision not only supportive but essential.

In our sessions, I was struck by the supervisees' commitment to relationship-based practice. They consistently presented dilemmas that sit at the intersection of clinical judgement, cultural safety, and community expectations. My role was to hold a calm, curious stance—offering containment so they can explore the effects of the emotional undercurrents of their work and the subsequent impact on families. Often, this included unpacking feelings of helplessness or uncertainty when working with families experiencing multiple stressors. Through this process, I have witnessed how the reflective space can provide opportunity to transform doubt into insight and renewed purpose, in addition to prospects for collaboration between local services.

As sessions progressed, I observed supervisees display continued growth in applying IMH principles to their roles, holding babies in mind often and wondering about early relationships and the outcomes for the future wellbeing of infants and children in their community.

Ultimately, supervising Geraldton-based practitioners reinforced the importance of reflective capacity in sustaining effective and compassionate IMH practices. I have grown in my own ability to tolerate ambiguity, to trust the process, and to honour the emotional load that practitioners carry. The experience proved to be a meaningful partnership, one that strengthened not only the practitioners themselves but the wellbeing of the infants and families they serve.

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