School of Nursing, Midwifery and Paramedicine

Investigation of a Culturally Secure Home Visiting Model for Aboriginal Family and Child Health Support in the Midland Community in Western Australia

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This thesis is presented for the Degree of
Doctor of Philosophy
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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received ethics approval from the Western Australian Aboriginal Health Ethics Committee (HREC Reference number 462) and Curtin University Human Research Ethics Committee (HR73/2013).

Ailsa Marie Munns
10th November 2017

Abstract

Introduction: This study investigated the development and implementation of peer-led home visiting support for Aboriginal families with young children in Midland, Western Australia. The need to develop such a culturally secure home visiting service, incorporating Aboriginal rights and values, in this urban area was identified by both Aboriginal and non-Aboriginal members of the community. These groups recognised that socio-economic disadvantage was impacting upon parents' abilities to provide the strong family environments necessary for their children's developmental wellbeing that had the potential, in part, to be addressed through support provided by peers in the same community with similar life experiences. Literature has identified the influence of enabling and adverse family environments on lifelong physical and psychosocial health, and that the support of parents is central to the effective adaptation of children to the stressors of everyday life. However, prior to the study described in this thesis, there was limited evidence regarding the provision of Aboriginal peer-led support intended to strengthen parenting environments. Following an invitation to collaborate with community agencies, peer support workers and families to design a home visiting support program, a child health researcher worked in partnership with these groups to investigate the development and implementation of an evidence-based innovative approach to peer-led parent support.

Aims: The aims of the study were to investigate the self-perceived suitability, feasibility and acceptability of the parent support and inform a model for an ongoing culturally secure, peer-led, home visiting program for Aboriginal families and children in the Midland community. The first three study objectives were to: implement and evaluate the culturally secure Aboriginal peer-led home visiting child health parent support program, identify and examine elements required to deliver the program, and explore the self-perceived suitability, feasibility, acceptability and effectiveness of the program in Midland. The final objective, was for the study findings to inform a model for the program in Midland and add to the body of knowledge on effective peer-led program models that encompass the self-perceived elements for suitability, feasibility, acceptability and effectiveness.

Research methodologies and method: Participatory Action Research enabled regular collaborative interaction between all participants and the Researcher that was facilitated through the use of Action Learning Sets. Focus groups via these Action

Learning Sets facilitated a partnership approach between peer support workers, parents, community agency workers and the Researcher to explore strategies for home visiting parent support. Interviews were transcribed and analysed using thematic analysis while demographic data were analysed by hand. Additionally, a comprehensive systematic review investigated and synthesised existing quantitative and qualitative evidence related to the effectiveness of peer-led home visiting parenting support programs and the experiences of both Indigenous and non-Indigenous families participating in these programs.

Results: The study results are presented through a sequence of five published papers. The comprehensive systematic review identified a range of affirmative impacts resulting from peer-led home visiting parent support programs. However, no studies were found relating to peer-led home visiting programs for Indigenous parents

When the new program was implemented, program staff included an Aboriginal program coordinator, four Aboriginal peer support workers, an Aboriginal education support officer, a non-Aboriginal parent support worker who provided beginning assistance with program development and non-Aboriginal program managers from within the parent support agency, who oversaw the program. There was a total of 179 families visited by peer support workers over the study period who provided a wide range of specialist referrals and health information topics. Many of the families were visited more than once. Five Aboriginal and non-Aboriginal staff from community agencies provided study data on the benefits and challenges of the program in addition to local issues affecting families. Difficulties were experienced by the Researcher in accessing parents for their evaluations of the program. Aboriginal family responsibilities and adverse social determinants of health such as lack of housing contributed to this data shortage. However, responses from the two parents who contributed to the data were comprehensive and affirmed supportive program features.

Qualitative analysis of peer support worker data on their self-perceived role revealed one overarching theme, *Providing parental support*, and five supporting sub-themes: *Developing client acceptance and trust, Delivering culturally relevant support, Advocating for families, Developing therapeutic engagement and communication strategies and Creating safe home visiting practices.* Five additional themes were derived from peer support and community agency workers when further exploring the program's suitability, feasibility, acceptability and effectiveness,

highlighting multiple influences on the development of Aboriginal parent support: *Peer support worker home visiting skills; Responding to impacts on families of social determinants of health; Client support and engagement; Interagency collaboration, and Issues addressing program sustainability.* Responses from the parents strengthened these themes.

Study findings have added to the body of knowledge needed for the development of a strengths-based culturally secure Aboriginal peer-led home visiting parent support model. From these findings, required elements of the model have been identified. The first element is peer support worker home visiting skills supported by peer support worker education and training needs, and peer support worker attributes and strategies. The second element is responses to the impacts on families from social determinants of health facilitated by peer support worker non-judgemental listening, knowledge of accessible local resources and development of meaningful, realistic and empathic strategies in partnership with their clients. The third element is client support and engagement related to availability of culturally relevant client support, client engagement and client acceptance of peer support workers. The fourth element is interagency collaboration, with the final element being issues addressing program sustainability as identified by funding and management governance.

It is recommended that peer-led home visiting support is offered universally to Aboriginal parents in all geographical locations in Western Australia, with recognition of the role of Aboriginal peer support workers who are able to work in partnership with parents to provide psychosocial support and community agency linkage. Implementation of this model will support parents to develop empowering culturally relevant parenting strategies that will have lifelong health and wellbeing benefits for their children.

Conclusion: The study outcomes have highlighted innovative data informing the development of suitable, feasible, acceptable and effective peer-led home visiting parent support for Aboriginal families in Midland. The value of a partnership approach between peers, parents, and the community and child health nurse researcher has been identified, with the emerging role of the peer support worker being noted as integral to strengthening parenting environments.

The author recognises that Aboriginal and Torres Strait Islander people are two different cultural groups and prefer to be acknowledged as such. However, respectfully throughout the thesis participants will be described as Aboriginal people.

Acknowledgements

This thesis was made possible through the significant support and assistance of many people.

As an academic, researcher and child health nurse at Curtin University in Western Australia, I am working in Noongar (or Nyungar) Country. I acknowledge the Nyungar people and their Elders past, present and future and thank them most sincerely for their willingness to allow me to work in partnership with their peer support workers, families and community in Midland to explore the development of home visiting support for parents.

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"Dedicated to Edie, for all her hopes and dreams"

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2013: National Health and Medical Research Council (NHMRC): The Centre for Research Excellence in Aboriginal Health and Wellbeing, Telethon Kids, Perth Western Australia.

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Munns, A., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2014). The role of the Aboriginal peer support worker. Oral presentation October 2014, The Australian College of Children and Young Peoples Nurses 2014 International Conference, Cairns.

Munns, A., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2014). Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia. Oral presentation November 2014, Mark Liveris Research Symposium, Curtin University, Perth.

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016). Engaging a diverse community: Development of peer support for Indigenous parents and young children. Poster presentation August 2016, 28th International Congress of Pediatrics, Vancouver, Canada.

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016). Peer-led parent support: Strength-based practice using Indigenous methods and models. Oral presentation November 2016, Lowitja Institute International Indigenous Health and Wellbeing Conference, Melbourne.

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016). The role of the community nurse in Aboriginal parent support. Oral presentation November 2016, 8th International Congress on Innovations in Nursing, Perth.

Publications and Statement of Contributions from Others

This thesis contains published works, all of which have been co-authored. The bibliographical details and descriptions of the works, and the contributions of each author are listed below. The papers are documented in order of their placement within the thesis chapters.

Paper 1

Munns, A., Hegney, D., & Walker, R. (2014). Effectiveness and experiences of families participating in peer-led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 12*(3), 1–13.

Ailsa Munns conducted the literature review, developed the protocol and drafted the manuscript. Desley Hegney assisted with protocol development. Desley Hegney and Roz Walker critically reviewed the manuscript.

Paper 2

Munns, A., Watts, R., Hegney, D., & Walker, R. (2016a). Effectiveness and experiences of families and support workers participating in peer-led parenting support programs delivered as home visiting programs: A comprehensive systematic review. *JBI Database of Systematic Reviews and Implementation Reports, 14*(10), 167-208. DOI: 10.11124/JBISRIR-2016-003166

Ailsa Munns conducted the literature review. Papers selected for retrieval were independently assessed by Ailsa Munns and Desley Hegney. Ailsa Munns, Robin Watts and Desley Hegney independently extracted the systematic review data. All authors contributed to interpretation of the data and critically reviewed the manuscript.

Paper 3

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2017a). Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research. *Contemporary Nurse.* http://dx.doi.org/10.1080/10376178.2017.1358649

Ailsa Munns conducted the literature review, data extraction and interpretation, and developed the manuscript. All authors contributed to interpretation of the data for the work and critically reviewed the manuscript.

Paper 4

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Ailsa Munns conducted the literature review, data extraction and interpretation, and developed the manuscript. All authors contributed to interpretation of the data for the work and critically reviewed the manuscript.
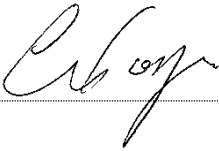
Paper 5

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2017b). Aboriginal parent support: A partnership approach. *Journal of Clinical Nursing*. DOI: 10.1111/jocn.13979

Ailsa Munns conducted the literature review, data extraction and interpretation, and developed the manuscript. All authors contributed to interpretation of the data for the work and critically reviewed the manuscript.

Confirmation of Permission of Contributing Authors

We confirm author contributions for all papers and that permission has been obtained from all authors to include the manuscripts in this PhD thesis.
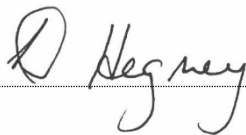
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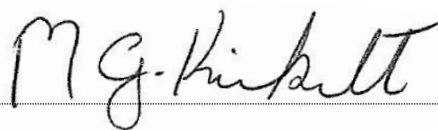
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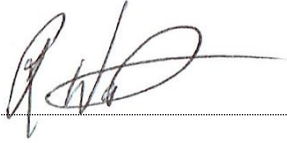
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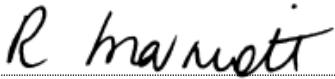
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10th November 2017

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Ailsa Marie Munns

10th November 2017

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List of Abbreviations

ALS	Action Learning Set
CMP	Community Mothers Program
PAR	Participatory Action Research
PSW	Peer Support Worker

Glossary of Terms

Action Learning Set	A formal structure for participants to meet regularly in small learning groups over a fixed program cycle to collaboratively discuss issues relevant to their workplace and undertake programme strategies between Action Learning Sets (ALSs) to address identified issues (Smith & O'Neil, 2003).
Cultural Security	Cultural security seeks to ensure that the cultural rights, values, beliefs and expectations of Aboriginal people are sensitively central to development of programs, services, policies and strategies that impact on their people, families and communities (Casey, 2014, p. 451).
Cultural Safety in Nursing and Midwifery Practice	The effective nursing and midwifery practice of a person or family from another culture, and is determined by that person or family (Nursing Council of New Zealand, 2011, p. 7).
Participatory Action Research	Participatory Action Research (PAR) has been identified in this research as a methodology situated within a critical social theory paradigm. PAR is an appropriate methodology for program development for participants, based on cycles of planning, acting, reflection, learning from their experiences and further action planning (Hegney & Francis, 2015).
Peer Support Worker	Peer Support Workers (PSWs) have been identified in this research as parent support workers. PSWs have no formal parent support qualifications and work in a voluntary or paid capacity to support their own community members. They may have some training (Walker, 2010; Munns, Watts, Hegney & Walker, 2016a).

Chapter 1.   Setting the Scene

1.1   Chapter overview

Chapter One introduces this study, which implemented a culturally secure home visiting service model for Aboriginal family and child health support in the Midland community in Western Australia (WA). The background to the research project is presented along with the rationale for undertaking this work and the significance of study findings. Importantly, the positioning and intent of the non-Aboriginal Researcher is highlighted, given that this is central to the credibility of the partnership with Aboriginal communities. The aims and objectives of the study are outlined. The chapter concludes with a summary of the structure of the thesis.

1.2   The researcher and research method

The Researcher is a non-Aboriginal Registered Nurse, Registered Midwife and Community Child and Adolescent Health Nurse working as an academic, practitioner and researcher in the areas of community health, family, child and adolescent health and primary health care within a range of urban, rural and remote settings. Locating a non-Aboriginal researcher within a critical social theory paradigm to explore the strengths and challenges of Aboriginal parent support required the Researcher to consider how to collaboratively engage with study participants, to explore their needs and be guided by their worldview beliefs and feelings (Denzin & Lincoln, 2011). Historically, research on Aboriginal populations by non-Aboriginal researchers has used Western research paradigms which have had little demonstrative benefits for Aboriginal individuals, families and communities, resulting in harmful outcomes such as exploitation and disrespectful representation of Aboriginal knowledge and beliefs (Gray & Oprescu, 2016; Dudgeon, Kelly, & Walker, 2010; Humphrey, 2000). It is recognised that contemporary research needs to facilitate genuine collaborative and equal partnerships between Aboriginal and non-Aboriginal researchers to enable empowering, positive and practical health and wellbeing outcomes (Gray & Oprescu, 2016; Dudgeon, Kelly, & Walker, 2010).

The use of Participatory Action Research (PAR) can promote a partnership model for Aboriginal peer support workers, families, their community and the Researcher, allowing all participants to hold equal power within the research team (Baum et al., 2006). In this study, PAR enabled genuine participation in knowledge acquisition and interpretation and how the learnings would be implemented within a home visiting support service. The value and worth of individual and collective empowerment, health outcomes, self-determination and leadership can be developed through this approach (Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011; Dudgeon, Scrine, Cox, & Walker, 2017). Through critical self-reflection, the Researcher was able to identify personal subjectivities and potential unequal power relationships impacting upon participants, enabling more responsive support to be developed for complex family and community circumstances (Walker, Scultz, & Sonn, 2014). The partnership with Aboriginal peer support workers reduced risks of misinterpretations and enhanced better understandings of local cultural nuances (Kildea, Barclay, Wardaguga, & Dawumal, 2009). This facilitated a reflexive model of engagement and practice for the Researcher, thereby enhancing the potential for physical and psychosocial wellbeing outcomes for study participants.

Within the research method, it is important to highlight the guiding principle of a culturally secure approach between the Researcher, Aboriginal clients, peer support workers and community agency workers. Cultural security is integral to the development of programs, services, policies and strategies within organisations that demonstrate respect for cultural values and beliefs, linking understanding to action (Casey, 2014; Coffin, 2007). However, prior to cultural security being fulfilled, cultural safety needs to be upheld (Coffin, 2007).

The meaning of *cultural safety* within the health context was first developed by Maori nurse Irihapeti Ramsden in 1992, where it was highlighted as being the provision of safe nursing and midwifery care as defined by the recipients of the service. However, prior to this were the beginning steps of *cultural awareness*, where there is a need to understand there are differences between ethnic groups, followed by *cultural sensitivity* that points to the legitimacy of these differences and the process of self-reflection by health professionals (Ramsden, 1992).

Working in partnership with Aboriginal families, peer support workers and community agency workers, and engaging in reflexive activities enabled the Researcher to seek a culturally secure home visiting parent support program with relevant policies and strategies. It is recognised that without culturally responsive and relevant services, the physical and psychosocial needs and wellbeing of Aboriginal peoples will not be addressed (Walker et al., 2014).

1.3   Midland, Western Australia: The research setting

Midland is an outer metropolitan local government authority town situated within the City of Swan in WA, 18 km east from the state's capital city of Perth (Figure 1.1) (profile.id, n.d.; Main Roads WA, 2017). In the urban regions of WA, Aboriginal families are more likely to live in suburbs with low socioeconomic status (WA Department of Indigenous Affairs, 2010). In 2011, Midland was identified as being very disadvantaged nationally and the most disadvantaged location within the City of Swan as measured by the Australian Socio-Economic Index for Areas (SEIFA) – Index of Relative Socio-Economic Disadvantage (profile.id, n.d.; ABS, 2013; Swan Alliance, 2015a). In this study region, there are approximately three times as many people self-identifying as being Aboriginal (4.2%) compared with those within the total metropolitan areas in WA (1.5%) (ABS, 2007, 2014). The median age of the Aboriginal population is 21 years as compared to 38 years for the general population (ABS, 2017).
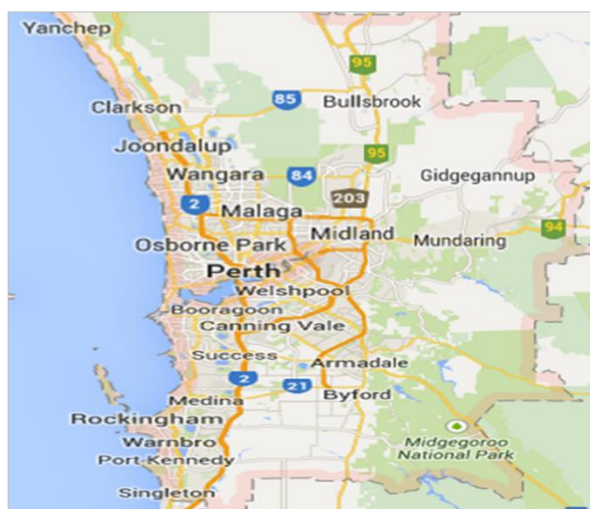
Figure 1.1   Perth and Midland map
Source: Googlemaps

1.4   Background

1.4.1   Health in the early years

Health in the early years is a strong indicator for lifelong physical and psychosocial wellbeing. Adverse childhood experiences weaken people's adaptive responses to the challenges and stressors of everyday life, with greater susceptibility to acute and chronic diseases, as well as physiological and behavioural responses to stress. This exposure has the potential to restrict ongoing learning and employment opportunities and incur associated societal costs (Center on the Developing Child at Harvard University, 2010). Recent research has highlighted cumulative lifelong disadvantages resulting from influences such as childhood poverty, poor adult and parenting experiences, parental mental illness and lack of professional support services (Nurius, Green, Logan-Greene, & Borja, 2015), with a diversity of negative outcomes related to health and wellbeing, crime, social engagement and trust (Heckman & Mosso, 2014). Heckman and Mosso (2014) and Munns, Watts, Hegney and Walker (2016a) also highlight the value of community based parent support strategies, identifying that effective approaches positively alter parents' behaviours and attitudes towards their children, which subsequently improve the home child rearing environment and children's developmental progress.

Australian Aboriginal children tend to be more developmentally vulnerable than non-Aboriginal children across a range of domains, including health and education. Family stressors and adverse social determinants of health such as lack of housing critically impact upon their families' abilities to maintain healthy and enabling environments (AIHW, 2015). There are adverse intergenerational risks impacting on Aboriginal families, children and communities resulting from circumstances associated with colonisation and following events such as the forced removal of children from their families. Issues such as unresolved grief and loss along with trauma and abuse have affected multiple generations, with adverse impacts on their feelings of social, spiritual and cultural wellbeing not being well appreciated or understood through Western constructs of health (Social Health Reference Group, 2004; Zubrick et al., 2014). The complex and diverse situations also place great stress on women, children and families during the crucial perinatal period, influencing foetal growth and development and

family role adjustment following birth, along with the quality of parenting knowledge and skills to optimally facilitate their children's developmental progress (Hoffman, Marvin, Cooper, & Powell, 2006; Marriott & Ferguson-Hill, 2014).

A 2014 community asset and gap analysis highlighted a significant number of Aboriginal children in Midland as having the highest vulnerability within the City of Swan, based on SEIFA, low income, housing difficulties and Australian Early Development Census (AEDC) results (profile.id, n.d.; ABS, 2013; Swan Alliance, 2015a). The AEDC measures Australian children's developmental progress across five domains which critically inform strengths of and challenges to adult trajectories in health, education and social abilities. The domains address physical health and wellbeing, social competence, emotional maturity, language and cognitive school based skills, communication and general knowledge (Commonwealth of Australia, 2014-2015). The analysis also identified significant gaps in community based services to support parents including: the availability of accessible activities targeting disadvantaged Aboriginal families; assistance with transition to parenting and provision of early parenting support. Of note, were the substantial number of young parents requesting help to support their families (profile.id, n.d.; Swan Alliance, 2015a,b).

Throughout Australia, community child health nurses work with Aboriginal and other families and their communities, delivering a suite of diverse programs to both maintain optimal developmental health for children and enhance parenting capacity within a range of positive and challenging environments. In WA, community based child health nurses have traditionally delivered these services, working either autonomously or in collaboration with Aboriginal Health Workers within the WA Department of Health (WADoH) or Aboriginal Community Controlled Health Services. Studies by Larson and Bradley (2009), Boulton, Brown and Long (2010) and Walker (2010) acknowledged the necessity for parent and child health service delivery for Aboriginal families to be further developed to include innovations such as peer-led home visiting parent support programs that are embedded in culture, language and lore. Walker (2010) further considered that the effectiveness of home visiting was dependent on the development, implementation and evaluation of programs within broader social and cultural contexts, acknowledging impacts of trans-generational issues and identifying Aboriginal peer-led programs as emerging effective models of

support. Borrow, Munns and Henderson (2011) also confirmed the need for change and flexibility of child health practice to address the complex needs of vulnerable families and communities.

1.4.2 History of peer-led home visiting support in Western Australia

In 1995, the *Community Mothers Program* (CMP) was introduced into community child health nursing practice in an urban WA region. This was a pilot home visiting model implemented from 1995 to 1998 using a non-professional peer-nurse partnership to universally support first time parents in their first year of parenting. Based on the Bristol Child Development Program Model (Miller, 1998), the program utilised a home visiting framework by volunteer non-Aboriginal parents working with child health nurses to provide support and encouragement for Aboriginal and non-Aboriginal families in their local communities. The CMP philosophy is one of peer support, which encourages parent empowerment. This philosophy assists parents to develop skills to positively manage their own lives and that of the health, development and wellbeing of their children (Miller, 1998). The 1998 evaluation report identified the main benefits as being in the areas of childhood immunisation, breast feeding and family nutrition (Miller, 1998) and recommended continuance. During 1997 to 1999, the WADoH funded expansion of the program into other urban areas and one rural area with demonstrated positive outcomes for families, volunteer peers and community child health nurses (Miller & Hughes, 1999; Munns, Downie, Wynaden, & Hubble, 2004; Downie, Clark, & Clementson, 2004-2005). The Researcher commenced working in the CMP in 1999. Further research demonstrated that families and communities being supported by the CMP managed the effects of social stress more effectively. There was also enhanced community capacity to support and develop positive long-term outcomes for families, children and communities (Miller & Hughes, 1999; Munns et al., 2004; Downie et al., 2004-2005). Of note, there was improved community child health nursing practice as this model facilitated collaborative practice partnerships between the nurses, families and communities (Munns et al., 2004; Downie et al., 2004-2005).

Following cessation of funding support for the CMP in the mid- 2000's, the Researcher was requested to develop a peer-led home visiting parent support program for Aboriginal families in the remote area of Halls Creek, WA, using the services of paid peer support workers. The *Yanan Ngurra-ngu Walalja – Halls Creek Community Families Program* was funded through the Australian Better Health Initiative and the WADoH as part of the Council of Australian Governments (COAG) agreement (Government of Western Australia, Department of Health, n.d.) and was offered universally to all Aboriginal families with young children from birth to four years of age from 2008 until 2009. Evidence from the CMP underpinned the development of the Halls Creek program. Being able to work in a reflexive partnership with both male and female peer support workers, families, their local community, the Researcher and an independent evaluator enabled the development of a community child health model of practice to collaboratively identify culturally relevant solutions to complex social and parent support issues (Munns & Walker, 2015). The evaluation confirmed that Aboriginal families and peer support workers considered the program to be beneficial and meaningful, with cultural and structural strategies such as sensitivity to transgenerational issues, planning for a range of community language groups and incorporation of relevant early child development health promotion material (Walker, 2010). Changes in funding have since necessitated structural changes to the program, with reduced staffing and changes to coordination. However, parent support activities are ongoing.

The Researcher was requested by Ngala in 2012 to consider the development of a peer-led parent support program in the outer urban area of Midland, WA. Ngala is a community not-for-profit non-government family support agency that offers parenting support to families throughout WA, including Aboriginal families in this low socioeconomic, highly disadvantaged area (ABS, 2011; Ngala, 2009). Local community agencies working with Aboriginal families confirmed the need for this type of support and their interest in collaboration. In 2013, the program commenced using a PAR framework to inform and develop peer-led home visiting family support. The program team consisted of Ngala's Aboriginal program coordinator, four part time remunerated Aboriginal peer support workers and the Researcher. A non-Aboriginal parent support worker supported the team for six months and an Aboriginal education support officer joined the team nine months into the program (Munns et al., 2016b). A

partnership approach between the team and Researcher facilitated development of locally informed, acceptable parent support which was informed by, but very distinct from, evidence-based strategies from the CMP and Yanan Ngurra-ngu Walalja – Halls Creek Community Families Program. The journey and outcomes from the Ngala Indigenous Parenting Service were the basis for the Researcher's doctoral studies and will be explored throughout this thesis.

1.5   Rationale and significance

Investigating a model of home visiting parent support for Aboriginal parents with children aged from birth to four years of age, in an urban setting, was particularly relevant at this time as, before this study, there was very little known about the need for or effectiveness of the role of Aboriginal peer support workers supporting Aboriginal families with young children in an urban-based context (Munns et al., 2016a). However, it was anticipated that Aboriginal parents would have increased knowledge and appreciation of their roles in their children's development, thereby enhancing personal and family empowerment and augmenting their ability to actively participate in their children's physical and psychosocial growth and development from birth to four years of age.

As families are central to their children's health and development, early support needs to focus on evidence-based innovative approaches that enhance supportive relationships between health care providers, Aboriginal families and their children (Ah Chee, Boffa, & Tilton, 2016). This is in addition to Aboriginal parents being able to identify their family and child rearing needs and participate in developing meaningful and culturally relevant support strategies. Early childhood social and economic disadvantage influence lifelong physical and psychosocial adversity (Center on the Developing Child at Harvard University, 2010) and with complex social and cultural impacts on Aboriginal families' lives, it is imperative that relevant and meaningful critically informed parent support is investigated (Milroy 2014; Silburn & Walker, 2008). In addition to investigating a model of peer-led home visiting parent support, it is important to explore how community child health nurses can source evidence to assist them to develop contemporary and culturally relevant models of practice, to enable optimal early years Aboriginal child and family support.

Identifying the need for parental capacity to foster developmentally and culturally relevant environments for their children warrants investigation into new perspectives on parent home visiting support strategies and how these can inform culturally relevant, peer-led approaches. Critically informed partnerships between Aboriginal parents, peer support workers, their local communities and child health nurse facilitators have the potential to develop relevant, accessible and acceptable programs. As such, it is vital that all participants are engaged in research to collaboratively develop these enabling strategies.

1.6   Aims and objectives

In partnership with the peer support workers, Midland community and Aboriginal parents, the **aims of the study** were to investigate the self-perceived suitability, feasibility and acceptability of parent support and inform a model for a culturally secure, peer-led, home visiting program for Aboriginal families and children in the Midland community, Western Australia.

The specific study objectives were all related to this program and were to:

1. Implement and evaluate the program;
2. Identify and examine the elements required to deliver the program in Midland;
3. Explore the self-perceived suitability, feasibility, acceptability and effectiveness of the program in Midland;
4. Inform a model for the program in Midland and add to the body of knowledge on effective peer-led program models.

1.7   Thesis structure

Chapter One, Setting the Scene, introduces the context of the study and positions the non-Aboriginal Researcher within the Aboriginal research environment. An overview of the project's background, rationale and significance has been presented, along with the aims and objectives.

Chapter Two, Review of the Literature, includes two papers, these being a systematic review protocol and subsequent findings of the comprehensive systematic review examining existing research investigating peer-led home visiting parent

support. The national and international literature examines both Aboriginal and non-Aboriginal peer-led home visiting programs.

Chapter Three, Research Methodologies and Method, introduces the research methodology, highlighting a critical paradigm using a PAR design to enable a culturally appropriate investigative partnership between the Researcher, Aboriginal peer support workers, Aboriginal families and community agencies. The paper in this chapter critically examines program development for vulnerable populations, such as Aboriginal families, using PAR.

Chapter Four, Research Outcomes, presents two papers that focus on the research outcomes. The first paper explores the self-perceived role of Aboriginal peer support workers involved in the new program, highlighting their innovative approaches towards parent support in challenging psychosocial environments. The second paper addresses the overall program outcomes, investigating the suitability, feasibility and acceptability and the necessary elements of peer-led home visiting interventions for Aboriginal families and children in urban areas.

Chapter Five, Discussion and Conclusion, is the concluding chapter in which all research findings are discussed. The role of PAR as an enabling methodology is explained, in addition to the future of Aboriginal parent support. Community child health nurse partnerships with peer support workers and families to facilitate this support are examined. The potential knowledge translation and dissemination of research findings is discussed, with study challenges, limitations and strengths addressed. Recommendations for future research are proposed. Figure 1.2 identifies the specific papers supporting each study objective.

The Reference List, including references from the exegesis; the Bibliography, comprising references from the papers; and the Appendices are presented at the end of the thesis document.

Objective 1: Implement and evaluate a culturally secure Aboriginal led visiting child health parent support program

- The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study (Paper 4, Chapter 4)
- Aboriginal parent support: A partnership approach (Paper 5, Chapter 4)

Objective 2: Identify and examine the elements required to deliver a culturally secure Aboriginal led visiting child health parent support program in Midland

- Effectiveness and experiences of families participating in peer-led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: A systematic review protocol (Paper 1, Chapter 2)
- Effectiveness and experiences of families and support workers participating in peer-led parenting support programs delivered as home visiting programs: A comprehensive systematic review (Paper 2, Chapter 2)
- Peer led Aboriginal parent support: Program development for vulnerable populations with participatory action research (Paper 3, Chapter 3)
- The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study (Paper 4, Chapter 4)

Objective 3: Explore the self-perceived suitability, feasibility, acceptability and effectiveness of a culturally secure Aboriginal led visiting child health parent support program in Midland

- The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study (Paper 4, Chapter 4)
- Aboriginal parent support: A partnership approach (Paper 5, Chapter 4)

Objective 4: Inform a model for a culturally secure Aboriginal led visiting child health parent support program in Midland and add to the body of knowledge on effective peer-led program models

- Effectiveness and experiences of families participating in peer-led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: A systematic review protocol (Paper 1, Chapter 2)
- Effectiveness and experiences of families and support workers participating in peer-led parenting support programs delivered as home visiting programs: A comprehensive systematic review (Paper 2, Chapter 2)
- Peer led Aboriginal parent support: Program development for vulnerable populations with participatory action research (Paper 3, Chapter 3)
- The emerging role of the urban-based Aboriginal peer support worker: A Western Australian study (Paper 4, Chapter 4)
- Aboriginal parent support: A partnership approach (Paper 5, Chapter 4)

Figure 1.2   Papers supporting the objectives of the study

Chapter 2.   Review of the Literature

2.1   Chapter overview

In order to reduce adverse influences from early childhood disadvantage and address the needs of vulnerable families, innovative peer-led home visiting support programs need to be critically informed from evidence-based studies. To inform a culturally appropriate design for this study, a comprehensive systematic literature review was undertaken. Additionally, to ensure that the results of this study were informed by contemporary literature, the author continued to critically evaluate new work published. No further studies or grey literature were identified that could further inform this study.

This chapter includes six sections. Section One has introduced the chapter. Sections Two and Three present the published peer-reviewed systematic review protocol and subsequent comprehensive systematic review that sought to address two main aims, to ascertain current evidence of:

a. The effectiveness of peer-led parenting support programs delivered as home visiting programs to Indigenous and non-Indigenous families and the characteristics of successful programs; and

b. The experiences of families and support workers participating in parenting support programs delivered as home visiting programs including the relationships between the program participants.

The fourth section highlights the rationale and benefits for the current research arising from the findings and recommendations of the systematic review. To ensure that the discussion and recommendations from this study are contemporary, the fifth section critically appraises new literature that has emerged since the commencement of the study subsequent to the finalisation of systematic review, followed by the conclusion to this chapter.

2.2   Systematic review protocol

Questions that guided this systematic review:

- What is the effectiveness of peer-led parenting support programs delivered as home visiting programs, what are the experiences of families and support workers participating in these programs, and how can the programs be improved?

Aims of the systematic review:

- To identify the effectiveness of peer-led parenting support programs delivered as home visiting programs to Indigenous and non-Indigenous families and the characteristics of successful programs.

- To identify the experiences of families and support workers participating in these parenting support programs delivered as home visiting programs, including the relationships between the program participants.

More specifically, the objectives were to identify:

- The types of peer-led home visiting programs that are or have been undertaken.

- The effectiveness of peer-led home visiting parent support programs for families.

- The successful components of peer-led home visiting parent support programs.

- The experiences of families with regard to peer-led home visiting parent support programs.

- The experiences of both peer support workers and their supervisors with regard to peer-led home visiting support programs.

- The differences between peer-led home visiting programs offered to Indigenous and non-Indigenous families.

Inclusion criteria

The quantitative and qualitative components of this review considered community-based studies that included:

- Families/parents (including Indigenous and non-Indigenous) with one or more children aged zero to four years. After four years, children are usually in the formal education system, for example, kindergarten and preschool, and are supported by educational services (OECD, 2015).

- Parents in married, single or in de facto and/or same sex relationships.

- Peer support workers – one or both of the following types of family support worker:

  o Peer support workers have no formal educational qualifications in the area of parent support and work in a voluntary or paid capacity to support members of their own community (Walker, 2010). They may, however, have some training.

  o Those community workers with more training in family support are often referred to as paraprofessional support workers and usually work in a paid capacity (Olds et al., 2004).

- Supervisors of support workers who were community-based registered nurses undertaking home visits to support families.

Prior to the development of the comprehensive systematic review, the objectives, inclusion criteria and methods of analysis were published in the systematic review protocol (Munns, Hegney, & Walker, 2014). Three changes were made to the comprehensive systematic review during data analysis and accepted by the editor of the Joanna Briggs Institute Library of Systematic Reviews. One of the sub-objectives was intended to explore 'meaning', bringing forward the significance of families' and support workers' experiences (Larson & Bradley, 2009). However, whilst undertaking the review, the authors determined that assessment of 'meaning' was outside the scope of the review. The second modification was made when data analysis demonstrated the need to document the experiences of support workers in addition to those of the families. The third variance was the supplementary inclusion criterion of 'supervisor of support workers' category. Examination of the data highlighted the impact of the supervisors on the experiences of the peer support workers.

PAPER 1: SYSTEMATIC REVIEW PROTOCOL

Munns, A., Hegney, D., & Walker, R. (2014). Effectiveness and experiences of families participating in peer-led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 12*(3), 1–13.

Effectiveness and experiences of families participating in peer led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: a systematic review protocol

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Review question/objective

What is the effectiveness and experience of families participating in peer led parenting support programs delivered as home visiting programs?

The objective of this review is to identify the effectiveness and experience of families participating in peer led parenting support programs delivered as home visiting programs.

The quantitative objective is to identify the effectiveness of peer led home visiting parent support for families.

More specifically, the objectives are to identify:

The types of peer led home visiting programs that are, or have been undertaken.

The effectiveness of peer led home visiting parent support programs on families.

The qualitative objectives are to identify the experiences and meanings of peer led parenting support programs for families.

More specifically, the objectives are to identify the evidence on:

The meaning that families place on peer led home visiting parent support programs.

The experiences of families with regard to peer led home visiting parent support programs.

The successful components of peer led home visiting parent support programs.

The differences between peer led home visiting programs offered to Indigenous and non-Indigenous families.

Background

This review will examine peer led home visiting parenting support for families with young children, including Indigenous families. The age range for children is from birth to four years, after which it is anticipated that they will have more sustained contact in the preschool environment.

In Australia, support for Indigenous and non-Indigenous families with young children has been traditionally undertaken by community child health nurses working as sole practitioners or in conjunction with Aboriginal Health Workers within the state's Departments of Health (DOH) or Aboriginal Community Controlled Health Services (ACCHS). The service provision has been traditionally defined by DOH or ACCHS policies and protocols, focussing on universal first home visits after discharge from hospital and client clinic attendance for developmental screening. Families in contemporary societies have become increasingly diverse in their structure and function, with more vulnerabilities being identified.

To minimize risks of early disadvantage and lifelong psychosocial health impacts, active, alternate engagement strategies addressing barriers to participation in support services are needed. Designing child and family health services to meet these needs include the use of home visiting.[1] While community nurse led home visiting is an established strategy to support parents, there is increasing recognition of the value of peer led home visiting from parents in local communities. However, the evidence around models for peer led home visiting requires systematic evaluation to review effectiveness and the elements of successful implementation.

An evaluation of family support in South Australia by Community Matters Pty Ltd. highlights the necessity for responsive programs that adapt to varying circumstances, also allowing families to create their own change.[2] Community members engaged in effective peer support have been acknowledged as having open, non-judgemental, reflective and positive modelling behaviors. One study researched the interactions of paraprofessionals supporting families of mixed race in North America, who had low psychological resources.[3] Paraprofessional positions may include trained paid or unpaid supplementary assistants to professionals such as nurses. Volunteers may also be used in these positions. This research demonstrated that these parents provided home environments that enhanced early learning and produced positive effects on mother-child interaction.

Recent studies and reviews by Larson & Bradley, Boulton, Brown and Long and Walker, in Western Australia have identified the need for improved, innovative ways of parent support and child health service delivery for Indigenous families, including home visiting.[4-6] There is recognition that support needs to include trans-generational aspects and be embedded within culture, language and lore. Central to the effectiveness of home visiting is the need to develop, implement and evaluate programs within the broader context of impacting social and cultural factors. However, there is little supporting evidence in relation to this sociocultural approach.[6] While this background information talks about 'home visiting,' the visit may not always be in the family home. Rather, in consultation with the family, the place of meeting can be the home, or it could be another place chosen by the parent such as the local park, the swimming pool or other location. The main emphasis is on a place where the parent feels secure.

There have been few recent (2003-2013) mixed methodology or qualitative studies investigating peer led parenting support programs delivered as home visiting programs. Studies by Olds et al., have reviewed the use of paraprofessionals in home visiting programs in North America for families where paraprofessional impact was lower on maternal and child health outcomes.[3,7] However, the results of these studies were from randomized controlled trials (RCTs), not taking into account qualitative research methods where the experiences of families participating in peer led parenting support programs and their self-perceived meaning could be explored. Similarly, an RCT in North America by Vogler et al., with no inclusion of qualitative evidence, demonstrated little differences in results of home visiting between nurses and paraprofessionals.[8] Rigorous non-statistical research approaches such as community-based participatory action and Most Improved Change Technique have the potential to fill knowledge gaps around concepts of empowerment and capacity building for families and communities in cross-cultural contexts.[6]

The population for this comprehensive systematic review will be Indigenous and non-Indigenous families and parents with children 0-4 years of age. The quantitative component will consider studies evaluating the effectiveness of peer led home visiting parent support programs for families in developed and underdeveloped countries, while the qualitative component will consider studies investigating the meaning and experiences of these programs. The expected outcomes will be to identify the types of peer led home visiting programs that are/or have been undertaken, their effectiveness and meaning for Indigenous and non-Indigenous families and the components of the programs that facilitate success.

Peer led support for families delivered as home visiting programs is important as local parents working as peers are cognizant of the lived experiences of families in their immediate geographical area, along with contemporary psychosocial impacts. Research evaluation is imperative to maximize the impact of these programs on parenting support and their outcomes.

Examination of Joanna Briggs and Cochrane reviews have not found any current or planned reviews on the same topic.

Keywords

Indigenous; Peer support; parent support; home visiting

Inclusion criteria

Types of participants

The quantitative and qualitative components of this review will consider studies that include:

1. Families/parents (including Indigenous and non-Indigenous) with one or more children aged 0-4 years of age. Parents may be married, single or in defacto and/or same sex relationships.
2. Parent/Peer support workers.

Exclusion Criteria

All exclusion criteria are addressed in the relevant sections of the protocol.

Types of intervention(s)/phenomena of interest

Peer led parenting support programs delivered as home visiting programs include the use of volunteer or paraprofessional parents who have shared similar parenting experiences in the local community.

The quantitative component of the review will consider studies that evaluate the effectiveness of peer led home visiting parent support programs for families/parents with children 0-4 years of age. Interventions delivered as non-home visiting support or delivered with non-peer support will not be included.

The qualitative component of this review will consider studies that investigate the meaning and experiences of peer led parenting support programs for families with children 0-4 years of age.

Types of outcomes

This review will consider studies that include the following outcome measures: effective peer led home visiting parent support programs for families with children from 0-4 years of age, that have been measured as effective through quantitative and/or qualitative studies. Effectiveness can be assessed through measures such as client self-reported satisfaction with parent support, increased feelings of coping and confidence with parenting and decreased feelings of parenting stress. Quantitative tools to measure effectiveness can use methods such as surveys and questionnaires. Qualitative tools to measure effectiveness can use methods such as open-ended questions in questionnaires, focus groups and face to face or telephone individual interviews.

Types of studies

The quantitative component of the review will consider both experimental and epidemiological study designs including RCTs, non-randomized controlled trials, quasi-experimental, before and after studies, prospective and retrospective cohort studies, case control studies and analytical cross sectional studies for inclusion.

The quantitative component of the review will also consider descriptive epidemiological study designs including case series, individual case reports and descriptive cross-sectional studies for inclusion.

The qualitative component of the review will consider studies that focus on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

In the absence of research studies, other texts such as expert opinion, discussion papers and position papers will be considered.

Search strategy

The search strategy aims to find both published and unpublished studies. A three-step search strategy will be utilized in this review. An initial limited search of MEDLINE and CINAHL will be undertaken, followed by analysis of the text words contained in the title and abstract and of the index terms used to describe the article. A second search using all identified keywords and index terms will then be undertaken across all included databases. Third, the reference lists of all identified reports and articles will be searched for additional studies. Only studies published in the English language will be considered for inclusion in this review. Studies on programs that are delivered as non-peer support and non-home visiting programs will not be included, along with those identifying families with children aged zero to four years of age. Authors of primary studies will be contacted for missing information or to clarify unclear data. This review will consider studies from 2000-2014, as the year 2000 was the time from which volunteer or paraprofessional visiting began to emerge on a substantial basis in the literature. Home visiting peer support is a relatively new intervention, with most previous studies being professional home visiting support.

The databases to be searched include:

MEDLINE, CINAHL, Science Direct, Scopus, ProQuest, Web of Science, AIATSIS - Indigenous studies bibliography(Informit), ATSIhealth - Aboriginal and Torres Strait Islander health bibliography (Informit), Australian Indigenous HealthInfoNet

The search for unpublished studies will include:

Grey Literature Network Service, Australian National Library, WorldCat, Conference Papers Index through ProQuest

Initial keywords to be used will be:

Paraprofessional parent support; Peer led parent support; Peer led home visiting parent support; Home visiting parent support

Assessment of methodological quality

Quantitative papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) (Appendix I). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Qualitative papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix I). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Textual papers selected for retrieval will be assessed by two independent reviewers for authenticity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI) (Appendix I). Any disagreements that arise between the reviewers will be resolved through discussion, or with a third reviewer.

Data collection

Quantitative data will be extracted from papers included in the review using the standardized data extraction tool from JBI-MAStARI (Appendix 1). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Qualitative data will be extracted from papers included in the review using the standardized data extraction tool from JBI-QARI (Appendix 1). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Textual data will be extracted from papers included in the review using the standardized data extraction tool from JBI-NOTARI (Appendix 1). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Data synthesis

Quantitative papers will, where possible, be pooled in statistical meta-analysis using JBI-MAStARI. All results will be subject to double data entry. Effect sizes expressed as odds ratios (for categorical data) and weighted mean differences (for continuous data) and their 95% confidence intervals will be calculated for analysis. Heterogeneity will be assessed statistically using the standard Chi-square and also explored using subgroup analyses based on the different quantitative study designs included in this review. Where statistical pooling is not possible, the findings will be presented in narrative form including tables and figures to aid in data presentation where appropriate.

Qualitative research findings will, where possible, be pooled using JBI-QARI. This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings rated according to their quality and categorizing these findings on the basis of similarity in meaning. These categories are then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible, the findings will be presented in narrative form.

Textual papers will, where possible, be pooled using JBI-NOTARI. This will involve the aggregation or synthesis of conclusions to generate a set of statements that represent that aggregation, through assembling and categorizing these conclusions on the basis of similarity in meaning. These categories are then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice. Where textual pooling is not possible, the conclusions will be presented in narrative form.

Conflicts of interest

There are no actual or potential conflicts of interest by Ailsa Munns, Prof. Desley Hegney or A/Prof. Roz Walker in relation to the undertaking of this systematic review and its findings.

Acknowledgements

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Appendix I: Appraisal instruments

MAStARI Appraisal Instrument

JBI Critical Appraisal Checklist for Randomised Control / Pseudo-randomised Trial

Reviewer _ Date _

Author _ Year _ _ _ _ _ _ _ Record Number _ _ _ _ _ _

	Yes	No	Unclear	Not Applicable
1. Was the assignment to treatment groups truly random?	☐	☐	☐	☐
2. Were participants blinded to treatment allocation?	☐	☐	☐	☐
3. Was allocation to treatment groups concealed from the allocator?	☐	☐	☐	☐
4. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐	☐
5. Were those assessing outcomes blind to the treatment allocation?	☐	☐	☐	☐
6. Were the control and treatment groups comparable at entry?	☐	☐	☐	☐
7. Were groups treated identically other than for the named interventions	☐	☐	☐	☐
8. Were outcomes measured in the same way for all groups?	☐	☐	☐	☐
9. Were outcomes measured in a reliable way?	☐	☐	☐	☐
10. Was appropriate statistical analysis used?	☐	☐	☐	☐
	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info. ☐

Comments (Including reason for exclusion)

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24

QARI appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer _ Date _

Author _ Year _ _ _ _ _ _ _ Record Number _ _ _ _ _ _ _

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐   Include ☐   Exclude ☐   Seek further info. ☐

Comments (Including reason for exclusion)

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JBI Critical Appraisal Checklist for Descriptive / Case Series

Reviewer _ Date _

Author _ Year _ _ _ _ _ _ _ Record Number _ _ _ _ _ _ _

		Yes	No	Unclear	Not Applicable
1.	Was study based on a random or pseudo-random sample?	☐	☐	☐	☐
2.	Were the criteria for inclusion in the sample clearly defined?	☐	☐	☐	☐
3.	Were confounding factors identified and strategies to deal with them stated?	☐	☐	☐	☐
4.	Were outcomes assessed using objective criteria?	☐	☐	☐	☐
5.	If comparisons are being made, was there sufficient descriptions of the groups?	☐	☐	☐	☐
6.	Was follow up carried out over a sufficient time period?	☐	☐	☐	☐
7.	Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐	☐
8.	Were outcomes measured in a reliable way?	☐	☐	☐	☐
9.	Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info ☐

Comments (Including reason for exclusion)

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JBI Critical Appraisal Checklist for Comparable Cohort/ Case Control

Reviewer _ Date _

Author _ Year _ _ _ _ _ _ _ Record Number _ _ _ _ _ _ _

		Yes	No	Unclear	Not Applicable
1.	Is sample representative of patients in the population as a whole?	☐	☐	☐	☐
2.	Are the patients at a similar point in the course of their condition/illness?	☐	☐	☐	☐
3.	Has bias been minimised in relation to selection of cases and of controls?	☐	☐	☐	☐
4.	Are confounding factors identified and strategies to deal with them stated?	☐	☐	☐	☐
5.	Are outcomes assessed using objective criteria?	☐	☐	☐	☐
6.	Was follow up carried out over a sufficient time period?	☐	☐	☐	☐
7.	Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐	☐
8.	Were outcomes measured in a reliable way?	☐	☐	☐	☐
9.	Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info. ☐

Comments (Including reason for exclusion)

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NOTARI appraisal instrument

JBI Critical Appraisal Checklist for Narrative, Expert opinion & text

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

		Yes	No	Unclear	Not Applicable
1.	Is the source of the opinion clearly identified?	☐	☐	☐	☐
2.	Does the source of the opinion have standing in the field of expertise?	☐	☐	☐	☐
3.	Are the interests of patients/clients the central focus of the opinion?	☐	☐	☐	☐
4.	Is the opinion's basis in logic/ experience clearly argued?	☐	☐	☐	☐
5.	Is the argument developed analytical?	☐	☐	☐	☐
6.	Is there reference to the extant literature/evidence and any incongruency with it logically defended?	☐	☐	☐	☐
7.	Is the opinion supported by peers?	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info ☐

Comments (Including reason for exclusion)

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2.3   Comprehensive systematic review

Munns, A., Watts, R., Hegney, D., & Walker, R. (2016a). Effectiveness and experiences of families participating in peer-led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: A comprehensive systematic review. *JBI Library of Systematic Reviews, 14*(10), 167-208.

Effectiveness and experiences of families and support workers participating in peer-led parenting support programs delivered as home visiting programs: a comprehensive systematic review

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EXECUTIVE SUMMARY

Background
Designing child and family health services to meet the diverse needs of contemporary families is intended to minimize impacts of early disadvantage and subsequent lifelong health and social issues. Innovative programs to engage families with child and family support services have led to interest in the potential value of peer-led home visiting from parents in local communities. There is a range of benefits and challenges identified in a limited number of studies associated with home visiting peer support.

Objectives
The objective of the review is to identify:
- The effectiveness of peer-led parenting support programs delivered as home visiting programs to Indigenous and non-Indigenous families and the characteristics of successful programs.
- The experiences of families and support workers participating in parenting support programs delivered as home visiting programs including the relationships between the program participants.

Inclusion criteria
Participants
Families/parents with one or more children aged zero to four years, peer support workers and their supervisors.

Intervention and phenomenon of interest
Peer-led home visiting parenting support programs that use volunteer or paraprofessional home visitors from the local community compared to standard community maternal-child care. The phenomenon of interest will be the relationships between participants in the program.

Types of studies
Quantitative studies: randomized control trials (RCTs). Qualitative studies: grounded theory and qualitative descriptive studies.

Outcomes
Parental attitudes and beliefs, coping skills and confidence in parenting, parental stress, compliance with child health checks/links with primary healthcare services, satisfaction with peer support and services and the nature of the relationship between parents and home visitors.

Search strategy
The search strategy will include both published and unpublished studies. Seven journal databases and five other sources will be searched. Only studies published in the English language from 2000 to 2015 will be considered.

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Methodological quality
Studies were assessed by two independent reviewers using standardized critical appraisal tools from the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) and the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) as appropriate.

Data extraction
Both quantitative and qualitative data were independently extracted by two reviewers using standardized data extraction tools from the JBI-MAStARI and the JBI-QARI, respectively, including qualitative and quantitative details about setting of interventions, phenomena of interest, participants, study methods and outcomes or findings.

Data synthesis
For quantitative findings, statistical pooling was not possible due to differences in interventions and outcome measures. Findings were presented in narrative form. Qualitative findings were aggregated into categories based on similarity of meaning from which synthesized findings were generated.

Results
Quantitative results from two RCTs demonstrated positive impacts of peer-led home visiting parent support programs including more positive parenting attitudes and beliefs, and more child preventative health care visits. Fifteen qualitative findings from two studies were aggregated into five categories from which two synthesized findings emerged. Parents and home visitors identified similar components as contributing to their program's success, these being quality of relationships between parents and home visitors with elements being mutual respect, trust and being valued within the partnership. In addition, home visitors identified importance of enabling strategies to develop relationships. They also needed supportive working environments with clinical staff and management.

Conclusion
The current review indicates a positive impact of peer-led home visiting parent support programs, incorporating a framework of partnership between parents and home visitors, on mother-infant dyads. Positive changes in parenting attitudes and beliefs, and increased number of child preventative healthcare visits are supported by the quality of the relationship between parent and home visitor, and home visitors' working environments.

Implications for practice
The essential characteristics of an effective parent support program are strategies for relationship building between parents and home visitors; ongoing staff and home visitor education to enhance communication, collaboration and working in partnership; supervision by team leaders; and continuous quality improvement.

Implications for research
The focus of further research should be on confirmatory studies using an action research methodology and the cost-effectiveness of these models.

Keywords Home visiting parent support; parent support programs; peer-led home visiting; volunteer home visitors

Background

The current review aimed to examine peer-led home visiting parenting support for families with young children. This was undertaken by synthesizing existing quantitative and qualitative evidence on the effectiveness of peer-led home visiting parenting support programs and the experience of both indigenous and non-indigenous families and staff participating in these programs.

The early years in a child's life have a significant impact, positively or negatively, on their future. This is a critical period when interactions between children's genes and environmental experiences influence brain development, particularly in relation to emotions, self-control and stress responses.[1,2] Risk factors such as poverty, emotional and physical neglect, family dysfunction and low community support impede positive long-term developmental trajectories, particularly for Indigenous families who are vulnerable in relation to a number of child's wellbeing and developmental outcomes.[1,2]

Evidence to date suggests that early intervention parent support programs to enhance protective factors and moderate social and economic disadvantage

in this early childhood period, from infancy to when the child enters the formal educational system, have a positive impact on these factors and moderation of disadvantage.[1,2] Designing and implementing child and family health services to meet these needs include the use of home visiting. This is a home-based outreach service by professional, paraprofessional and volunteer staff based on identification of client needs to ensure that every family has access to appropriate support and assistance.[3] Central to the benefits of home visiting is the need to develop, implement and evaluate programs within the broader context of impacting social and cultural factors as these influence parents' acceptance of and engagement with the support.[4]

Home visiting parent support programs are not standardized in relation to intervention delivery,[1] with variations in aspects such as facilitators, resources and the period of support for the parent(s). A significant feature is the use of nurses, paraprofessionals or community volunteers to undertake the home visiting. While community nurse-led home visiting is an established strategy to support parents,[5-7] there is increasing interest in the potential value of peer-led home visiting from parents in local communities,[4,8] the rationale being that shared social characteristics and experiences increase the support worker's ability to empathize with the parents, who in turn are more likely to trust those similar to themselves.[4,8]

There are a various terms for and definitions of a peer support worker. "Home visitor" and "family visitor" are terms used in different countries and programs.[4-9] Peer support workers have no formal educational qualifications in the area of parent support and work in a voluntary or paid capacity to support members of their own community.[4] They may, however, have some training. Those community workers with more training in family support are often referred to as paraprofessional support workers and usually work in a paid capacity.[9]

A research program in North America on the impact of nurse-led home visiting programs on parental care and child health began three decades ago. The Nurse Family Partnership (NFP) program was designed for low-income first-time mothers from the antenatal period to two years postnatally.[1,5-7,10,11] More recently, the NFP program engaged the use of paraprofessional workers to assist the nurses.[9,12] A randomized control trial (RCT)[12]

and a follow-up study[9] two years later investigated the impact over a two-year period on both nurses and paraprofessionals supporting families of various ethnicities who had limited psychological resources. At the end of the first study,[12] the effect of paraprofessional support on maternal and child health outcomes was only half that of nurses. However, at the end of four years, the paraprofessionals had a greater effect on some of the mothers' outcomes than the nurses when compared to the controls, for example, mental health scores, but not on the children's outcomes.[9]

The Healthy Tomorrows for Denver program provided early intervention home visiting paraprofessional and nurse-led support for low socio-economic parents with children from newborn to age of five years, with research evaluation data collected one year after referral. There were no significant statistical differences in results of home visiting support between nurses and paraprofessionals.[13] However, none of the above studies[5-7,9,12,13] took into account qualitative research methods where the experiences of families participating in peer-led parenting support programs could be explored nor did they address indigenous populations.

In a strategy to provide empathic meaningful support for parents, local community volunteer and remunerated peer-led home visiting has been undertaken in various communities in England and Australia. The Community Mothers Program is one of the earlier documented community-based volunteer parent peer support projects, commencing in Dublin, Ireland and extended in later years to Bristol, England. A significant aspect of this home visiting program was the use of non-professional mothers from a low socio-economic area to support first-time mothers from the same community.[14-16] The peer support workers were able to work in partnership alongside parents and facilitate capacity building and empowering strategies to encourage maternal self-esteem and self-confidence in child rearing. Volunteer peers were able to spend more time with parents in a supportive, relaxed and informal environment, as compared to a professional community nurse, who tends to provide a specific service.[14-16] Strategies included promotion of parents' potential through praise and encouragement for their parenting activities rather than advice giving and direction. Parents were encouraged to stimulate their children through activities such as

reading, encouraging breastfeeding and praising their children as well as focusing on child safety. The program used illustrated health promotion sequences to trigger peer-parent discussions on healthy and developmentally appropriate coping strategies for child-rearing challenges.[17]

The Family by Family program in South Australia links families seeking to make positive changes to their parenting to volunteer peer support workers from local families who have successfully transitioned though their own difficulties, with assistance lasting 10, 20 or 30 weeks. A mixed method evaluation highlighted the necessity for responsive programs that adapt to varying circumstances and allowing families to create their own change.[18]

Recent studies and reviews in Western Australia[4,19,20] have identified the need for improved, innovative ways of providing parent support and child health service delivery for indigenous families, including home visiting. To strengthen culturally meaningful child and family health services provided by child health nurses, peer-led support for indigenous families delivered as home visiting programs is considered important as local parents working as peers are cognizant of the lived experiences of these families in their immediate geographical area, along with contemporary psychosocial impacts. Given the vital importance of early childhood development, it is timely to undertake a systematic evaluation of peer-led home programs to review their effectiveness and identify the elements of successful implementation in order to enhance the evidence base, thereby informing further program development.

An initial search of the databases through MEDLINE (Ovid) and CINAHL between May to June 2014 elicited a meta-analysis of quantitative studies[21] that identified characteristics of prenatal and early childhood home visiting programs that strongly predicted outcomes. As few studies were located, the focus was on program content with only a very brief reference to non-professional home visitors. No systematic reviews (SRs) specifically reviewing quantitative and qualitative data for peer-led home visiting parenting support programs for indigenous or non-indigenous families were identified.

The objectives, inclusion criteria and methods of analysis for this review were specified in advance and documented in a protocol.[22] The SR deviates from the *a priori* protocol[22] in three ways. First, the main objective and intent of the SR was to explore the experiences of the participants. While a sub-objective of the review was also to explore "meaning", which highlights the attraction and significance of the experiences to families and support workers,[19] more complete consideration and understanding of the topic during the conduct of the review led to the determination by the review authors that exploration of "meaning" was beyond the scope of the review. Second, while the intent in the protocol[22] was to explore the experiences of families, from the data it became clear that the experiences of the support workers were integral to a comprehensive approach to peer-led parent support. The third area of difference from the protocol[22] is an addition to the inclusion criteria of the category "supervisor of support workers". The data supported this inclusion, emphasizing the supervisors' influence on peer support workers' experiences.

Objectives

The questions that led to this review were: what is the effectiveness of peer-led parenting support programs delivered as home visiting programs, what are the experiences of families and support workers participating in these programs, and how can the programs be improved?

The aim of the review was:

- To identify the effectiveness of peer-led parenting support programs delivered as home visiting programs to indigenous and non-indigenous families and the characteristics of successful programs.
- To identify the experiences of families and support workers participating in these parenting support programs delivered as home visiting programs, including the relationships between program participants.

More specifically, the objectives were to identify:

- The types of peer-led home visiting programs that are or have been undertaken.
- The effectiveness of peer-led home visiting parent support programs for families.
- The successful components of peer-led home visiting parent support programs.
- The experiences of families with regard to peer-led home visiting parent support programs.
- The experiences of both peer support workers and their supervisors with regard to peer-led home visiting support programs.

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- The differences between peer-led home visiting programs offered to indigenous and non-indigenous families.

Inclusion criteria
Types of participants
The quantitative and qualitative components of this review considered community-based studies that included:

- Families/parents (including indigenous and non-indigenous) with one or more children aged zero to four years. After four years, children are usually in the formal education system, for example, kindergarten and preschool, and are supported by educational services.[23] Parents may be married, single or in de facto and/or same sex relationships.
- Peer support workers – one or both of the following types of family support worker:
  - Peer support workers have no formal educational qualifications in the area of parent support and work in a voluntary or paid capacity to support members of their own community.[4] They may, however, have some training.
  - Those community workers with more training in family support are often referred to as paraprofessional support workers and usually work in a paid capacity.[9]
- Supervisor of support worker: community-based registered nurses undertaking home visits to support families.

There are a various terms for and definitions of a peer support worker. "Home visitor" and "family visitor" are interchangeable terms used by different countries and programs. In this review, the term "home visitor" was used.

Exclusions: studies that included children older than four years.

Programs delivered as non-home visiting support or in which support was provided by individuals other than peers.

Types of intervention(s)/phenomena of interest
The quantitative component of the review considered studies that evaluated effectiveness of peer-led home visiting parent support programs that used volunteer or paraprofessional workers who had shared similar parenting experiences in the local community to deliver the intervention. There were no requirements regarding minimum duration or frequency of interventions or essential elements or topics that need to be addressed in the interventions.

Comparator: standard care provided by local health and social services to the families in that community.

The qualitative component of this review considered studies that investigated:

- Experiences of peer-led parenting support programs for families who used volunteer or paraprofessional parents who had shared similar parenting experiences in the local community to deliver the intervention
- Experiences of the volunteer or paraprofessional parents delivering the intervention.

Context
The context was rural and urban community-based services involving home visits.

The "home visit" did not necessarily have to take place in the family home. The support sessions could occur in an alternative location chosen by the parent, such as the local park.

Outcomes
The current review considered studies that included but were not confined to the following outcome measures:

Program effectiveness as measured by

- Changes in parental attitudes and beliefs, as measured by the Bavolek's Adult-Adolescent Parenting Inventory (AAPI).
- Improved coping skills with parenting, as measured by the AAPI and client self-reported improved coping skills.
- Increased confidence in parenting, as measured by the AAPI and client self-reported increased confidence in parenting ability.
- Decreased parental stress, for example, client self-reported decrease in parental stress.
- Increased compliance with child health checks/links with primary healthcare services, for example the number of well-infant care and immunization visits.

Participant experience of peer-led parent support programs as assessed through a variety of research methods such as individual and focus group interviews providing qualitative data on:

- Client self-reported satisfaction with peer support.

- Client self-reported satisfaction with home visiting services.
- Self-reported satisfaction of relationships from the perspectives of both clients and home visitors.
- Self-reported satisfaction of relationships from the perspectives of both home visitors and supervisors.
- Any other self-reported experiences that impacted on participants' parenting.

Types of studies

The quantitative component of the review considered both experimental and epidemiological study designs including RCTs, non-randomized controlled trials, quasi-experimental, before and after studies, prospective and retrospective cohort studies, case-control studies and analytical cross-sectional studies for inclusion. Descriptive epidemiological study designs including case series, individual case reports and descriptive cross-sectional studies were also considered.

The qualitative component of the review considered studies that focused on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

As a number of studies were identified, other texts such as expert opinion, discussion papers and position papers were not considered.

Search strategy

The search strategy aimed to find both published and unpublished studies.

A three-step search strategy was utilized in this review. An initial limited search of MEDLINE (Ovid) and CINAHL was undertaken, followed by analysis of the text words contained in the title and abstract and of the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Third, the reference lists of all identified reports and articles were searched for additional studies.

Initial keywords were paraprofessional parent support, peer-led parent support, peer-led home visiting parent support and home visiting parent support. The databases searched included MEDLINE Ovid and CINAHL, Science Direct, Scopus, AIATSIS – Indigenous studies bibliography (Informit: Melbourne, VIC, Australia), ATSI Health – Aboriginal and Torres Strait Islander health bibliography (Informit) and Australian Indigenous

Health*InfoNet*. The search for unpublished studies included Gray Literature Network Service, Australian National Library, WorldCat, Conference Papers Index through ProQuest and Google.

For details of specific search strategies, see Appendix I.

Methods of the review

All studies identified during the database search were screened for relevance to the review based on the information provided in the title, abstract and descriptor terms. A full report was retrieved for all studies that met the eligibility criteria.

Only studies published in the English language were considered for inclusion in this review as no translation services were available. No authors of primary studies needed to be contacted for missing information or to clarify unclear data. This screening was undertaken between May 24, 2014 and June 4, 2014, considering studies from 2000–2014 as the year 2000 was the time from which volunteer or paraprofessional visiting began to emerge on a substantial basis in the literature. Home visiting peer support is a relatively new intervention, with most previous studies being related to professional home visiting support. As the search was conducted over 12 months ago, additional searches were undertaken in November 2015 and March 2016, with no further relevant studies identified.

Studies identified from the reference list searches were assessed for relevance based on the study title and abstract.

Assessment of methodological quality

Quantitative papers selected for retrieval were assessed by two independent reviewers, with the assistance of a third reviewer, for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) (Appendix II). Qualitative papers selected for retrieval were similarly assessed for methodological validity prior to inclusion in the review using the standardized critical appraisal instrument from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix II). To facilitate inter-rater reliability, the reviewers came to an agreement on aspects of appraisal criteria

wording needing clarification or interpretation. For the second criterion (is there congruity between the research methodology and the research question or objectives?), it was agreed that the term "method-ology" would incorporate study designs congruent with the interpretive paradigm. The reviewers also discussed the questions in each of the critical appraisal checklists to identify those components considered essential for a study to be included in the SR. For RCT's questions 1, 5-10 were selected as were questions 2-4, 6, 8, 9 for descriptive/case series. The questions in the JBI-QARI checklist for inter-pretive and critical research selected were 1-5 and 8-10 (Appendices II).[24]

Data extraction

Quantitative data were independently extracted from papers included in the review using the stand-ardized data extraction tool from JBI-MAStARI (Appendix III). Data extracted included specific details about study setting, study method, partici-pant details, intervention treatment, intervention control, outcome measures, study results and author conclusions (Appendix V).

Qualitative data were independently extracted from papers included in the review using the stand-ardized data extraction tool from JBI-QARI (Appendix III). The data included specific details about study context, study populations, study methods, study interventions and findings of signifi-cance to the review question and specific objectives (Appendix V).

There were no disagreements between the re-viewers that needed to be resolved through discussion.

Data analysis and synthesis

As there were no comparable RCTs identified, the quantitative data could not be pooled. The two studies differed considerably in terms of partici-pants, interventions and outcome measures. As meta-analysis is only indicated when studies are homogeneous in relation to participants, interven-tions and outcome measures, the extracted data were developed into a narrative summary.[25]

The qualitative data were synthesized. This involved synthesis of qualitative findings to create a set of statements representing data aggregation. The findings were collated (Level 1 findings) and were categorized based on similarity of meaning

(Level 2 findings). The Level 2 findings were syn-thesized, and synthesized findings generated (Level 3 findings). These will be foundational for evidence-based practice recommendations. The Level 3 findings were then assessed using the JBI levels of credibility:

- Unequivocal – the findings are not open to chal-lenge and are directly observed from textual data in the studies.
- Credible – the findings can be logically inferred from the data, but could be challenged.
- Unsupported – the findings are not supported by the data.[26]

Two primary reviewers collaboratively examined all extracted findings and grouped these into draft categories. The draft categories were linked to their associated findings and were reviewed, discussed and clarified. Central to the grouping of findings into categories was affiliation in relation to terms of meaning. The synthesized findings were drafted by the primary author, following which they were sent to the second reviewer for review, clarification and validation.

Review results
Description of studies
The initial database search resulted in a total of 401 records being identified. Following removal of 33 duplicates, there were 386 abstracts screened against keywords resulting in the exclusion of 376 records, with the keywords being parent* program; peer support; home visit*; parent* support. If any key-words did not appear in the abstract, they were not included. If there were any queries by reviewers, full texts were obtained. The full-text articles for the remaining 10 records were retrieved and assessed against the inclusion criteria. Three of the studies did not meet the inclusion criteria (Appendix IV) and three of the studies did not meet the criteria of methodological quality (Appendix II), leaving four studies (two quantitative and two qualitative) to be included in the SR (Figure 1). The four included studies (Appendix V) were published over a four-year period (2003-2007). See Appendix V for details of included studies.

Location
Both quantitative studies[28,29] were conducted in major cities in the United States of America – Baltimore and Washington, DC, respectively.[29] The
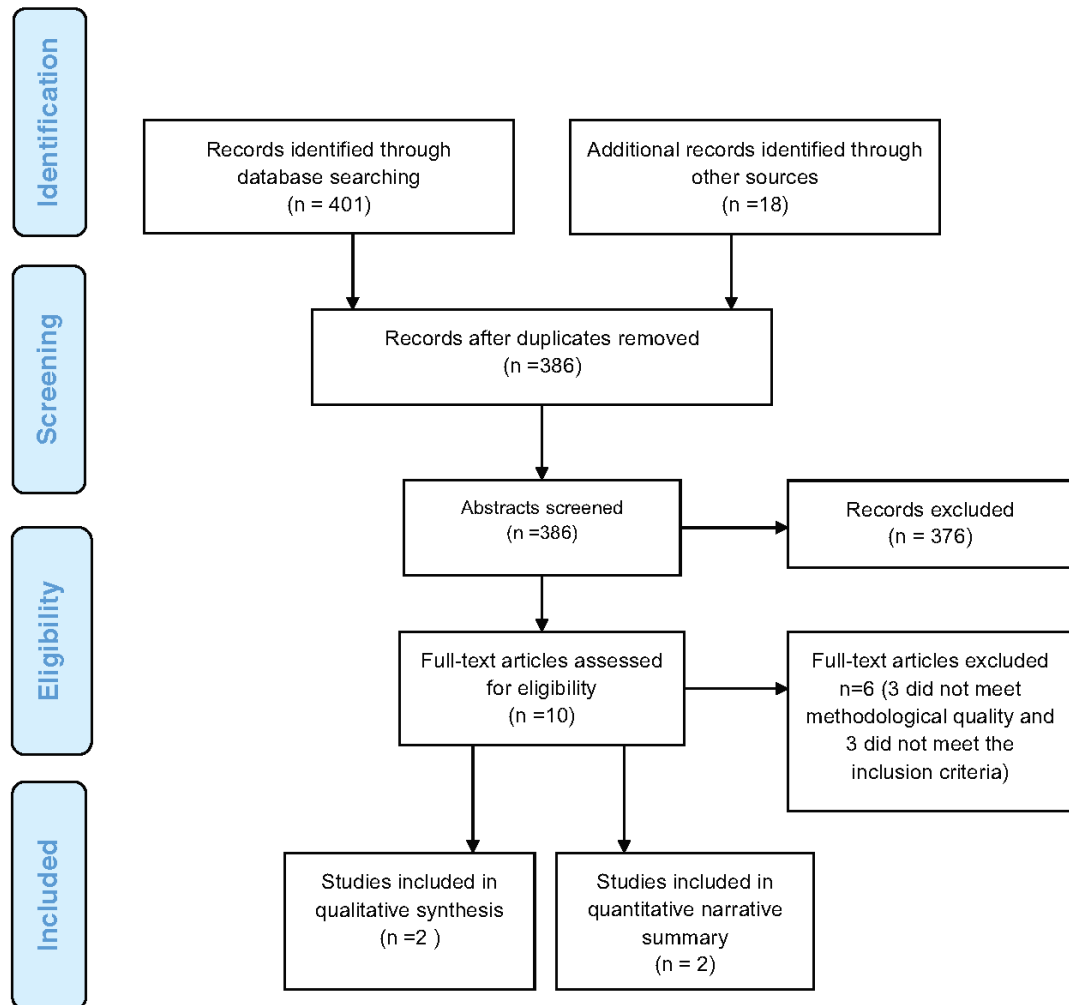
Figure 1: Flowchart of the study selection process[27]

two qualitative studies[30,31] were conducted in Canada, one working with at-risk mothers within rural and urban areas in the province of Manitoba[30] with the second targeting at-risk families in a non-specified location within the province of Manitoba.[31]

Participants
All programs within this SR were targeted toward at-risk mothers, with participation being voluntary.

The study by Jack *et al.*[31] recruited participants (with no identified age range) during 2001-2012, with data collection and analysis occurring simultaneously. In 2002, Heaman *et al.*[30] enlisted participants with a mean age of 24.7 years into the BabyFirst program with data collection undertaken over a five-month period from October 2003 to February 2004. The randomized control study undertaken by El-Mohandes *et al.*[29] recruited participants between April 1995 to April 1997 for

a year-long intervention. The mean age of the mothers was 24.8 years. Barnet *et al.*[28] recruited participants for an RCT between February 2001 and January 2003 for an engagement of two years. This study focused on adolescent mothers with a mean age of 16.9 years.

One quantitative[28] and one qualitative[30] study identified parent support by peer-led home visitors working alone, with the remaining quantitative[29] and qualitative[31] studies documenting a partnership approach for home visiting between the home visitors and community nurses. In all program implementation, the home visitors were supported by supervisory community nurses.[28-31]

The number of mother and child dyads enrolled in the four studies totaled 410 with the majority of the participants ($n = 286$) contributed by one of the RCTs.[29] The two quantitative studies collected detailed data on maternal characteristics including marital status, education, socio-economic status, reproductive history, abuse and violence exposure and substance use. There were some commonalities between the participants in these two studies, for example, very high percentage of African-American mothers (91% and 98.6%) and the majority receiving Medicaid health insurance (77% and 79%). In other areas, there were differences in several characteristics due, at least in part, to the age difference between the two samples. For example, with respect to substance use in the adolescent study[28] (mean age of 16.9 years), on entry to the program, 10% reported smoking compared to 28% in the older age group (mean of 25 years).[29] Similar differences were noted in alcohol use (5% compared to 20%) and illicit drugs (5% compared to 13%). In the adolescent group, 13% had had a prior pregnancy, while the average number of children in the study with older participants was 2.9 children.

Only one of the qualitative studies[30] provided demographic data on the families involved. Of the 20 participants, 45% were married or in common law relationships. The mean length of education was 12 years, and the majority (65%) reported they were homemakers. Twenty per cent identified themselves as indigenous (either First Nation or Métis). The mean age of the children in the program was 14.7 months.

The current study[30] also included information on the home visitors and their supervising public health nurses. The 14 home visitors were all women with an average age of 39 years who had worked in the support program for a mean of 35 months prior to the study commencing. Four of them identified themselves as of Aboriginal descent. The average age of the supervisors was 46 years. They were very experienced nurses and had worked in public health on average for 14 years and for 56 months in the support program.

Study design

The two RCTs[28,29] used a two-group design. One qualitative study[30] used a descriptive approach describing findings related to relationships between lay home visitors and parents participating in an early childhood home visiting program. The remaining qualitative study employed grounded theory to describe the process of engagement between paraprofessional home visitors and mothers.[31]

Sampling

The RCTs utilized randomized sampling,[28,29] while the qualitative studies[30,31] employed purposeful sampling. The number of participants in the four studies totaled 438: 410 mothers, 14 public health nurses and 14 home visitors. The numbers in each study ranged from 20 to 286. One RCT[28] focused on pregnant adolescents between 12 and 18 years of age, while the other[29] selected mothers who had had inadequate or no prenatal care.

Intervention

While the "control" intervention used by both quantitative studies was the same – standard health and social services – the home visiting intervention programs varied in several respects. One variation was the number of components included in the intervention. In the study by El-Mohandes *et al.*,[29] the home visits were accompanied by playgroup visits with an associated parent support group and monthly support telephone contact. Barnet *et al.*[28] relied on home visits only. The period of support offered also varied. Barnet *et al.*'s study, having commenced in the third trimester of pregnancy, extended over the first two years of the child's life with biweekly home visits for one year and then monthly visits for the following two years. The other study[29] intervention provided weekly visits until the baby was five months old then two weekly visits to 12 months of age.

For the qualitative studies, the phenomena of interest were the mothers' experiences, beliefs and

expectations in relation to engagement with home visitors[31] and the relationships between study participants, public health nurses and home visitors.[30]

The program content of all four studies was similar. Both quantitative studies employed a standardized curriculum for training home visitors, including instruction on parenting and child care topics aligned with children's ages and developmental stages, modeling of good parenting attitudes in addition to encouragement of parent engagement with community health and social service resources. One study[28] also emphasized adolescent appropriate learning for safer sexual practices, prevention of repeat pregnancies and communication skills for maintaining both parents in the family. The qualitative studies[30,31] promoted positive parenting skills and child engagement, improvement of children's health and development, and linking families with community resources.

Data extraction

Both the qualitative studies[30,31] employed in-depth interviews to obtain data with one study[31] also using client record interviews. The two quantitative studies used different data collecting methods, client record interviews[29] and interviews to obtain responses to validated assessment tools.[28]

Outcomes

Outcome measures employed by Barnet et al.[28] included scores obtained on the Bavolek's AAPI and the Centre for Epidemiologic Studies Depression scale (CES-D). The AAPI measured changes in parenting attitudes and beliefs around aspects of raising children. Four subscales contributed to an overall score: appropriate expectations, empathy, avoidance of physical punishment and avoidance of role reversal. The CES-D was used to measure maternal mental health (score ≥ 21). Program impacts on a variety of other outcomes – contraception use, pregnancy, school completion and linkage with primary care – were measured by means of self-report on follow-up at 12 and 24 months.

El-Mohandes et al.[29] measured the impact of the home visiting support program on the use of preventative healthcare services in the first year of life. The specific measures of interest were the initiation and frequency of well-infant care visits and compliance with scheduled immunization visits. These self-reports were verified against providers' records.

Methodological quality

Of the 10 studies meeting the screening criteria for consideration for inclusion in the review, three were excluded on the basis of methodological quality[15,33,34] (Appendix VI), as they did not meet the essential criteria for inclusion using the JBI-MAStARI and JBI-QARI checklists (Appendix II).

Methodological assessment of the four included quantitative and qualitative studies are detailed in Table 1.

Quantitative studies

Both included quantitative studies[28,29] met seven of the criteria: assignment to treatment groups being truly random (criterion 1), those assessing outcomes

Table 1: Methodological assessment of included studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Quantitative studies – randomized control trials										
Barnet et al.[28]	Y	N/A*	U*	N	Y	Y	Y	Y	Y	Y
El-Mohandes et al.[29]	Y	N/A*	U*	N	Y	Y	Y	Y	Y	Y
Qualitative studies										
Jack et al.[31]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Heaman et al.[30]	Y	Y	Y	Y	Y	N	N	Y	Y	Y

Quantitative: Criteria 1, 5-10 were essential for inclusion. Criteria 2, 3 and 4 were not essential for inclusion. Qualitative: Criteria 1-5, 8-10 were essential for inclusion. Criteria 6 and 7 were not essential for inclusion. U, Unclear.
*N/A, not applicable – not possible to blind recipients for intervention.

being blinded to treatment allocation (criterion 5), control and treatment groups being comparable at entry (criterion 6), groups treated equally other than for the named interventions (criteria 7), outcomes being measured in the same way for all groups (criterion 8), outcomes measured in a reliable way (criterion 9) and use of appropriate statistical data (criterion 10).

The number of participants withdrawing from the quantitative studies were identified and rationale given (criterion 4). However, their outcomes were not described.

The weakest methodological areas for both studies were as to whether participants were blinded to treatment allocation (criterion 2), allocation to treatment groups was concealed from allocators (criterion 3), and were the outcomes of people who withdrew described and included in the analysis (criterion 4). As it was not possible to blind the participants to the intervention, criterion 2 was not applicable to both studies.

Qualitative studies

Both included studies[30,31] met seven of the criteria: congruity between the stated philosophical perspective and research methodology (criterion 1), congruity between methodology and research question or objectives (criterion 2), congruity between the research methodology and methods used to collect data (criterion 3), congruity between research methodology and representation of analysis of data (criterion 4), congruity between research methodology and interpretation of results (criterion 5), ethical approval by an appropriate body (criterion 9) and relationship of conclusions to analysis or interpretation of data (criterion 10).

Methodological weaknesses were identified for both studies. Only one study met the criteria: influence of the researcher on the research and vice versa[31] (criterion 7). Locating the researcher culturally or theoretically was not addressed in either study (criterion 6).

Results
Quantitative studies
As data from the two studies[28,29] could not be pooled nor was a narrative synthesis possible given the differing interventions and outcome measure, a narrative summary of the outcomes of each study has been provided. The outcomes measured

were parenting skills; parental attitudes and beliefs related to parenting; impact of life events; maternal knowledge, skills and behavior; and mental health and compliance with well child care. Each of these outcomes was addressed by only one of the two quantitative studies, with the exception of maternal knowledge and skills which both studies addressed, albeit focusing on different knowledge sets and skills.

Parenting scores
These skills were measured by the Bavolek's AAPI and included confidence and coping skills in parenting. In the first study,[28] 84 participants were randomized to either receive home visits ($n = 44$) or the usual standard social and health services as a control ($n = 40$). The two groups were comparable at the start of the study on most measures except for their parenting scores. The authors stated that they controlled for baseline differences in the follow-up analyses.[28] The intervention group scored higher than the control group (mean score 114.4 versus 108.0, respectively, $P = 0.04$ – higher scores indicating better parenting).

Parent attitudes and beliefs
The first study[28] also used the AAPI to measure the impact of the home visiting program on parental attitudes and beliefs. The program had a positive impact on the participants' parenting attitudes and beliefs. Compared with the control group, participants in the intervention group displayed significantly improved changes over the two follow-up periods of one and two years. Total AAPI scores were higher for the home visiting group. The AAPI scores for the home visiting cohort were 119.6 at year one and 122.0 at year two, compared with the control group scores of 110.1 at year one and 111.8 at year two. These results indicated a statistically significant benefit of the home visiting program to those parents relative to standard support provided to the control group parents (5.5 points higher, confidence interval [CI] 95% – 0.5-10.4, $P = 0.03$).

Maternal knowledge, skills and behavior
A number of other maternal outcomes were measured by the AAPI in the first study[28]: continuing with schooling, repeat pregnancies, use of hormonal contraception and use of primary healthcare services. The program showed a positive effect on school

continuation with the adjusted odds ratio (AOR) being 3.5 times greater than that of the control group's AOR of 1.0 (CI 95% – 11.8, $P < 0.05$). However, the program had no impact on repeat pregnancies or births, use of hormonal contraception or linkage with primary care.

In the second study,[29] earlier engagement with and use of infant healthcare services was associated with improved maternal knowledge of health issues and life skills in relation to child care. The authors concluded that the association between program intensity and desired outcomes was suggestive of the intervention effectively impacting on maternal health choices and behaviors in addition to enhanced decision making, coping and organizational capabilities.

Mental health

In Barnet et al.'s[28] study, assessment of maternal depression (CES-D score) indicated that the intervention had had no impact at years one and two of the study, despite therapy being provided and recommending further treatment by primary care and mental health services to the affected adolescent mothers. Of note was that there was a significant statistical difference at the end of the second year of the study in the percentage of those participants with a CES-D score of ≥ 21 and with no regular personal doctor when compared to the percentage of the group with a CES-D score of ≥ 21 but with a regular personal doctor ($P < 0.05$, 17 compared to 41%, respectively). The authors suggested several possible explanations for this unexpected outcome.

Compliance with well child care

The second study[29] found that mothers in the intervention group initiated care earlier than did control mothers. A higher percentage of infants in the intervention group, as compared with the control group, had attended at least one well infant outpatient visit by two, four and six weeks of age. However, the difference between the two groups was only statistically significant at six weeks ($P < 0.05$).

A comparison of timing of preventive healthcare visits between the intervention and control groups at four, six, nine and 12 months demonstrated that infants in the intervention group attended more well infant visits than those in the control group. At four months, 78.3% of the intervention infants had attended at least one well infant visit versus 64.1% of control infants ($P < 0.02$). At six months, 68.2% of the intervention infants had attended at least two visits versus 50.6% of control infants ($P = 0.01$). At this point in time, the mean number of visits for infants in the intervention group was 3.14, whereas for infants in the control group the mean was 2.18, a difference that was highly statistically significant ($P < 0.01$), demonstrating greater adherence by mothers to the age-appropriate health supervision schedule for their infants. At nine months, 65.9% of the intervention infants had attended at least three well infant visits as opposed to 44.2% of control infants ($P = 0.004$). By 12 months, there was no longer a significant difference between the groups with 52.7% of participating intervention infants having attended at least four visits as opposed to 41.6% of the control group ($P = 0.09$). However, the mean number of visits was statistically significant with a higher percentage of infants in the intervention group having attended at least three well infant visits (71.4 versus 51.9%, $P < 0.01$) which was a number adequate to deliver the prescribed immunizations.

A comparison of immunization visit attendance highlighted the greater number of immunization visits for the intervention group than for the control group. At four months, the mean number of immunization visits for the intervention group was 1.01, whereas for the control group the mean was 0.77 ($P < 0.05$). At six months, the mean was 1.5 immunization visits for the intervention group and 1.13 for the control ($P < 0.03$), and at nine months the mean was 2.20 immunization visits for the intervention infants and 1.64 for the infants in the control group ($P > 0.01$). At 12 months, the mean number of immunization visits was 2.44 for the intervention group and 2.00 for the control group ($P < 0.09$), which was not statistically significant. At nine months, those mothers who had had 30+ visits from study personnel (classed as the "high intervention" subgroup) were more likely to have followed age-appropriate immunization schedules than those who had received less than 30 visits ("low intervention" subgroup) (OR = 3.63, CI 95% – 1.58-8.33, $P = 0.002$). However by 12 months, there was no

statistical difference between the two groups, although the infants of the low intervention group of mothers had not caught up with the infants in the high intervention group.

Data synthesis: qualitative studies
The accompanying illustrations for each finding are provided in Appendix VII.

Meta-synthesis of parent and home visitor findings
Meta-synthesis of parent and home visitor findings included in the review generated two synthesized findings. These were derived from 15 study findings that were aggregated into five categories.

Parent findings
Synthesized finding 1
A number of factors influence a parent's engagement with the home visitor, including trust/lack of

trust and perception of equality and partnership. Those who do engage employ strategies to limit the family's vulnerability.

This synthesized finding was derived from two categories and six findings (Table 2).

Single supported findings
There were also two single supported findings that related to engagement with the home visitor: difficulties in working with a new home visitor and flexibility in working with another home visitor. As these could not be combined with any other like finding, they did not contribute to a category and consequently nor to a synthesized finding. These findings have been included to complete the reporting of the extracted supported data.

Some parents reported that changing home visitors was difficult but not problematic. Others expressed considerable concern about having to

Table 2: Synthesized finding 1

Findings	Category	Synthesized finding
Central to creating a supportive relationship was developing trust. (U) As trust in the HV increased, the mother's sense of vulnerability decreased and she was more willing to take a risk and discuss personal, sensitive issues. (U) Mothers who did not trust the HV…many were hesitant because they were fearful…a telephone call to the child welfare agency. (U)	Trust/lack of trust	A number of factors influence a parent's engagement with the home visitor, including perceived risks of participating in the home visiting program, fear, trust/lack of trust and perception of equality and partnership. Those who do engage employ strategies to limit the family's vulnerability.
Seeking mutuality is the third phase of limiting family vulnerability: -positive effects of a respectful and non-judgemental approach from the HV. (U) -lack of partnership and collaboration leading to a lack of mutuality, cooperation and positive relationships. (U) Mothers placed a high priority on collaborating with the HV to define common goals for home visits. More common for HV …not to provide this. (U)	Perception of equality and partnership	

end their relationship with and change their visitor. Willingness to adjust to another home visitor if necessary was the second single supported finding which relates to the mothers' flexibility in working with a new home visitor.

These supported findings highlight that some parents were concerned about and may experience difficulty in disengaging with home visitors, while others demonstrated readiness to be flexible when engaging and working with a new home visitor. Parents disengaging and re-engaging with home visitors demonstrated a range of coping styles.

Summary

Parental self-identified effectiveness was highlighted as being the development of trust through supportive relationships with their home visitors. This was impacted by their ability to disengage and re-engage with different home visitors when moving to new geographical areas, emphasizing the influence of their individual coping styles.

The experiences of parents in relation to the programs influenced the meaning they placed on them. Lack of a communicative partnership approach by home visitors and not following through with what was expected of them led to a sense of fear, reduced trust, reduced perception of equality, feelings of increased vulnerability and lessening of parent cooperation and collaboration. A parent's need for respectful, non-judgmental support, guidance and information influenced their decision to participate in a program, following which they employed various strategies to safeguard the integrity of their family including overcoming fear and pretending acquiescence.

Positive experiences of trust with home visitors enabled parents to freely discuss personal sensitive issues, finding they had feelings of mutuality and respect. Considerable concern was expressed by some parents when there was a need to change home visitors, but those better able to cope with change were able to accept and adapt to the new relationship.

Home visitor findings

Meta-synthesis of home visitor findings included in the review generated one synthesized finding. This was derived from nine study findings that were aggregated into three categories.

Synthesized finding 2

Home visitors identify the importance of strategies for establishing, maintaining and terminating relationships with parents. Being authentic, listening to parents, confirming their needs and parenting abilities contribute to developing and maintaining positive, trusting relationships with parents. Maintaining professional boundaries are important but pose challenges for home visitors who work with parents in everyday parenting activities. Terminating relationships are most optimally achieved through long-term planning. However, there can be negative impacts in terms of disruption of trust and continuity of care for families when the home visitor is reassigned.

This synthesized finding was derived from three categories and nine findings (Table 3).

Single supported findings

There were also four single supported findings relating to mutual respect, trust, valuing of contribution and lack of acknowledgement. As these could not be combined with any other like finding, they did not contribute to a category and consequently nor to a synthesized finding. These findings have been included to complete the reporting of the extracted supported data.

Two central components that home visitors in particular talked about in establishing and maintaining relationships were showing respect and being shown respect, that is, mutual respect. The second single supported finding was that most home visitors considered the supervisory relationship with the public health nurses in a positive light and valued the nurses' input and guidance, particularly when they detected problems and crises with their families. This relates to the valuing of the home visitors' contribution and contrasts with the third finding that articulated the lack of acknowledgement of their contribution.

Summary

The ability to establish positive relationships between home visitors and parents was viewed as crucial to the success of home visiting programs. Following successful establishment of relationships, it was found that, by working together, the home

Table 3: Synthesized finding 2

Findings	Category	Synthesized finding
Making initial connection – establish own individual relationship with parents. (U) Helping to establish priorities for parents. (U) Being one's self. (U)	Strategies for establishing the relationship	Home visitors identify the importance of strategies for establishing, maintaining and terminating relationships with parents. Being authentic, listening to parents, confirming their needs and parenting abilities contribute to developing and maintaining positive, trusting relationships with parents. Maintaining professional boundaries are important but pose challenges for home visitors who work with parents in everyday parenting activities. Terminating relationships are most optimally achieved through long term planning. However there can be negative impacts in terms of disruption of trust and continuity of care for families when the home visitor is reassigned.
If HVs could establish an initial connection with the parents, they could usually progress with their work. (U) Building mother's self-esteem. Reinforcing parenting ability. HVs were also required to maintain professional boundaries with clients. In many ways, this was more challenging for the HVs than the nurses…whereas HVs' interactions with parents were often day to day activities such as talking about child care and taking the bus together to a parents' group. (U)	Strategies for maintaining the relationship	
HVs considered that terminating relationships with families was best accomplished when there was a planned exit over a number of visits. (U) HVs considered the requirement to terminate their relationship with families when they moved to another area to be problematic…in addition, changing HVs meant severing bonds rather than building consistent, trusting relationships. (U)	Strategies for terminating the relationship	

visitor and parent could make satisfactory progress with the program.

Home visitors had varied experiences with both parents and their supervising public health nurses. Confirming parent experiences, the home visitors identified trust as being central to creating supportive relationships. Aligned with this was proficiency in establishing and maintaining these relationships by demonstrating respect and for this to be reciprocated by parents. While some home visitors acknowledged a positive engagement with mothers, others did not always consider that they were treated with respect or as partners in this relationship.

Maintaining professional boundaries are important but posed challenges for home visitors who work with parents in everyday parenting activities. Home visitor interactions with mothers were often around day-to-day activities in relation to themselves and their children, with many mothers wanting the home visitor as a friend. Substantiating parent experiences, home visitors expressed concern relating to difficulties with the disengagement of families from the program due to their relocation to other geographical areas.

The home visitors' sense of self-worth in supporting families was important along with trust and respect between themselves and the supervising public health nurses which either encouraged or inhibited their feelings of being an equal program team member. Home visitors identified the essential elements of this relationship as being mutual respect, trust and the perception and valuing of partnership within the home visiting program. However, these essential elements were not demonstrated in the working relationship. Most home visitors valued the contribution of their supervisory public health nurse, particularly with assistance of parents during periods of family crisis or with difficult problems. However, for some, a lack of acknowledgement from their supervisor contributed to feelings of frustration.

Discussion

The objective of this SR was to synthesize the existing quantitative and qualitative evidence on the effectiveness of peer-led parenting support programs delivered as home visiting programs and the experience of both indigenous and non-indigenous families participating in these programs. Although one study[30] included indigenous participants, there was no subgroup of findings obtained. Therefore no reporting could be undertaken.

Following a comprehensive literature search and critical appraisal, two quantitative[28,29] and two qualitative[30,31] studies of peer-led home visiting programs were assessed as eligible for inclusion in this SR. All four studies were conducted in North America – two in Canada[30,31] and two in the United States of America.[28,29] The following discussion will compare synthesized findings from these studies with that of related published evidence.

Components of successful programs

Peer-led home visiting has been identified as an innovative, parent support strategy for indigenous and non-indigenous families which has the potential to enhance parenting skills and minimize risks of early disadvantage.[4,8,16] This SR has investigated a range of peer-led home visiting programs along with the successful components influencing their effectiveness and the experiences of the families, peer support workers and their home visitor supervisors. The included studies related to programs delivered to vulnerable parents in rural and urban settings, focusing on the broad family social and cultural contexts.[28-31] No study investigated peer support for indigenous families or had an aim of predictive outcomes in their study design.

The programs' psychosocial and psychocultural approaches for families assisted facilitation of relevant and sustainable parent support.[4,14,15] In the qualitative studies,[30,31] both parents and home visitors recognized similar components which they identified as contributing to their program's success. The quality of relationships between parents and home visitors was paramount, with the essential elements being mutual respect, trust and being valued within the partnership. Home visitors more specifically identified the importance of enabling strategies to develop the relationships; being authentic, listening to parents, confirming their needs and parenting abilities, maintaining professional boundaries and long-term planning for terminating relationships. In addition, home visitors regarded the valuing of their contribution to the home visiting process by their supervisory public health nurse as being a successful contributory factor. Implementation of these components facilitated

positive engagement and ongoing relationships between parents and home visitors, enabling parents to feel supported in their parenting journey, similar to the affiliation between home visitors and supervising public health nurses.

A sense of self-worth was vital for both parents and home visitors, with proficiency in maintaining reciprocal respect underpinning relationships. However, failure to recognize the importance of these components by all participants, including supervisory public health nurses, can lead to challenges to program effectiveness which has been a similar feature in other indigenous and non-indigenous peer-led parent support activities.[4,8,16]

The quantitative studies[28,29] identified statistically significant results following program implementation for parenting attitudes and beliefs,[28] initiation of well care visits for infants and likelihood of completion of immunization schedules.[29] Comparing the relationship of these findings with those of a meta-analysis of home visiting programs,[21] mean effect sizes from the meta-analysis were significant and positive for three of the six outcome domains, these being maternal life course outcomes, child cognitive outcomes and parent behaviors and skills, with no consistent pattern of effective program components being identified across all outcome domains. Similar to the SR studies,[28,29] research design characteristics in the meta-analysis[21] were not predictive of effect sizes. In addition, the meta-analysis did not discuss any components previously identified as contributing to program success.[30,31]

Children's outcomes

There was no general consensus on children's health and developmental outcomes. Following peer home visiting program implementation with short specialist-led developmental playgroups, El-Mohandes *et al.*[29] demonstrated statistically significant results for children's health through initiation of well care visits for infants and likelihood of completion of immunization schedules, but no significant difference for linkage with primary care services. Randomized controlled trials and follow-up studies[9,12] for a home visiting program utilizing a partnership between community nurses and home visitors identified smaller child health effect sizes for the paraprofessionals at 12 months and four years. A similar professional and home visitor partnership[13] demonstrated no significant statistical

differences in relation to child outcomes. In contrast, a peer-led program[15] with no accompanying community nurse documented sustainable improvements in parenting skills, which has the potential to be extrapolated to enhanced health and developmental outcomes for children.

Maternal outcomes

Differences in program structure and scope of outcomes on maternal lifestyle and parenting attitudes are varied.[28] In a program's partnership approach with home visitors and infant developmental specialists facilitating playgroups,[28] significant mean effect sizes for parenting attitudes and beliefs demonstrated a positive impact on maternal attitudes toward their roles as parents. However, there were no significant impacts on maternal depressive symptoms. The use of the AAPI scale to measure changes in parental attitudes and beliefs could not directly measure maternal coping or parenting ability. In relation to lifestyle elements, the program outcomes demonstrated statistically significant effects for parents remaining in school, a positive statistical trend for birth control and reduction of sexually transmissible diseases through condom use, but no statistically significant differences for hormonal contraception, repeat pregnancy and repeat birth. These findings compare with a home visiting program where home visitors assisted community nurses,[9,12] with the impact of home visitor support on maternal health at 12 months being identified as lower than that of the nurses.[12] However, long-term follow-up at four years demonstrated that home visitors had a greater maternal health effect than the nurses, such as positive mental health outcomes,[9] revealing different aspects and influences of peer-led home visiting support over time. In contrast, a home visitor program without community nurse involvement highlighted sustainable improvements in parenting skills and associated maternal self-esteem over a seven-year period.[15]

Limitations

There are several important limitations to this SR. Only four studies were identified as meeting the study criteria. No studies were found with information on peer-led parenting support programs delivered as home visiting programs for indigenous parents. In addition, there have been no identified randomized controlled trials with large cohorts of

parents whereby greater understanding of the change mechanisms of the peer-led parenting support programs can be evaluated and understood.

Specifically, in the study undertaken by Barnet et al.,[28] the authors acknowledged that direct observation by researchers may have derived different parenting outcomes in comparison to the self-report measures that were used in this study.

Conclusion

A limited number of studies employing qualitative or quantitative designs of several types of peer-led home visiting programs have been undertaken. Overall, the findings indicate positive effects of such programs in respect to the mother-infant dyad. The SR has demonstrated that for peer-led home visitors to be effective in their support of families, they need to establish effective relationships with parents.

The current supportive relationship requires mutual respect, trust and working in partnership with parents. Professional-client boundaries need to be maintained. The peer home visitors also need a supportive working environment through partnership, support and positive supervision from clinical staff and management. Given the positive findings from these initial studies, further development of peer-led home visiting programs and their evaluation is supported to establish best practice models and the cost-effectiveness of these models. The ability of community nurses to develop new or alternate models of practice that include lay peers from a local community who are capable of facilitating positive outcomes for parents is encouraging.

Recommendations

Recommendations for practice and ongoing research are based on JBI Grades of Recommendation and the Feasibility, Appropriateness, Meaningfulness and Effectiveness (FAME) scale[32] (Appendix IX).

Based on the research currently available and given the following indicators, it is recommended that peer-led parenting support programs delivered on a home visiting basis be implemented (Grade A):

- There is evidence of adequate quality to support the use of a peer-led home visiting program for parental support.
- The benefits to the parent-infant dyad are supported by the findings with no significant negative effects being demonstrated.

- The values, preferences and parent experiences have been taken into account (see Appendix IX for detailed linkage of the findings to the FAME scale).

Based on elements of the FAME scale,[23] cost-effectiveness has not been addressed in relation to the use of human and physical resources.

Implications for practice

Results from this SR provide a model of support for parents with young children that is acceptable to parents. The framework for the model is one of partnership between parents and peer home visitors. The essential characteristics of this partnership based, peer-led home visiting program are:

- Community health services considering introducing this model need to ensure inclusion and ongoing evaluation of these features and participant responses,
- It is important that regular reflective practice and education sessions are facilitated for staff, including lay or paraprofessional peers,
- Strategies for the development, maintenance and termination of relationships between peers and parents are crucial to the model's effectiveness,
- A team partnership framework is needed with particular emphasis on collaborative communication and supervision by community nurse team leaders.

Health services need to develop and maintain these programs for both "at risk" and "universal need" population groups through an inclusive program approach for all families with young children which, in turn, requires staff and resource funding.

Provision of enabling strategies to assist parents in identified need, together with designing prevention and health promotion approaches for lower risk families, will enhance short- and long-term benefits to a greater scope of parents and children.

Implications for research

Further research is required to develop and confirm effective models of practice for peer home visitors and community nurses. An action research approach is recommended to facilitate ongoing learnings incorporating the perspectives of parents, peer home visitors, community nurse facilitators and community parenting support agencies. Qualitative research approaches such as community-based

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participatory action research and most improved change technique[4] have the potential to fill knowledge gaps such as concepts of empowerment and capacity building for parents, families and communities in indigenous and other cross-cultural contexts.

Recognizing the gap in the literature related to indigenous family support, it is recommended that a culturally appropriate, participatory action research study be undertaken to assess the feasibility, acceptability and effectiveness of this model in different indigenous communities. There would be similarities in a core framework that could be used in a number of these communities, but each would require the identification of their own unique facilitating features.

Much of the data analysis and discussion focuses on client outcomes and their perceptions of quality of services and relationships. Research is needed on cost-effectiveness of parent support programs, identifying economic advantages and challenges to these early intervention strategies.

Acknowledgements

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Appendix I: Search strategy

Databases searched
Medline (Ovid)
CINAHL
Science Direct
Scopus
AIATSIS
ATSI Health
Australian Indigenous Health*InfoNet*
Other sources:
World Cat
Australian National Library
Conference papers through Proquest
Grey Literature Network service
Google

Search strategies

MEDLINE (Ovid)
Searched on 24/05/14
Results = 145
Additional articles retrieved from reference lists = 3
NOTE: / = MeSH heading; Exp = an exploded MeSH
heading that retrieves relevant narrower terms
- Volunteers/
- Peer Group/
- social support/
- "peer support" OR "paraprofessional home visitor*" OR
  "peer led" OR "trained home visitor*" OR "community-
  based" OR "community based"
- 1 OR 2 OR 3 OR 4
- House Calls/
- Home Nursing/
- "home visit*" OR "home visit* program*"
- 6 OR 7 OR 8
- Education, Nonprofessional/
- Exp Parents/
- Parenting/
- "parenting education" OR parent*
- 10 OR 11 OR 12 OR 13
- 5 AND 9 AND 14 = 416
- Limit to: ("newborn infant (birth to 1 month)" or "infant (1 to
  23 months)" or "preschool child (2 to 5 years)") = 217
- Limit to 2000-2014 = 145
- NOTE: Including the term "family" in the Medline results
  decreased the number of relevant articles received

CINAHL
Searched on 24/05/14
Results = 138
Additional articles retrieved from reference lists = 6
NOTE: MH = major heading
- (MH "Volunteer Workers")
- (MH "Peer Counseling")

- (MH "Health Personnel, Unlicensed")
- "community based" OR "community-based" OR "parapro-
  fessional home visitor*" OR "peer led" OR "peer support"
- 1 OR 2 OR 3 OR 4
- (MH "Home Visits")
- (MH "Home Nursing")
- "house call*" or "home visit*" or "home visit* program*"
- 6 OR 7 OR 8
- (MH "Parents")
- (MH "Parenting Education")
- (MH "Parental Attitudes")
- (MH "Parenting")
- (MH "Family")
- Parent* or famil*
- 10 OR 11 OR 12 OR 13 OR 14 OR 15
- 5 AND 9 AND 16 = 186
- Limited results to years 2000-2014 = 138

NOTE: age limits found to be too restrictive and had
the effect of deleting relevant articles

Science Direct
Searched 30/05/14
Results = 23
Additional articles retrieved from reference lists = 1
"peer-led" OR "peer counsel?ing" OR "peer sup-
port" OR paraprofessional
AND
"home visit*" OR "home nursing" OR "house call"
OR "home visit progr*"
AND
Parent* OR famil* OR "parent* educat*" OR
"parent* attitude*"

Scopus
Searched 30/05/14
Results = 76
Additional articles retrieved from reference lists = 8
"peer-led" OR "peer counsel?ing" OR "peer sup-
port" OR paraprofessional
AND
"home visit*" OR "home nursing" OR "house call"
OR "home visit progr*"
AND
Parent* OR famil* OR "parent* educat*" OR
"parent* attitude*"

Informit (Health, indigenous and Social Sciences)
Includes AIATSIS and ATSI Health

AIATSIS
Searched 05/06/14
Results = 0

"peer-led" OR "peer counsel?ing" OR "peer sup-
port" OR paraprofessional
AND
"home visit*" OR "home nursing" OR "house call"
OR "home visit progr*"
AND
Parent* OR famil* OR "parent* educat*" OR
"parent* attitude*"

ATSI Health
Searched 05/06/14
Results = 0
"peer-led" OR "peer counsel?ing" OR "peer sup-
port" OR paraprofessional
AND
"home visit*" OR "home nursing" OR "house call"
OR "home visit progr*"
AND
Parent* OR famil* OR "parent* educat*" OR
"parent* attitude*"

Australian Indigenous Health*InfoNet*
Searched 05/06/14
Results = 0
The above search strategy from Informit is too
detailed for the Australian Indigenous Health*InfoNet*
Home visit AND family (better results than using
phrase searching for "home visit")

World Cat
Searched 05/06/14
Results = 18
"Home visit*" AND family 1654
"Home visit*" AND "peer-led" 23

"home visit*" AND "peer led" AND (famil* OR
parent*") 18

Australian National Library – Trove (advanced search) - very low precision
Searched 05/06/14
Results = 0
(peer-led OR "peer support" OR paraprofessional)
AND ("home visit*" OR "home nursing" OR visit)
AND (Parent* OR famil*)

Conference Papers Index Through ProQuest
Searched 05/06/14
Results = 0
"peer-led" OR "peer counsel?ing" OR "peer sup-
port" OR paraprofessional
AND
"home visit*" OR "home nursing" OR "house call"
OR "home visit progr*"
AND
Parent* OR famil* OR "parent* educat*" OR
"parent* attitude*"

Grey Literature Network Service
Searched 05/06/14
Results = 0
(peer-led OR "peer support" OR paraprofessional)
AND ("home visit*" OR "home nursing" OR visit)
AND (Parent* OR famil*)

Google
Searched 05/06/14
Results = 1
home visit parent support filetype:pdf

Appendix II: Appraisal instruments
MAStARI appraisal instruments

JBI Critical Appraisal Checklist for Randomised Control / Pseudo-randomised Trial

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Was the assignment to treatment groups truly random?	☐	☐	☐	☐
2. Were participants blinded to treatment allocation?	☐	☐	☐	☐
3. Was allocation to treatment groups concealed from the allocator?	☐	☐	☐	☐
4. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐	☐
5. Were those assessing outcomes blind to the treatment allocation?	☐	☐	☐	☐
6. Were the control and treatment groups comparable at entry?	☐	☐	☐	☐
7. Were groups treated identically other than for the named interventions	☐	☐	☐	☐
8. Were outcomes measured in the same way for all groups?	☐	☐	☐	☐
9. Were outcomes measured in a reliable way?	☐	☐	☐	☐
10. Was appropriate statistical analysis used?	☐	☐	☐	☐
	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info. ☐

Comments (Including reason for exclusion)

_____

_____

_____

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JBI Critical Appraisal Checklist for Descriptive/ Case Series

Reviewer_____Date _____

Author_____Year_____Record Number _____

	Yes	No	Unclear
1. Was study based on a random or pseudo- random sample?			
2. Were the criteria for inclusion in the sample clearly defined?			
3. Were confounding factors identified and strategies to deal with them stated?			
4. Were outcomes assessed using objective criteria?			
5. If comparisons are being made, was there sufficient descriptions of the groups?			
6. Was follow up carried out over a sufficient time period?			
7. Were the outcomes of people who withdrew described and included in the analysis?			
8. Were outcomes measured in a reliable way?			
9. Was appropriate statistical analysis used?			

Overall appraisal: Include ☐   Exclude ☐   Seek further info ☐

Comments (including reasons for exclusion):_____
_____
_____

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QARI appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice-versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐   Include ☐   Exclude ☐   Seek further info. ☐

Comments (Including reason for exclusion)

_____
_____
_____

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Appendix III: Data extraction instruments
MAStARI data extraction instrument

JBI Data Extraction Form for
Experimental / Observational Studies

Reviewer _ Date _

Author _ Year _

Journal _ Record Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Study Method

RCT	☐	Quasi-RCT	☐	Longitudinal	☐
Retrospective	☐	Observational	☐	Other	☐

Participants

Setting

Population

Sample size

Group A _____   Group B _____

Interventions

Intervention A

Intervention B

Authors Conclusions:

Reviewers Conclusions:

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Study results

Dichotomous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

Continuous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

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QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____

Journal_____ Record Number _____

Study Description

Methodology
_____

Method
_____

Phenomena of interest
_____

Setting
_____

Geographical
_____

Cultural
_____

Participants
_____

Data analysis
_____

Authors Conclusions
_____

Comments
_____

Complete   Yes ☐   No ☐

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Findings	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete   Yes ☐   No ☐

58

Appendix IV: Excluded studies and reasons for their exclusion

The following studies were not included as they did not meet the inclusion criteria.
Munns A. Yanan Ngurra-ngu Walalja Halls Creek community families programme. Neonatal Paediatr Child Health Nurs.2010; 13 (1): 18-21.
Reason for exclusion: This paper was a program description and not a research study.

Rautio S. Parents' experiences of early support. Scand J Caring Sci.2013; 27 (4): 927-934.
Reason for exclusion: Intervention. Combined peer and nurse led program. Unable to separate peer-led data.

Tandon D, Parillo K, Jenkins C, Jenkins J, Duggan A. Promotion of service integration among home visiting programs and community coalitions working with low-income, pregnant, and parenting women. Health Promot Pract.2007; 8 (1): 79-87.
Reason for exclusion: Intervention. Study investigates promotion of service, not client outcomes.

The following studies were excluded on the basis of inadequate methodological quality.
Johnson Z, Molloy B, Scallan E, Fitzpatrick P, Rooney B, Keegan T, *et al.* Community mothers program – seven year follow-up of a randomized controlled trial of non-professional intervention in parenting. Public Health Med.2000; 22 (3): 337-342.
Reason for exclusion: Study excluded on quality for randomized control trials, not meeting criteria 1-5, 9-10.

Katz KS, El-Mohandes AA, Johnson DM, Jarrett PM, Rose A, Cober M. Retention of low income mothers in a parenting intervention study. J Community Health.2001; 26 (3): 203-218.
Reason for exclusion: Study investigating retention rates of study participants, not program outcomes. Study excluded on quality for randomized control trials, not meeting criteria 1-5, 8-10.

Katz KS, Jarrett PM, El-Mohandes AA, Schneider S, McNeely-Johnson D, Keily M. Effectiveness of a combined home visiting and group intervention for low income African American mothers: the pride in parenting. Matern Child Health J.2011; 15 (Suppl 1): S75-S84.
Reason for exclusion: Intervention. The intervention not exclusively home visiting. Period of intervention not listed in Exclusions.

Appendix V: Summary of included studies
Quantitative studies

Study details	Study method	Participant details	Intervention A treatment	Intervention B Control	Outcome measures	Study results	Author conclusions
Barnet et al.[28] Baltimore, USA	Randomized control trial (RCT) $n - 84$ 2 groups: Intervention (HV) — 44 Control — 40 Intention-to-treat analysis Setting of intervention Urban community setting	Inclusion criteria Pregnant adolescents 12-18 y. Gestation at least 24 wk. Exclusion criteria Over 18 y. Gestation less than 24 wk. Mean (SD) age of entry to trial 16.9 (1.4) $n - 84$ 1-y follow-up $n - 62$ (74%) 2-y follow-up $n - 63$ (75%) Completion 2 assessments $n - 56$ (67%) Completion one assessment $n - 70$ (83%)	Paraprofessional home visitors – home visits, mentoring and case management 1. Home visiting commenced 3rd trimester. 2. Home visiting biweekly to infant age 1 y; monthly to age 2 y. *Home visitor training* – 2 d and ongoing Standardized curricula – parenting and adolescent	"Usual care" – presumed standard social and health services	Baseline interviews; outcome data at 12 and 24 mo 1. Bavolek's Adult-Adolescent parenting Inventory (AAPI) (parenting attitudes and beliefs) 2. Centre for Epidemiologic Studies Depression (CES-D) scale (Depressive symptoms)	AAPI scores *Baseline* HV group: mean −114.4 (13.8) Control: mean −108.0 (14.5) $P - 0.44$ *12 mo* HV group: mean −119.6 (14.6) Control: mean −110.1 (13.7) $P - 0.03$ *24 mo* HV group: mean −122.0 (17.2) Control: mean −111.8 (14.7) Mean difference in score change HV relative control group − 5.5 (CI 95% 0.5-10.4, $P - 0.03$) Home visited participants completing >75% of sessions scored 8.3 points ($P < 0.005$) higher than controls on AAPI School status In school or graduated at y 2 Adjusted odds ratio HV − 3.5 (CI 95% 1.1-11.8, $P < 0.05$) (71 vs 44%) Use of condoms "always" in last 12 mo Adjusted odds ratio HV group − 3.6 (CI 95% 0.9-14.4, $P - 0.07$) ("statistical trend") There were no statistically significant differences between groups for: Hormonal contraception Repeat pregnancy Repeat birth Depressive symptoms Linkage with primary care	Author's conclusion: Study findings found medium to large effect sizes on parenting outcomes. Program emphasized staff training and monitoring. Program significantly influenced school re-entry and graduation. Program did not reduce use of hormonal contraception, maternal depressive symptoms, reduce repeat pregnancy or achieve coordination with primary care. Coordinated care may require explicit mechanisms to promote communication between the community program and primary care.

(Continued)

Study details	Study method	Participant details	Intervention A treatment	Intervention B Control	Outcome measures	Study results	Author conclusions
El-Mohandes et al.[29] Washington, DC, USA four hospital sites	Randomized control trial (RCT) 2 groups: Intervention (HV) $n - 146$ Control $n - 140$ Intervention – 2 subgroups for analysis: High intensity: > 30 visits Low intensity: <30 visits Interviews with mothers at baseline then at 4, 8 and 12 mo Information verified by providers' records Intention-to-treat analysis	$n - 286$ mother-infant dyads Inclusion criteria Immediate post-partum hospital-ization Inadequate or no prenatal care Residence in Washington DC Exclusion criteria *Infant* Infants delivered < 34 wk Infants weighed <1500 g Infants had con-genital abnormal-ities *Mother* >18 y of age English speaking Not incarcerated No psychiatric history Adoption not planned $n - 286$ Intervention $n - 146$ Control $n - 140$ Groups were comparable - no significant differ-ences Mean age of entry to trial Control $n - 25.2$ Intervention $n - 24.8$ Setting of treat-ment Community set-ting, homes, hos-pital	Standard social ser-vices provided by recruiting hospital plus a year long, multi-component inter-vention: Home visiting: *Infant 0-5 mo* – weekly visits *Infant 5-12 mo* HV – 2 wk Group session: 2 wk – 45 min developmental playgroup followed by 45 min parent support group led by experienced infant developmen-tal specialist at hos-pital site. Telephone support monthly by Pride in Parenting (PIP) family resource specialist for refer-rals 32 home visits and 16 developmental playgroup and parent support group in total. *Home visitor train-ing:* 9 wk – stan-dardized curriculum (PIP)	Standard social services pro-vided by recruiting hospi-tal + telephone support monthly by PIP family resource specialist for referrals	Use of preventative health care services during first 12 mo infant's life: - well-infant care visits immunization visits – frequency, adherence to age appropriate immu-nization schedule and types of immunization.	Main limitation in inter-preting results attrition rates – >25% Initiation of well care for infant by 6 wk Group A: 62.5% Group B: 50% $P - < .05$ Frequency of well visits at 9 mo Group A: 3.5 visits Group B: 2.7 visits $P < 0.001$ Likelihood of immuniz-ation schedule Group A more likely to have completed – by 9 mo OR – 2.2 (CI 95% – 1.09-4.53)	Author's conclusion: Possible to influence health care usage pat-terns on high-risk minority populations through public health interven-tions that are global in their perspective

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(*Continued*)							
Study details	Study method	Participant details	Intervention A treatment	Intervention B Control	Outcome measures	Study results	Author conclusions
						Likelihood of following age-appropriate immunization schedules	Focusing on parental knowledge and beliefs regarding health-related issues and life skills in a self-efficacy model is associated with improved usage of infant health care resources
						Those with 30+ visits from study personnel more likely to have followed schedules – At 9 mo OR – 3.63 (CI 95% – 1.58-8.33)	

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Qualitative studies

Study details	Aims/purpose Phenomenon of interest	Study design and methods	Participants	Authors' conclusions
Heaman *et al.*[30] Manitoba, Canada Community setting	To investigate relationships between participants in a home visiting program	Qualitative descriptive study In-depth semi-structured interviews Data were analyzed manually using content analysis techniques.	24 public health nurses 14 home visitors 20 parents	There appear to be two periods that are particularly critical in establishing positive relationships with parents in a child health home visiting program. The first is the entry phase. The second critical period is in the development of the ongoing relationship. A number of factors identified in this study that positively influenced ongoing relationship work included showing respect, developing trust, supporting families, working in partnership and maintaining appropriate boundaries. The final phase involves termination when the home visitor ends their contact with the family. Forming and sustaining relationships requires adequate support including adequate training, sufficient human resources and administrative support.

(*Continued*)				
Study details	Aims/purpose Phenomenon of interest	Study design and methods	Participants	Authors' conclusions
Jack et al.[31] Ontario, Canada Community setting	Aim: to develop a theory of maternal engagement with public health nurses and home visitors To explore mothers' experiences, beliefs and expectations in relation to engagement with public health nurses and home visitors in a home visiting parent support program.	Grounded theory Data collection: - client record reviews -29 in-depth participant interviews	Purposeful sample of 20 mothers receiving home visits from a public health nurse and home visitors	Home visitors working with families at risk need to identify client fears and perceptions related to home visiting, and to explain the role of public health visitors and home visitors to all family members. Given the importance that mothers place on the development of an interpersonal relationship, it is important for home visitors continually to assess the quality of the relationships with clients.

Appendix VI: Methodological assessment of studies
Methodological assessment – quantitative studies
Included studies
Randomized control trials
Criterion 1, 5-10 are essential for inclusion. Criterion 2, 3 and 4 are not essential for inclusion.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Barnet et al.[28]	Y	N/A*	U*	N	Y	Y	Y	Y	Y	Y
El-Mohandes et al.[29]	Y	N/A*	U*	N	Y	Y	Y	Y	Y	Y

U, unclear.
*N/A – not applicable – not possible to blind recipients for intervention.

Studies excluded on quality
Randomized control trials

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Johnson et al.[15]	N	N	N	N	N	Y	Y	Y	N	N
Katz et al.[33]	N	N	N	N	N	Y	Y	N	N	N
Katz et al.[34]	Y	N	N	N	N	Y	N	Y	Y	Y

Methodological assessment – qualitative studies
Included studies
Criteria 1-5, 8-10 are essential for inclusion. Criteria 6 and 7 are not essential for inclusion.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Jack et al.[31]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Heaman et al.[30]	Y	Y	Y	Y	Y	N	N	Y	Y	Y

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Appendix VII: Study findings with illustrations

U, unequivocal; C, credible; Un, unsupported

Findings – parents

Synthesis 1: Factors influencing engagement with home visitor

Findings and illustrations
Central to creating a supportive relationship was developing trust. (U) *"As soon as I talked with her [home visitor], I knew she was nice and I could actually trust her. A lot of people I won't trust about anything" (P).*[30(p.326)]
As trust in the FV increased, the mother's sense of vulnerability decreased and she was more willing to take a risk and discuss personal, sensitive issues. (U) *[Mothers referred to this as] "opening up' and being able to 'talk from the heart'" (P).*[31(p.186)] *One parent reported that she was not expecting a weekly visit because she knew "how to raise a child," but once the HV came, she found her really "awesome" (P).*[30(p.324)]
Mothers who did not trust the FV … many were hesitant because they were fearful … a telephone call to the child welfare agency. (U) *One parent would "play along with them, so they would leave me alone" (P).*[31(p.187)]
Seeking mutuality is the third phase of limiting family vulnerability: -positive effects of a respectful and non-judgmental approach from the FV (U) *[The FV is] "a mother just like me" (P).*[31(p.187)] -lack of partnership and collaboration leading to a lack of mutuality, cooperation and positive relationships (U) *"I don't want the FV to get in my face about my daughter. Don't tell me what to do, things I am already doing! Instead, start by asking questions to find out what I am doing and why I am doing it" (P).*[31(p.188)] -mothers placed a high priority on collaborating with the HV to define common goals for home visits. More common for HV … not to provide this. (U) *"I don't want the FV to get in my face about my daughter. Don't tell me what to do, things I am already doing! Instead, start by asking questions to find out what I am doing and why I am doing it" (P).*[31(p.188)]

Supported single findings

Findings and illustrations
Some parents reported that changing HVs was difficult but not problematic. Others expressed considerable concern about having to end their relationship with and change their visitor. (U) *"If I move to another area, I can't have my same BabyFirst worker as here … we don't want to get someone else" (P).*[30(p.324)]
Willingness to adjust to another HV if necessary (U) *"I really like your program [BabyFirst] and the HV, but if I had to have someone else, I would accept them" (P).*[30(p.324)]

Findings – home visitors

Synthesis 2 – strategies for establishing, maintaining and terminating the home visitor/parent relationship

Findings and illustrations
Making initial connection - Establish own individual relationship with parents (U) - Helping to establish priorities for parents (U) - Being one's self (U) *"I get assigned a family and my number one thing is to be myself – not to go in with an agenda because I think that puts people off, [I] listen and talk to the family about what their needs are. So then what I would do after that initial visit, I would put together what I feel are the priorities. And then from there on the relationship just naturally occurs". (HV).*[30(p.324)]
If HVs could establish an initial connection with the parents, they could usually progress with their work. (U) *So then what I would do after that initial visit, I would put together what I feel are the priorities. And then from there on the relationship just naturally occurs" (HV).*[30(p.324)]
Building mother's self-esteem (U) *"I work with a mom who had really low self-esteem and doubted her parenting ability and she lives with her father, and he kept telling her, 'oh, you are a bad mother' … But I kept telling her she was a good mother … She was like 'Wow!' And she had lots of difficulty with her father and the baby, but she had another baby and now she says, 'I don't care what he says, I am a good mother'" (HV).*[30(p.325)]
Reinforcing parenting ability (U) *"I work with a mom who had really low self-esteem and doubted her parenting ability and she lives with her father, and he kept telling her, 'oh, you are a bad mother' …. But I kept telling her she was a good mother …. She was like 'Wow!' And she had lots of difficulty with her father and the baby, but she had another baby and now she says, 'I don't care what he says, I am a good mother'" (HV).*[30(p.325)]
HVs were also required to maintain professional boundaries with clients. In many ways, this was more challenging for the HVs than the nurses … whereas HVs interactions with parents were often day-to-day activities such as talking about child care and taking the bus together to a parents' group. (U) *"I really just let the relationship develop, with proper boundaries. Well, the big thing for me is having proper boundaries. Because a lot of families want to have you as their friend. So it is the defining line [boundaries]" (HV).*[30(p.327)]
HVs considered that terminating relationships with families was best accomplished when there was a planned exit over a number of visits (U). *"It's just a weaning process. You wean them off, visits become less. You give them lots of notice" (HV).*[30(p.325)]

HVs considered the requirement to terminate their relationship with families when they moved to another are to be problematic ... in addition, changing HVs meant severing bonds rather than building consistent, trusting relationships (U).
"if my family moves to a different area, I have at times been where I have to give that family up ... I feel that it is the failure of the program [that] every time our families move they get a new BabyFirst home visitor ... I don't feel that this is appropriate because we are not teaching these families about consistency. And I think that is about building a bond. Trust does not come overnight and to keep that trust is important, and that is to continue working with them when they move" *(HV).*[30(p.325)]

Supported single findings

Findings and illustrations
Two central components that HVs in particular talked about in establishing and maintaining relationships were showing respect and being shown respect. (U) *"I think [families] do respect us, they know that we [home visitors] do not make a barrel of money"* *(HV).*[30(p.325)]
Most HVs considered the supervisory relationship with the PHNs in a positive light. They valued the nurse's input and guidance, particularly when they detected problems and crises with their families.(U) *"They [PHN] are all approachable. Nobody makes you feel that 'I am a nurse and you are a HV' ... I think my word is appreciated along with everybody else. I often have people tell me 'I appreciate what you are doing with the family, I am happy they are with you'. I find that communication is very open. And nobody is condescending, and they appreciate me and respect me"* *(HV).*[30(p.325)] *"I love working with my [PHN]. She is a very easy person to talk to ... it is so nice to be able to come in and say, 'Look, this is what's happening' ... when I have really challenging visits – which I do – and I get a little uptight, then she's just a good person to bounce it off and, you know, sort of relieve some of that stress"* *(HV).*[30(p.326-327)] *Lack of acknowledgement of contribution (U)* *"We're [HVs] way at the bottom of that totem pole, and I feel that [HVs] are very much left out of things and we are the ones that are, well, working our ass[sic] off, and these public health nurses are sitting back and taking credit for everything and I just get really, really frustrated"* *(HV).*[30(p.326)]

Appendix VIII: Unsupported study findings
Parents

Unsupported Findings
A mother's decision to participate in a home visiting program is made by weighing the unknown risks and consequences of participating in the visit with her need for social support, guidance and information. (Un)
Those who take the risk of participating use various strategies to protect the integrity of their family and limit their vulnerability. Limiting family vulnerability has three phases, including overcoming fear. (Un)
Overcoming fear was considered important to enable the mother to identify with, and relate to the HV. (Un)

Home visitors

Unsupported Findings
Partnerships in relationships, although valued, were not always perceived as the norm. Some Public Health Nurses did not consider that HVs were always treated as partners. (Un)
Demonstrating respect for each other was a key component of positive relationships and some HVs felt they were not always treated with respect. (Un)
Building trust was highlighted as a fundamental component of effective home visiting (Un)
Following through with what was expected was an important component of building trust between HVs and parents. (Un)
Use of active listening skills (Un)

Appendix IX: JBI Grades of Recommendation and FAME Scale[32]
JBI grades of recommendation

Grade A	A "strong" recommendation for a certain health management strategy where: it is clear that desirable effects outweigh undesirable effects of the strategy; where there is evidence of adequate quality supporting its use; there is a benefit or no impact on resource use, and values, preferences and the patient experience have been taken into account.
Grade B	A "weak" recommendation for a certain health management strategy where: desirable effects appear to outweigh undesirable effects of the strategy, although this is not as clear; where there is evidence supporting its use, although this may not be of high quality; there is a benefit, no impact or minimal impact on resource use, and values, preferences and the patient experience may or may not have been taken into account

The FAME (Feasibility, Appropriateness, Meaningfulness and Effectiveness) scale may help inform the wording and strength of a recommendation.

F – feasibility; specifically:
- What is the cost effectiveness of the practice?
- Is the resource/practice available?
- Is there sufficient experience/levels of competency available?

A – appropriateness; specifically:
- Is it culturally acceptable?
- Is it transferable/applicable to the majority of the population?
- Is it easily adaptable to a variety of circumstances?

M – meaningfulness; specifically:
- Is it associated with positive experiences?
- Is it not associated with negative experiences?

E – effectiveness; specifically:
- Was there a beneficial effect?
- Is it safe? (i.e. is there a lack of harm associated with the practice?)

JBI grades of recommendation and FAME scale for systematic review

FAME scale	Evidence for FAME elements
Feasibility	
(i) What is the cost effectiveness of the practice?	Not addressed in the published papers.[28-31]
(ii) Is the resource/practice available?	peer-led parenting support programs delivered as home visiting programs available in two countries.[28-31]
(iii) Is there sufficient experience/levels of competency available?	In all quantitative[28,29] and qualitative[30,31] papers, there were sufficient levels of experience and competency from peer support staff.[28-31]

(*Continued*)	
FAME scale	**Evidence for FAME elements**
Appropriateness	
(iv) Is it culturally acceptable?	peer-led parenting support programs delivered as home visiting programs were identified by researchers and parents from a range of population and cultural groups as being acceptable.[28-31]
(v) Is it transferrable/applicable to the majority of the population?	peer-led parenting support programs delivered as home visiting programs have been identified in the systematic review as being transferrable and applicable to the majority of the population as evidenced by their use and acceptability in a range of population and ethnic groups. Further research is indicated on the transferability and applicability for Indigenous parent support.[28-31]
(vi) Is it easily adaptable to a variety of circumstances?	peer-led parenting support programs delivered as home visiting programs have been identified in the systematic review as being adaptable to a variety of circumstances as evidenced by their use, perceived and statistically demonstrated effectiveness and acceptability in a range of population and ethnic groups.[28-31] Further research is indicated to adaptability for Indigenous parent support.
Meaningfulness	
(vii) Is it associated with positive experiences?	peer-led parenting support programs delivered as home visiting programs have been associated with positive experiences and outcomes as evidenced by researchers, parents and home visitors from a range of population and cultural groups.[28-31]
(viii) Is it not associated with negative experiences?	Two papers had no associations with negative experiences.[28,29] Qualitative analysis in Jack *et al.*[31] identified trust issues at the commencement of the program between the parent and home visitor which resolved over time and the length of the program. Heaman *et al.*[30] identified a parent who had positive experiences with the program but expressed concern when she moved geographically and was unable to retain her home visitor. This was similar to a home visitor who expressed similar concern about not being able to maintain contact with parents when they moved.
Effectiveness	
(ix) Was there a beneficial effect?	All four papers[28-31] identified beneficial effects as evidenced by researchers, parents and home visitors from a range of population and cultural groups
(x) Is it safe	There was a lack of physical and psychological harm identified with peer-led parenting support programs delivered as home visiting programs in all four papers in this systematic review.[28-31]

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2.4   Rationale and benefits for the current research

The objective of the comprehensive systematic review was to synthesize the existing quantitative and qualitative evidence on the effectiveness of peer-led parenting support programs delivered as home visiting programs and the experience of both Indigenous and non-Indigenous families participating in these programs. The search strategy included international studies published in the English language from the years 2000 to 2015. Critically reviewed evidence identified a range of affirmative impacts resulting from peer-led home visiting parent support programs. No Indigenous peer-led programs for families meeting the inclusion criteria were identified from the literature. Those addressing non-Indigenous contexts were embedded within a partnership framework between parents and peers. The systematic review's database search initially identified 386 abstracts. Following the use of Joanna Briggs Institute standardised critical appraisal tools (JBI, 2014), four studies were available for analysis.

Positive changes included improved parenting attitudes and beliefs and enhanced attendance at community agencies for child preventative health care visits. These changes were augmented by the quality and integrity of the parent and home visitor relationships and the psychosocial settings in which the home visitors worked.

Critical evidenced based characteristics of a peer-led parent support program were highlighted as being the development of effective, trusting relationships between parents and home visitors. Additionally, there were recommendations for quality improvements of home visitors' education and their working environments. Access to credible, acceptable support for parents, peer support workers and community health nurses assists in facilitating effective developmental health for young children, which is a key determinant of health and wellbeing. The emergence of evidence based peer-led models of practice in partnership with community child health nurses is an encouraging step for beneficial parenting outcomes.

Essential elements for effective peer-led parent support were ascertained from the review, and these have the potential to enhance credible development and implementation of peer-led home visiting programs. The review also recommended further research on confirmatory studies using a culturally appropriate Action Research methodology. As there was no evidence addressing the feasibility and

acceptability of peer-led home visiting parent support in Indigenous populations, using culturally appropriate methodologies, this current study was designed to meet this knowledge and practice gap. An understanding of appropriate, acceptable and sustainable evidence based strategies and program delivery for this support, as identified by Aboriginal families and peer support workers, is vital for ongoing physical and psychosocial health and wellbeing of infants and children.

2.5   New literature

The comprehensive systematic review considered published and unpublished national and international quantitative and qualitative studies from the years 2000 to 2015. Following initial data analysis, supplementary searches were undertaken in November 2015, 2016 and July 2017, with no additional published studies or grey literature identified that met the systematic review search criteria. Of note, however, was a recent National Health and Medical Research Council (NHMRC) review of national and international evidence investigating the psychosocial development of infants in the perinatal period and first year of life in Australia. There was a recommendation for the use of professional and trained non-professional workers to offer universal support programs to promote healthy attachment and sensitivity between parents and babies. Five systematic reviews from 1999 to 2013 were cited in the NHMRC review, which explored the effects of home visiting on child outcomes. Within the systematic reviews, home visiting was recognised as being suitable for parents requiring extra support to existing universal programs, however, no peer-led services were identified. For families needing additional support due to issues such as age, social, educational and financial vulnerabilities, home visiting programs facilitated by trained workers were recommended to enhance parenting skills and appropriate child developmental progress. However, in none of the aforementioned reviews was the category of these workers defined, such as whether they could be peer support workers, paraprofessionals or professional personnel (Fisher & Hailes, 2017).

While there is literature supporting the suitability, feasibility, acceptability and effectiveness of peer-led home visiting programs for families in the early years, as evidenced by the systematic review by Munns et al. (2016a), no manuscripts for this model of parent support were identified. There have been some publications since the systematic review in the area of home visiting for both Aboriginal and non-Aboriginal

families, however the focus has been on child protection or spread over a broader age group. Grey literature published in 2016 – 2017 identified papers that centred on community health nurse-led home visiting programs (Sydney Local Health District, 2016; Commonwealth of Australia, Department of the Prime Minister and Cabinet, 2017); Aboriginal family worker home visiting for parents and children across a wide age range needing assistance due to statutory child protection interventions (Junaya Family Development Services, 2016) and programs provided by a variety of child protection workers with the aim of preventing family separation in addition to providing reunification support (AIHW, 2017).

2.6   Conclusion

The essential characteristics of effective peer-led home visiting support programs were highlighted in the comprehensive review, in addition to their suitability, feasibility and acceptability from the perspectives of parents and peer support workers. The findings of the review highlighted the limited qualitative and quantitative evidence relating to peer-led home visiting programs for parents with children in the early years. Outcomes from the four studies identified as meeting the inclusion criteria revealed that this support strategy was acceptable and suitable for vulnerable Indigenous and non-Indigenous parents due to their relevant and sustainable psychosocial and psychocultural approaches (Barnet, Liu, DeVoe, Alperovitz-Bichell, & Duggan, 2007; El-Mohandes et al., 2003; Heaman, Chalmers, Woodgate, & Brown, 2007; Jack, DiCenso, & Lohfield, 2005; Johnson, Howell, & Molloy, 1993; Johnson et al., 2000; Walker, 2010).

The systematic review also called attention to the need to explore how these critical features can be best integrated into culturally appropriate, Aboriginal peer-led home visiting parent support programs, which use research partnership methodologies such as PAR. Provision of empathic and meaningful strategies to strengthen Aboriginal parents in their child rearing journeys can be critically examined through PAR to confirm and adapt the unique features that are collaboratively established. This is of particular importance as there were no studies identifying peer-led home visiting support strategies for Indigenous families. As this research methodology has the flexibility to explore the enabling strategies identified by parents and peer support workers within the comprehensive systematic review across a range of socio-cultural

environments (Peters, Tran, & Adam, 2013), PAR was considered the most appropriate choice for this current study.

The importance of establishing empowering and supportive environments for Aboriginal families and their children is paramount for the development of parents' perceptions of self-efficacy in their roles. Identifying opportunities to assist vulnerable parents to promote their children's lifelong health and wellbeing through peer-led home visiting support needs to be investigated and integrated into program development.

Chapter 3.   Research Methodologies and Method

3.1   Chapter overview

The process of partnership between researchers and individuals, families and communities is integral to developing relevant, acceptable and sustainable approaches to parent support programs. Research methodologies such as PAR, enable regular collaborative interaction, where issues such as historical and intergenerational influences, social determinants of health, cultural norms and kinship expectations can be explored, along with their impacts on families and communities (Baird et al., 2015). The cyclic nature of participants' interactions within PAR allows all their voices to be heard, with every person able to contribute equally on the strengths, challenges and viability of suggested strategies.

This chapter includes three sections. Following the overview (Section One), Section Two presents the manuscript "Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research" that describes the methodology and methods used in this study. Section Three concludes the chapter, highlighting elements central to all participants being able to effectively work in partnership within PAR.

3.2   Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research.

PAPER 3: PEER-LED PARENT SUPPORT PROGRAM DEVELOPMENT

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Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research

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Background: Participatory action research (PAR) is a credible, culturally appropriate methodology that can be used to effect collaborative change within vulnerable populations.
Aim/objective: This PAR study was undertaken in a Western Australian metropolitan setting to develop and evaluate the suitability, feasibility and effectiveness of an Aboriginal peer-led home visiting programme. A secondary aim, addressed in this paper, was to explore and describe research methodology used for the study and provide recommendations for its implementation in other similar situations.
Methods: PAR using action learning sets was employed to develop the parent support programme and data addressing the secondary, methodological aim were collected through focus groups using semi-structured and unstructured interview schedules. Findings were addressed throughout the action research process to enhance the research process.
Results: The themes that emerged from the data and addressed the methodological aim were the need for safe communication processes; supportive engagement processes and supportive organisational processes.
Conclusions: Aboriginal peer support workers (PSWs) and community support agencies identified three important elements central to their capacity to engage and work within the PAR methodology. This research has provided innovative data, highlighting processes and recommendations for child health nurses to engage with the PSWs, parents and community agencies to explore culturally acceptable elements for an empowering methodology for peer-led home visiting support. There is potential for this nursing research to credibly inform policy development for Aboriginal child and family health service delivery, in addition to other vulnerable population groups. Child health nurses/researchers can use these new understandings to work in partnership with Aboriginal communities and families to develop empowering and culturally acceptable strategies for developing Aboriginal parent support for the early years.

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Impact Statement
Child health nurses and Aboriginal communities can collaborate through participatory action research to develop peer-led support for the early years.
Indigenous Australian peoples are people who identify as Aboriginal or Torres Strait Islander. Respectfully, throughout this paper, they will be described as Aboriginal.

Introduction

The confidence of Aboriginal families to provide positive environments for their children's developmental health is increasingly recognised as fundamental to lifelong well-being, educational and employment opportunities. Positive family environments supporting children's growth and development are influenced by a range of psychosocial circumstances (Zubrick et al., 2014), such as mental health and poverty. Therefore, there is a need for evidence-based innovative strategies to address these complex social determinants of health, in particular, informing support that community child health nurses offer to Aboriginal families. Exploring the types of programmes and engagement strategies that these nurses use with parents is vital (Schaffer, Keller, & Reckinger, 2015), as they guide culturally relevant service delivery.

However, use of inappropriate methodologies that cannot take into account life complexities of vulnerable population groups may misrepresent findings and compromise research for social change. Cultural and psychosocial realities for under-served families and communities reflect the need to protect their values, beliefs and worldviews, requiring researchers to refocus from traditional inquiry methods to those which work in partnership with participants to generate relevant and meaningful outcomes (Wilson & Neville, 2009). Positive researcher engagement with Aboriginal families is vital for results to be significant and meaningful for parents and children, and their wider community. Aboriginal people have identified issues of trust, credibility and worth, in relation to both researchers and research, as impacting on outcomes of value to them and Aboriginal society. Additionally, the extent to which they are equal participants with non-Aboriginal researchers is crucial to relevant outcomes, but more understanding is needed in developing their research participation and capacity building (Hunt, 2013).

A recent systematic review identified that effective partnerships between researchers, Aboriginal community members and service providers support Aboriginal people's participation in research, thereby improving quality of the investigations (Snijder, Shakeshaft, Wagemakers, Stephens, & Calabria, 2015). Furthermore, Bainbridge et al. (2015) emphasise the need for non-Aboriginal researchers to engage with Aboriginal people to increase the meaningfulness, applicability and sustainability of research by taking into consideration Aboriginal ethics and values. Incorporating Aboriginal knowledge systems within participatory action research (PAR) can be transformative for participants and researchers (Wright, 2011).

There are global recommendations for increased focus on how research methodology may be used to bring about improvements in Aboriginal health (Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006). International recognition of context on health research priorities and outcomes highlights the importance of appropriate methodologies to explore everyday challenges to Aboriginal health and well-being (Adelson, 2005; Campbell et al., 2007). Investigation into relevant critical paradigms and methodologies within Aboriginal populations is essential.

PAR is a methodology enabling engagement of community participants to ensure research integrity (Hegney & Francis, 2015), which is of particular relevance when investigating Aboriginal health and well-being. Australian Aboriginal peoples are the first inhabitants, with self-identification, community acceptance and ancestry significant to their identity (AHRC, 2017).

Background

An Australian remote area Aboriginal parent support programme utilised PAR with emerging positive outcomes (Munns & Walker, 2015). As there is limited evidence on culturally appropriate assistance for Aboriginal parents and culturally acceptable ways of identifying meaningful evidence in urban child health practice (Munns et al., 2016), a study was commenced in 2013 by a non-Aboriginal child health nurse researcher in an outer metropolitan region of Western Australia (WA).

During 2013, a WA non-government family support agency collaborated with the researcher to work with an Aboriginal urban community to explore new culturally acceptable strategies for engaging with Aboriginal parents and peer support workers (PSWs) to develop home visiting parent support. This low socioeconomic community had well-recognised adverse social determinants of health (ABS, 2011).

Aim

This PAR research study was undertaken in a WA metropolitan setting to develop and evaluate the suitability, feasibility and effectiveness of an Aboriginal peer-led home visiting programme. A secondary aim, addressed in this paper, was to explore and describe the research methodology used for the study and provide recommendations for its implementation in other similar situations.

Ethics approvals were granted by the WA Aboriginal Health Ethics Committee and the University's Human Research Ethics Committee.

Paradigm

PAR sits within a critical social theory paradigm, enabling researchers to better understand and help Aboriginal parents navigate sociocultural, economic and relational life experiences. PAR fosters self-reflection for both researchers and participants on how social position influences parents' everyday perceptions of reality, access to resources and empowering action within their community (Habermas, 1984; McDowell, 2015).

Methodology

In collaboration with study participants and an expert Aboriginal steering group (CREAHW), PAR was identified as the most appropriate methodology for the programme's development. The programme was based on connections between cycles of planning, acting, reflection, learning from their experiences and further action planning (Hegney & Francis, 2015). The researcher collaboratively engaged participants in exploring their own needs and directions (Roberts & Taylor, 2002). Interpreting these explorations and learnings was guided by participants' worldview beliefs and feelings (Denzin & Lincoln, 2011). PAR differs from more traditional research approaches where participants are viewed as passive recipients of research outcomes (Baum, MacDougal, & Smith, 2006), often resulting in non-sustainability of community research. Figure 1 identifies the PAR model underpinning the programme outline and methods.

Flexibility is a key PAR feature, enabling programme modification with outcomes of cumulative learning, capacity building and elements of participant empowerment. Therefore, PAR is a relevant collaborative research approach, especially in Aboriginal communities, being beneficial when focusing on complex inequalities in this marginalised population (Baird et al., 2015). In all research, but particularly in Aboriginal research, a partnership model is fundamental to participants becoming researchers, holding equal power in research teams (Baum et al., 2006), enabling local knowledge to be used to develop realistic, achievable goals and strategies (Turner, 2002).
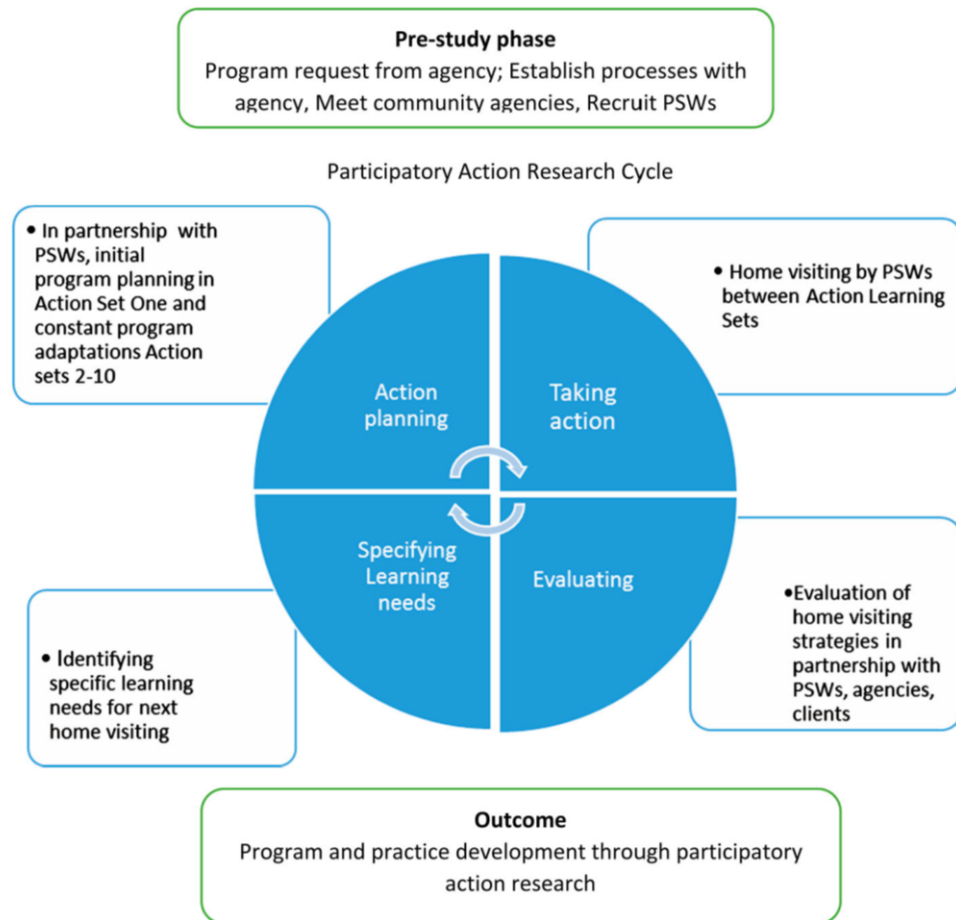
Figure 1.   PAR model (adapted from Munns et al., 2016; Sullivan et al., 2013; Susman & Evered, 1978).

Internationally, PAR is recognised as a culturally sensitive, respectful and appropriate methodology for Indigenous populations (Davis & Reid, 1999; Herbert, 1996). It has been implemented in a variety of Australian regions, providing opportunities for inclusion of stakeholder worldviews and redressing power imbalances between researchers and Aboriginal participants through encouraging active research partnerships, self-determination, capacity building and empowerment (Henry et al., 2002; Pyett, 2002).

Despite the rhetoric about PAR suitability within Aboriginal communities, searches for published evidence relating to use of PAR methodology to implement Aboriginal peer-led, home visiting parent support located only one paper which is from previous research by two of this study's authors (Munns & Walker, 2015). PAR presents a strengths-based research approach, with recognised challenges. Grant, Nelson, and Mitchell (2008) identified five categories of factors impacting on PAR studies, outlined below: building relationships; acknowledging and sharing power; encouraging participation; making change and establishing credible accounts.

Building relationships

Long-term collaborative relationships between researchers and communities are needed to build trust and are dependent upon researcher skills and reflexivity, emotional involvement from all

participants and joint resolutions of role conflicts. Reflexivity necessitates non-Aboriginal researchers to critically evaluate how their values and assumptions impact their perspectives on client self-identified needs, health and well-being strategies (Crane & O'Regan, 2010).

Acknowledging and sharing power

Enhancing genuine processes for meaningful research requires researchers to recognise unequal researcher–participant power relationships and need to relinquish leadership control usually evident in the research team leader role (Gray, Fitch, Davis, & Phillips, 2000; Walker, Schultz & Sonn, 2014).

Encouraging participation

Barriers impacting on engagement processes with community members include: research timeline constraints (Gray et al., 2000); changes in personal or family circumstances of the research team; divided or indifferent interest by participants to the perceived research benefits (Queensland Government, DoC, n.d.); feelings of being overwhelmed or intimidated by community "outsiders" (Gray et al., 2000); and low self-efficacy of non-academic research team members (Rosenthal & Khalil, 2010).

Making change

Potential for conflict exists between researchers and participants on the nature and time taken to achieve change (Grant et al., 2008). Conflicting and unrealistic expectations by researchers for helping people gain some control over their lives within complex disempowering environments can be problematic (Rosenthal & Khalil, 2010).

Establishing credible accounts

Research needs to explore participants' experiences, recognising their co-construction of knowledge that is jointly developed to include shared interpretations. This develops credible and meaningful participant and researcher understandings.

Incorporating these categories within PAR methodology encouraged this non-Aboriginal researcher to engage in culturally reflective practice (Rix, Barclay, & Wilson, 2014; Walker *et al.*, 2014), critically examining the relationship through self-reflection in collaboration with all participants. Structural positioning in relation to historical influences, such as negative impacts of colonial legacies, and contemporary issues, recognised sociocultural and socioeconomic effects from ongoing intergenerational trauma (Dudgeon et al., 2014; Pihama et al., 2014; Redman-MacLaren & Mills, 2015), allowing multifaceted aspects to be explored together.

In this study, a complex web of social determinants of health highlighted the need for engagement with a range of research partners (Baird et al., 2015). Following the partner agency's identification of need for parent support, four steps were collaboratively planned for PAR implementation: development of a plan of critically informed action; acting on implementing the plan; observing effects of critically informed action in the context in which it occurred; and reflection and evaluation on these effects as a basis for further planning and critically informed action. These steps were undertaken through a succession of cycles (Kemmis & McTaggart, 1988, p. 10).

PAR requires effective engagement which is dependent on creating safe "communicative spaces", and maintaining respectful interactions where participants are able to work in equal

partnership (Bevan, 2013). This collaborative approach is supported by the classical theorist Habermas, whose critical social theory examined influential concepts of social action, from which he proposed legitimacy of non-professional understandings and knowledge (Brand, 1990; Habermas, 1984). Physical and conceptual communication spaces are of equal importance. The requirement for a mutually agreeable physical space facilitates feelings of safe discussion while conceptual spaces incorporate types of human encounters that enable or impede open and reciprocal involvement (De Souza, 2009; Healey, White, Eshghi, Reeves, & Light, 2008).

Pursuit of change with Aboriginal communities is enhanced by using PAR methodology to guide critical issues related to programme development, allowing participants to respond to their own identified aspirations in a variety of contexts. As such, the methodology is guided by these multifaceted and changing requirements.

Method

Design

Ten action learning sets (ALSs) were facilitated over a 13-month period in which participants collaboratively developed locally responsive home visiting parent support and capacity building strategies for parents and PSWs (Munns et al., 2016). ALSs are an integral PAR facilitating tool (Bergold & Thomas, 2012; Sullivan, Hegney, & Francis, 2013), providing a formal structure for participants to meet regularly in small learning groups over a fixed programme cycle to collaboratively discuss issues relevant to their workplace realities, undertaking programme strategies between ALSs to address identified issues (Smith & O'Neil, 2003). Positive findings have been reported in relation to peer support with sharing of experiences and identification of topics for discussion (Spurell, 2000). Emotional discomfort related to disclosure, biased opinions, perceptions of participant powerlessness and lack of management support for initiating and maintaining groups impact on successful outcomes, along with the ability of participants to maintain regular attendance (Douglas & Machin, 2004; Lee & Porteous, 2010).

Research population

There were three participant cohorts.

1. Aboriginal PSWs, Programme Coordinator and Education Support Officer; a non-Aboriginal parent support worker. The inclusion criterion was employment in the family support programme, with no exclusion criteria.
2. Aboriginal clients. Inclusion criteria were engagement with PSWs and the presence of one or more children aged 0–4 years. The exclusion criterion was having no children aged 0–4 years.
3. Community agency staff. Inclusion criteria were provision of services either within or to the geographically area to assist Aboriginal families that met the inclusion criterion. The exclusion criterion was not having this purpose.

Data collection

To demonstrate flexibility needed for effective engagement, PAR utilises a non-prescriptive range of quantitative and qualitative data collection methods such as audits of document records, participant observation, semi-structured interviews and focus groups (Hegney & Francis, 2015). ALSs were held four to six weekly, during which separate focus groups were conducted for all

cohorts. PSW focus groups were conducted in every set where the researcher facilitated the participants' reflective practice, informing critical reviews of programme strengths, challenges and interagency collaboration and the researcher's cultural reflexivity. Client and community agency focus groups were planned for sets 1, 4, 7 and 10, relating to programme benefits, challenges, PSW engagement and interagency collaboration. Responses from all cohorts contributed to collaborative planning for the next home visiting implementation cycle.

During the focus groups, qualitative data were collected, through a semi-structured group interview process for PSWs and community agency participants and an unstructured group interview process with clients (Cohen & Crabtree, 2006) (Appendix). These non-prescriptive approaches encouraged participants' ideas to be heard, offering potential for influencing change (Fredericks et al., 2011). The methodology and data collection processes provided opportunities for participants to reflect, present unique Aboriginal perspectives and have direct influence on programme development (Figure 2).

Yarning is an Indigenous cultural form of conversation and was used as a data gathering tool during the unstructured client interview processes (Bessarab, 2012; Bessarab & Ng'andu, 2010). This is a rigorous and culturally safe data collection method and the preferred medium of interaction when Aboriginal people are research partners (Bessarab & Ng'andu, 2010; Geia, Hayes, & Usher, 2013).

Trustworthiness of data

Mechanisms such as peer debriefings, member checks and audit trails were used for credibility, along with acknowledgement of known research limitations (Polit & Beck, 2010). Reflective debriefings were used as member checks at the end of interviews for PSWs and parents.
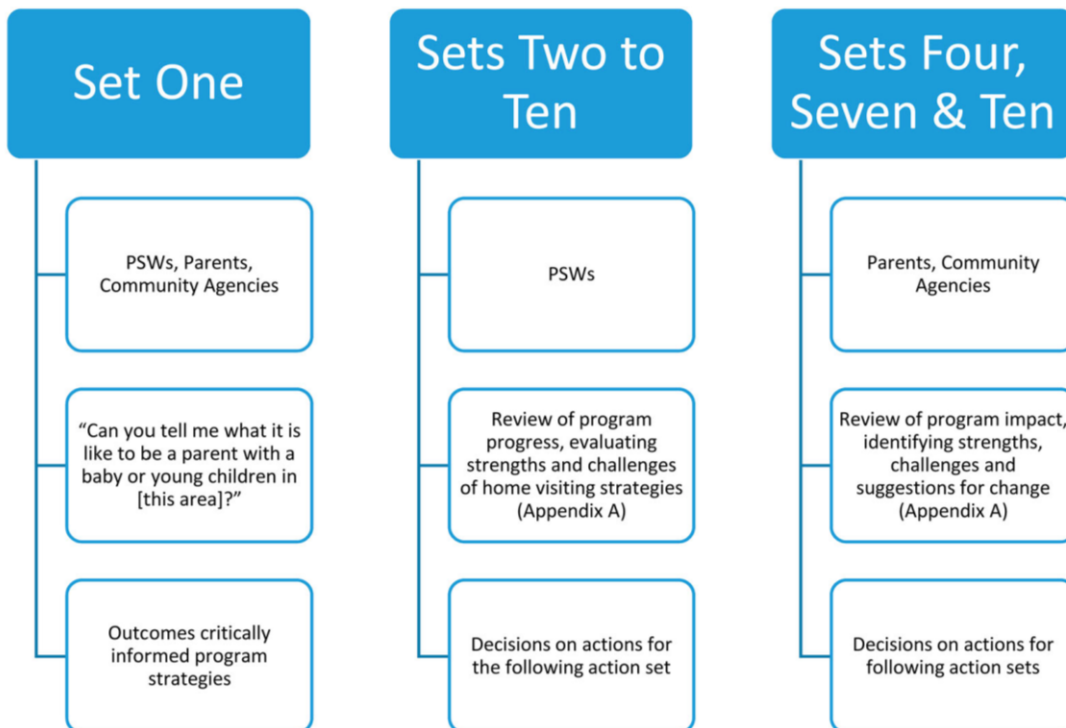

Figure 2.   Focus group interviews in ALSs.

Follow-up contact was problematic due to participant mobility, absence from work and PSW hesitancy in reviewing transcripts (Polit & Beck, 2010).

Stability of research data over time and differing research conditions facilitated dependability, with data checks by academic supervisors. Confirmability was evidenced by data analysis similarities between the researcher and supervisors (Polit & Beck, 2010). The researcher identified potential biases, documenting an audit trail providing transparency to method consistency, raw data, field notes and thematic analyses stages. The extent to which the research findings can be transferred to other settings correlates to research population similarities and alternate populations (Polit & Beck, 2010), with sufficient data enabling research consumers to recognise relevance of findings to other contexts (Lincoln & Guba, 1985).

Data analysis

Trusting, non-judgemental environments within ALSs provided rich data. Data were thematically analysed (Braun & Clarke, 2006), allowing categorisation, clustering and identification of common themes from research responses (Strubert-Speziale & Carpenter, 2003).

Results and discussion
Demographic data

Approximately, 21 study participants were anticipated; 4 Aboriginal PSWs, 1 Aboriginal Project Coordinator, 1 Aboriginal Education Support Officer (for three months), 1 non-Aboriginal parent support worker (for four months), 8–10 client families and 4 informants from community agencies supporting parents in this community. Engaging families for interviews was difficult (Milroy, 2014) with only 2 being able to contribute data, resulting in 14 participants.

Qualitative data

Three research process themes emerged relating to PAR implementation within ALSs: safe communication processes; supportive engagement processes and supportive organisational processes. These are presented with participant exemplars giving voice to their responses.

Safe communication processes ("we can have a bit of a chat")

Safe physical spaces for discussion were identified by all participants, with acceptable emotionally protective conceptual communication spaces being dependent on a range of influences. For PSWs, ALSs were undertaken in relaxed meeting rooms away from their working office. PSWs freely shared information for two to three hours in each of their focus groups, discussing a range of sensitive topics such as domestic violence, alcohol and drug abuse, justice system clients and mental health issues.

> I'll judge what the risk is, whether it's low, medium or high. That'll come down to if it's a domestic violence situation or drugs and alcohol, mental health. (Coordinator)

However, they confidentially acknowledged declining relationships and trust with senior members of the PSW management team which contributed to less discussion and data availability from ALSs seven to ten.

Community agency staff requested interviews at their workplace. They appeared to be relaxed during conversations of one to two hours, enabling safe psychological environments where interviews often extended into confidential personal discussions on their own parenting styles.

Clients requested home interviews. The researcher addressed cultural protocols, demonstrating respect to the family by being introduced as a credible non-Aboriginal researcher by a PSW who also presented a gift such as children's books or healthy breakfast cereal. Following this, visits were undertaken alone.

> It was our gesture of going on that first home visit, it is tricky that introduction. (PSW)

Issues of home visiting safety from partners with domestic violence histories necessitated phone interviews instead of face-to-face discussions.

> It's going to be harder to see her when her partner's out [of jail]. (PSW)

Participants appreciated flexibility of place for focus groups, choosing convenient places for interviews which were then facilitated by the researcher in acceptable, non-threatening and non-judgemental environments. Complexities in Aboriginal families' lives were acknowledged, along with subsequent challenges for PSWs and community agencies in developing support strategies, which were not recognised in other existing programmes.

> What is realistic? [The program] is the only one offering a culturally appropriate service. (Aboriginal community agency worker)

Respecting participants as equal partners in the programme development research was a significant feature, fostering long and informative discourses from PSWs and community agency staff. While parent interviews were short, there were relaxed exchanges of information covering a wide range of personal and community issues, demonstrating a non-judgemental and empathic researcher approach.

> Openness within our team. Support of each other. Voicing ideas and frustrations. Communication best key to success. (Coordinator)

Agreement was reached by the researcher and PSWs that focus group conversations would be respectfully acknowledged and discussed. This facilitated non-judgemental environments where PSWs raised issues, shared and practised home visiting strategies, explored their ideas to enhance the programme and acknowledged challenges without fear of failure.

> It's a good role play situation that you can look at and listen to, we can have a chat about it afterwards, what worked, what didn't work, what they observed and what they heard. (PSW)

Adequate time was required for yarning as a cultural form of conversation. This narrative approach needed gradual facilitation to allow participants to give their distinct perspectives (Bessarab, 2012). Intermittent yarning was utilised by Aboriginal community agency staff and PSWs, indicating relaxed psychological environments.

A partnership approach enabled the researcher to reflect on discussions, recognising participants' complex psychocultural environments. Of note was the ability of community agencies to frame their interview responses through a cultural lens, enabling greater contextual insight into local challenges and strengths for Aboriginal parents.

> Did the parents not get cuddles when they were young? Who brought the parents up? Were they from the Mission? (Aboriginal community agency worker)
> With Aboriginal families, the family relationship is everything. (Aboriginal community agency worker)

These responses highlight parents' adverse experiences from historical Australian Aboriginal policies of forced removal from their families as children (Dudgeon & Hirvonen, 2014). Growing up in government or mission institutions had long-term effects sometimes resulting in poor psychosocial health outcomes (Hertzman, 2013).

The researcher's cultural reflexivity and acknowledgement of PSW's right of ownership of their version of parent issues and adversities appeared to facilitate their acceptance of the researcher and development of an equal partnership approach within the PAR process. This enhanced common understanding, intimacy and confidence within ALSs (Roer-Strier & Sands, 2015), encouraging frank and valued conversations.

> We need somebody to push this forward please, [Researcher], up there, because if it's not happening we have to quit. I'm saying this in front of all the girls. It has to go forward. (PSW)

Communication processes throughout various ALS stages were understanding of participants' physical and psychosocial needs. Supportive facilitating research processes required continuous review and adaptation, with time being an important underpinning factor.

> I think it's just become the normal now that we sit down and we'll talk about it. We just help each other as we go along ... That's why it's going to work. (PSW)

Supportive engagement processes ("it takes time to build relationships")

PAR through ALSs facilitated positive engagement with PSWs and community agencies, with both cohorts willingly participating in focus groups.

> [ALS] It was very, very valuable. (PSW)

There was 75% interview acceptance by community agencies in sets three and four due to prolonged illness and competing work commitments, with 100% at other times. PSWs had intermittent absences through illness and family commitments. Use of yarning and researcher cultural reflexivity furthered participant engagement where their values and options for programme development could be freely acknowledged and explored (Bessarab, 2012). PSWs also identified the value of PAR in enhancing their integrity.

> (the ALSs) ... just to be able to say, "when I was doing my training", gives credibility to what you're doing. (PSW)

Despite positive anecdotal client feedback on the need for support, engagement of families within ALSs was problematic for a range of reasons. Researcher introductions to client families by PSWs were successful on two occasions. These families were available for interviews by the researcher at their homes; however, they only had two interviews each before moving from the area. Other clients were located opportunistically for support by PSWs at their homes, in the family support agency's office or elsewhere in the community, but due to a range of known and unknown factors,

were unavailable for specific introductions or interview times as the researcher did not live or work in this community. As such, flexibility of place was available but not in relation to time.

> There's lots of things going on with families. There's alcohol, drugs, looking after kids, proper housing, single mums, domestic violence, partners in jail. (PSW)
>
> Contact may be very opportunistic or variable due to drugs, alcohol, homelessness. (Community agency worker)

Parents undertaking interviews expressed no difficulty with the PAR approach and were accepting of the researcher.

> (Researcher: Can I call again) Yea, sure. (Parent)

The PAR framework enabled time for PSW reflections on practice, encouragement of skills and open, non-judgemental discussions.

> We all know our strengths and weaknesses and help each other as we go along. (PSW)
>
> How do they continue to engage with families who are constantly putting up barriers to receive help? What strategies can be used? Can we bring this to the next session so we can work together as a team? (Coordinator)

Supportive organisational processes ("given us encouragement")

There was positive organisational support for PSWs and community agencies to participate in PAR ALSs. Both partners scheduled time around client commitments. Due to compromised engagement processes, the researcher experienced difficulties with most attempts to interview clients. Organisational support was seen to enhance the ability of the methodology to engage as many participants as possible to be equal contributors to the development of home visiting peer support development.

> This is really important because to build confidence in parents you have to have confidence yourself. You might know all this stuff but this [ALS discussion] is confirming a lot of things, formalising it. (PSW)

Discussion

All participants viewed PAR with ALSs as providing a culturally acceptable and accessible format from which they could contribute ideas and strategies for peer-led home visiting support. The aim of this paper was to explore and describe the research methodology used for the parent support programme development, and provide recommendations for its implementation in other similar situations.

Participants identified safe communication processes as a key enabling feature of the methodology, where they could explore different approaches for the programme in supportive, non-judgemental environments. Cultural reflexivity was paramount in interviews, facilitating insight into participant parenting perspectives and practices (Aronowitz, Deen, Keene, Schnittker, & Tach, 2015; Redman-MacLaren & Mills, 2015). Relinquishing direct leadership control enhanced continuous respectful interactions, enabling meaningful and beneficial data collection and parent support development (Dawson & Sinwell, 2012; Dudgeon et al., 2014). Of note, was the use of yarning by PSWs, parents and some agency members which facilitated culturally safe

discussion on their values and perspectives on early years support. Yarning is viewed as an empowering process by Aboriginal researchers (Fredericks et al., 2011) where understandings, programme options and reflections can be examined in-depth without prejudice. Relinquishing direct leadership control enhanced continuous respectful interactions, enabling meaningful and beneficial data collection and parent support development (Dawson & Sinwell, 2012; Dudgeon et al., 2014). This enhanced group trust, and accommodated participants' individual identities and impacting social environments (Bessarab, 2012; Ng'andu, 2004). Time was an important functional element of their communication.

Participants identified engagement with each other and the researcher as an important element of the methodology. Along with safe communication environments, regular work time to participate in ALSs was considered significant for fostering engagement, enabling them to reflect on practice, critique strategy strengths and challenges, and formulate further programme development. However, several multilayered complexities contributed to challenging client engagement processes within this research framework which were identified by PSW and community agencies as being homelessness, transience, mental health, family issues and general life chaos, which is well established in the literature (Milroy, 2014; Rosenthal & Khalil, 2010; Zubrick et al., 2014). These social determinants of health also contributed to clients' low self-efficacy and lack of capacity to undertake advance planning for ALS participation.

Additionally, it appeared that PSWs lacked confidence to give encouraging explanations to clients on the value of participating in ALSs. Developmental progress in their support role was influenced by a number of issues relating to being members of a disempowered population and experiencing concerns with PAR methodology, such as negotiating realistic expectations. Feelings of low self-efficacy and hesitancy with communication skills, particularly in not wishing to offend parents, resulted in caution with their parent engagement until they gained more experience and confidence (Grant et al., 2008; Rosenthal & Khalil, 2010). Encouragement to participate in ALSs was always secondary to client issues, with PSWs at times not advocating for parent focus groups due to complexities of immediate family concerns and time required to manage them. This highlighted the need for flexible engagement of PSWs in their support role, over time developing confidence, teamwork and maintaining their focus through practice and peer and researcher support during ALSs.

Variable participant involvement is a common feature of PAR when used with vulnerable groups, potentially influencing establishment of reliable accounts (Grant et al., 2008) and posing challenges for PAR development. Complexities in acquiring consistent research data may never be fully understood by the researcher who, to ensure success, needs to be reflexive to participants' circumstances.

The practical aspect of researcher availability for ad hoc and opportunistic interview opportunities is a question of flexibility of time and place. Use of credible secondary data may assist in developing future strategies, such as information from PSWs who are members of the same community as clients. The ability of PSWs to be equal research partners with skills to interview clients opportunistically is recommended. Their competence for this role requires programmes of educational support which would add to research costs and planning time. However, the ongoing capacity building would be beneficial to PSWs and their community for future programme development relevant to their needs.

Collaborative partnerships developed through this methodology were integral in engaging participants and the researcher in long-term trusting relationships. PAR enabled more time for review of programme strengths, challenges and collaborative strategies than in other research methodologies (Dentith, Measor, & O'Malley, 2012; Rath, 2012). The ability of researchers to recognise and negotiate this issue has the potential to influence PAR integrity in the research

process and quality of outcomes (Roberts & Dick, 2003), thereby positively impacting on development of culturally relevant, acceptable and sustainable PSW strategies and outcomes.

Continuous respectful negotiations between the researcher and participants to facilitate collective approaches to data collection and action were facilitated by this methodology (Dawson & Sinwell, 2012), developing an important emerging long-term element of research reliability and relevance. However, communication and organisational factors such as competing goal setting and lack of trust between group members can negatively influence the process.

Building relationships, encouraging participation and facilitating change in complex psychosocial environments through PAR is a long-term process needing organisational support (Grant et al., 2008; Rosenthal & Khalil, 2010), which was recognised by participants as being fundamental to their participation. The regular participation time given to PSWs and community agency staff enhanced discussions and relationship development, programme review and development of meaningful strategies. PSWs were also made available to assist the researcher with culturally appropriate parent introductions, thereby enhancing trust and quality of data from parent ALSs.

Limitations

With qualitative studies generally having small participant numbers, a potential weakness in the methodological approach can be identified (Mason, 2010). However, qualitative frameworks facilitated the researcher's close association and iteration with participants where issues and self-identified strategies were comprehensively explored (Crouch & McKenzie, 2006).

Participants did not often comment on PAR methodology, but indicated acceptance with long interviews undertaken. Although this research was undertaken in a specific Australian urban Aboriginal community, the methodological data can inform use of PAR to facilitate programme development in a range of other cultural and geographical settings.

While significant engagement issues with Aboriginal clients reduced data that may have further informed programme improvements, the value of the two parent in-depth, descriptive responses and usefulness of data from the Aboriginal PSWs living in the same community as the clients, and being parents themselves, gives credence to their data analysis being aligned with parent responses.

Impact statement

Community child health nurses, Aboriginal PSWs, parents and their community can work in partnership through PAR to explore and develop culturally relevant parent support programmes in the early years. The three elements integral to engaging and working within this research methodology have been identified as: safe communication processes; supportive engagement processes and supportive organisational processes.

Conclusion

There is little evidence on relevant research methodologies for early years support within Aboriginal populations. It is therefore vital that views of Aboriginal PSWs, parents and community agencies are heard to advance the use of PAR for development and implementation of culturally acceptable peer-led home visiting support. They have identified three important elements central to their capacity to engage and work within PAR: safe communication processes; supportive engagement processes and supportive organisational processes, recognising both enabling and challenging influences for research development. Significantly, adverse social determinants of health were recognised as impacting on participation through reducing participants' control over life events.

Creating environments for engaging programme participants and identifying research data is challenging for researchers working with vulnerable populations. This research has provided innovative data, highlighting processes and recommendations for child health nurses to engage with Aboriginal PSWs, parents and community agencies to collaboratively define and explore culturally acceptable elements for an empowering methodology for peer-led home visiting support. There is potential for this nursing research to credibly inform policy development for Aboriginal child and family health service delivery, in addition to other vulnerable population groups, promoting culturally responsive and effective community health care.

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Appendix

Interview questions

Peer support workers

1. Unstructured question: Tell me about the program and how you see it is going?
2. Semi-structured questions:
   - Think about your visits   what is working well? How are these visits encouraging and supporting parents?
   - What is not working well? Why do you think this is happening?
   - How could you have said things differently that allowed parents time to talk and work on their ideas?
   - Have you had any visits where the problems have been too hard to handle?

Client families

Unstructured question:

- "Can you tell me about the program and the Parent Support Worker who is coming to see you?"

Community agencies

Semi-structured questions:

- Can you tell me about the program and how you see it is helping or not helping parents in [this area]?
- Can we work together more collaboratively?"

3.3   Conclusion

From this study, PAR is recognised as a culturally appropriate methodology central to effective program development. The use of Action Learning Sets to facilitate PAR encouraged the Aboriginal parents, peer support workers, community agencies and Researcher to collaboratively engage and explore appropriate and acceptable strategies for peer-led home visiting parent support. Three themes were identified as supporting an empowering research methodology: communication, engagement and organisational processes. All these processes enhanced participants' abilities to work together to explore culturally acceptable features for program development. The influences of these processes will be explored in the following chapter.

Chapter 4.   Research Outcomes

4.1   Chapter overview

This chapter includes five sections. Following the overview, Section Two describes the participants and their roles and activities. Sections Three and Four present two papers reporting on the study's outcomes through the self-perceived role of the Aboriginal peer-support worker and the elements central to the success of peer-led home visiting support for Aboriginal parents. The conclusions to this chapter are in Section Five in which the value and meaning of the peer-led home visiting parent support approaches are discussed.

4.2   The participants

Within this study, the partnerships between peer support workers, families and community agencies were integral to the program's suitability, feasibility, acceptability and effectiveness. Reflective practice and feedback from all participants through Action Learning Sets facilitated meaningful ongoing program improvements and fidelity.

The Researcher undertook data collection interviews during the Action Learning Sets with program staff that included Aboriginal peer support workers, program managers, an education support officer and a non-Aboriginal parent support worker; community agency staff members and parents. The results of these are presented in the following sections. All data were recorded according to the program's Australian Government data reporting requirements (Department of Social Services, 2014; Department of the Prime Minister and Cabinet, 2014).

4.2.1   Program staff

There were eight program staff in total. During each Action Learning Set, the Researcher aimed to interview each staff member and deliver educational sessions on a variety of child and parent topics in order to enhance the program's outcomes. These interactions are detailed in Table 4.1.

Table 4.1   Program staff information

	Program Managers	Peer Support Workers	Non-Aboriginal Parent Support Worker	Education Support Officer
Number of participants	2	4	1	1
Number of interviews by Researcher	6	10	4	3
Number of educational support sessions by Researcher	6	10	4	6

Peer support worker visits to families were sometimes planned and sometimes opportunistic. Planned visits were undertaken at parents' homes or at other venues that parents identified as preferred accessible and safe locations, such as a park or community agency. Many booked home visits required multiple attempts by peer support workers before clients could be located. Opportunistic contacts were in varied locations such as the family support agency office, community agencies and shopping centres. The peer support worker role was not to provide direct physical care but to develop therapeutic, enabling relationships with parents to deliver culturally relevant psychosocial support, affirmation of their parenting efforts and advocacy (Munns et al., 2016b, 2017b). Client acceptance and trust was enhanced through peer support workers' feelings of empathy and mutuality for their clients' parenting environments and their range of communication strategies. The workers' experiences as Aboriginal parents in the local area heightened their awareness of social determinants of health influencing the families' abilities to develop positive parenting practices. Advocacy and referrals to community agencies were important aspects of their role (Munns et al., 2016b; Munns et al., 2017b).

Table 4.2 shows an increase in peer support worker service delivery over an eighteen month period July 2013 to December 2014 which confirms the suitability and acceptability of their support strategies.

Table 4.2   Number of clients visited

	01/07 – 31/12/2013	01/01/ - 30/06/2014	01/07 – 31/12/2104	Total
Aboriginal adults and children	47	55	77	179

Further data revealed:

a. Referrals to specialist support included community child health nurse, medical officer, maternal antenatal and postnatal health professionals, mental health services, housing and tenancy support, food and clothing, budgeting support and legal advice.

b. Health information topics included use of alcohol and other drugs, smoking, adult and child nutrition, dental health, child development, child safety, safe sleeping practices, perinatal mental health and immunisation.

4.2.2   Community agencies

Five Aboriginal and non-Aboriginal staff from community agencies were key informants in relation to local issues affecting Aboriginal parents and the benefits and challenges of the peer-led home visiting support program. The four agencies differed in the types of support they offered to clients due to their primary purpose and budgetary constraints (Table 4.3).

Table 4.3   Community agency support services and strategies

Agency	Support services and strategies
Agency 1	Parent support No outreach Individual and group support
Agency 2	Parent support Outreach Individual and group support
Agency 3	Antenatal and postnatal health Outreach Individual and group support
Agency 4	Antenatal and postnatal health No outreach Individual support

Data from five community agency staff (Table 4.4) highlighted their ability to work in reciprocal partnership with peer support workers to link families to the most appropriate services for their needs. As reported in paper five, peer support workers were able to both refer and take client referrals (Munns et al., 2017b).

Table 4.4   Community agency information

	Agency 1	Agency 2	Agency 3	Agency 4
Number of participants	1	1	2	1
Number of interviews by Researcher	4	3	4	4

4.2.3   Parents

There was a total recorded number of 179 parents and children visited by peer support workers (Table 4.2). However, this is an estimated under recorded statistic due to opportunistic contacts being difficult to record by peer support workers. Additionally, the 2014 reporting templates for numbers of clients visited did not differentiate between adult family members and children (Department of Social Services, 2014; Department of the Prime Minister and Cabinet, 2014).

Although the Researcher experienced difficulties in accessing parents for their perspectives of the program, the two parents who contributed data during the Action Learning Sets affirmed the supportive program features. Life events common to Aboriginal family responsibilities such as funeral attendance and family support affected parents' availabilities for data collection interviews. Additional influencing social determinants of health, including 'couch surfing' because of a lack of secure accommodation and chronic stress, further impeded their access to the Researcher (Shonkoff et al., 2009; Rosenthal & Khalil, 2010; Marriott & Ferguson-Hill, 2014; Zubrick et al., 2014). The effects from these challenges is supported by Maslow's hierarchy of needs where it is highlighted that families place a priority on addressing these urgent practical needs before they are able to consider participation in further areas such as program evaluation (Caruana & McDonald, 2011). It was noted that their data had strong affiliations with data from the peer support workers who were also parents from the same community. These similarities acknowledged the credibility of parent feedback and its value in contributing to ongoing program and peer support worker role development.

4.3　The emerging role of the urban-based aboriginal peer support worker: A Western Australian study

Munns, A., Toye, C., Hegney, D., Kickett, M., Marriott, R., & Walker, R. (2016b). The emerging role of the urban-based aboriginal peer support worker: A Western Australian study. *Collegian, 23*, 355–361. http://dx.doi.org/10.1016/j.colegn.2016.08.007

The emerging role of the urban-based aboriginal peer support worker: A Western Australian study

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ABSTRACT

Purpose: To explore the self-perceived role of the Aboriginal peer support worker working with families with young children. This study was a component of a larger participatory action research study undertaken in a Western Australian metropolitan setting to develop and evaluate the suitability, feasibility and effectiveness of an Aboriginal peer-led home visiting program.

Methods: Focus group interviews were carried out with peer support workers using unstructured and semi-structured interviews within Action Learning Sets. Data were analysed using thematic analysis.

Results: The overarching theme on the self-perceived role of the Aboriginal peer support worker was Giving Parent Support, with subsidiary themes relating to development and ongoing sustainability of the support.

Discussion: The peer support workers viewed their role as providing parent support through enabling strategies which developed client acceptance and trust, delivered culturally relevant support, advocated for families, developed therapeutic engagement and communication strategies, and created safe home visiting practices. They recognised the importance of linking families with community support such as community child health nurses which was important for improving long term physical and psychosocial health outcomes for children.

Conclusion: Aboriginal Peer Support Workers identified their emerging integral role in the development of this unique culturally acceptable home visitingsupport for Aboriginal parents. Innovative approaches towards client engagement demonstrated their value in developing creative ways of working in partnership with families, community support services and child health nurses across a range of challenging psychosocial environments.

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1. Introduction

Internationally, support for parents with young children is a significant issue. Affirming and enhancing parental competence in the early years positively influences lifelong physical, learning and socioemotional trajectories of children (Hertzman, 2010).

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In Australia there is concern regarding vulnerability of Indigenous parents and their children (Australian Government, 2013; RCYO-OPHO, 2015). The capacity of Aboriginal parents to develop positive health and wellbeing environments for their children is influenced by social determinants such as poverty, unemployment and substandard housing (Eckermann et al., 2006; Irvine, 2009). It is imperative for immediate and extended families, communities and governments to support parents in providing safe, stable and responsive relationships with their children (AMA, 2013; NSCDC, 2010).

Traditionally, developmental child health for Australian Aboriginal families has been supported by health professionals (community child health nurses working as sole practitioners or Aboriginal Health Workers) (Department of Health Western Australia, 2007). Recent studies have highlighted the need for new approaches including peer support and home visiting. Peers, it is argued, can facilitate meaningful program strategies that integrate important cultural influences of culture, language and lore into health care provision (Boulton, Brown, & Long, 2010; Larson & Bradley, 2009; Walker, 2010).

International studies highlight positive impacts and families' self-perceived benefits from voluntary and remunerated peer support in non-Indigenous populations (Barnet, Liu, DeVoe, Alperovitz-Bichell, & Duggan, 2007; Heaman, Chalmers, Woodgate, & Brown, 2007; Jack, DiCenso, & Lohfield, 2005). However, a recent systematic review investigating peer led home visiting parenting support programs identified only one study relating to Aboriginal populations (Munns, Watts, Hegney, & Walker, 2016). That study was conducted in a remote area of Western Australian (WA), using remunerated Aboriginal peer support workers, and was found to facilitate positive parenting support approaches. In their role in encouraging parental confidence, these workers were recognised as integral to a culturally secure model of parent support (Walker, 2010). A defining feature of Aboriginal peer support workers is their ability to engage and work in partnership with community health and support services and parents in developing culturally appropriate strategies for children's care and development relevant to each family's unique circumstances (Munns, 2010). As there is limited evidence on the effectiveness and structure of this form of family support, including the role of the Aboriginal peer support worker in urban settings (Munns et al., 2016), a study was commenced in 2013 in a metropolitan region of WA, to investigate development of home visiting peer support for Aboriginal families with young children.

2. Background

In this study region, 4.2% of people self-identified as Aboriginal, compared with 1.5% for the total metropolitan area of WA (ABS, 2007, 2014). Adverse social determinants of health influence this population group with the region scoring 888.2 on the most recent Socio-Economic Index for Areas (SEIFA) – Index of Relative Socio-Economic Disadvantage, indicating high disadvantage in state and national contexts (ABS, 2011). Aboriginal families in this region encounter potentially harmful psychosocial and environmental impacts including poverty, lack of suitable housing and unemployment (ABS, 2012; Profile.id, n.d.), subsequently affecting parents' ability to develop healthy physical and psychosocial environments for their children's developmental wellbeing.

Homelessness in particular heavily influences parents' capability to provide healthy environments for their children and on the capacity of support professionals to facilitate empowering parental strategies. Statistical information on homelessness for this region is limited, but national evidence demonstrates that 23% of people accessing accommodation assistance in 2013–2014 were Aboriginal Australians (AIHW, 2014a). In 2011, overcrowding among Aboriginal homeless people was estimated to be 79% in WA, including multiple temporary house sharing (AIHW, 2014b).

In 2013, a WA non-government family support agency was exploring contemporary, innovative models of engagement with Aboriginal families in an outer metropolitan area where previous programs had not produced expected outcomes. The agency worked in partnership with an academic child health nurse researcher who had established experience with Indigenous and non-Indigenous home visiting peer support programs in remote and metropolitan WA settings (Munns, 2010; Munns & Walker, 2015).

The researcher and the agency's Indigenous parenting coordinator liaised with local community agencies working with Aboriginal families, who endorsed the development of a home visiting peer support program and confirmed interest in engaging with the research. The agency provided finance to undertake the program. This involved the employment of an Aboriginal Program Coordinator and four part time Aboriginal peer support workers. The team was supported by a non-Aboriginal support officer for six months and an Aboriginal education support officer (employed nine months into the project). They also provided infrastructure such as an office, computer and car.

The aim of the overall project the program team (as described previously) to work in partnership with the researcher, families and community agencies to facilitate a peer-led home visiting parent support program. The Aboriginal coordinator's role was to work with the researcher to recruit peer support workers and manage the peer support program. The potential peer support workers were interviewed and selected by the coordinator and researcher. Interviews were undertaken with selection criteria being: positive standing in the community as evidenced by referees; willingness to support parents with young children in their community; stable residency in the local area and good communication skills with the ability to maintain confidentiality (Munns, 2010). The non-Aboriginal support officer assisted the newly recruited workers to develop visiting strategies such as appropriate communication and door step introductions. The Aboriginal education support officer continued this support, also identifying resources to assist parents to effectively engage with their children. The researcher's role was to facilitate program development by incorporating features identified by the workers, families and supporting community agencies. The aim of this study component was to explore the self-perceived role of the Aboriginal peer support workers while they were working with families to develop home visiting support. Their perceptions were investigated as their role had the potential to benefit local Aboriginal families along with informing national and international policy relating to peer support of these vulnerable communities.

This study, therefore, is the first study to investigate the self-perceived role of Australian Aboriginal peer support workers providing support to urban based Aboriginal parents. It also provides data on the similarities and differences of the role during provision to rural/remote Aboriginal families (Walker, 2010) versus urban families.

3. Methods

3.1. Design

This study employed Participatory Action Research, a critical, respectful overarching methodology (Roberts & Taylor, 1998) which is relevant to critical theory paradigms, employing a variety of qualitative and quantitative methods to engage participants (Baum, MacDougall, & Smith, 2006). This methodology enables

a multiperspective, diverse and contextual framework (Denzin & Lincoln, 2011), assisting peer support workers to consider characteristics and directions of their roles, taking into account psychosocial and psychocultural viewpoints.

An action learning set which is a structured process allowing a group of people to meet regularly, collectively developing strategies for issues faced in their area of work (ODI, 2009), facilitated this methodology. In the action learning sets the researcher conducted focus groups sessions with the peer support workers, supporting them in clarifying issues and developing systematic, creative steps for change which could be tested, reviewed and incorporated into practice strategies (Vince, 2008). Ten action learning sets were undertaken four to six weekly over a period of 13 months (Appendix A). Findings from the focus groups are presented.

3.2. Instruments

Unstructured and semi-structured data collection schedules were used to elicit qualitative data. Questions facilitated reflection upon program progress and explored home visiting strengths and challenges (see Appendix B).

3.3. Procedures

Ethics approvals were granted by the WA Aboriginal Health Ethics Committee (HREC 462) and Human Research Ethics Committee of Curtin University (HR73/2013). All of the four peer support workers agreed to participate.

Interviewing participants in focus groups facilitated many-layered, multifaceted and nuanced thick and rich data over the ten action learning sets. Each set lasted approximately two hours. This facilitated data saturation through a small sample size (Fusch & Ness, 2015). In the first set, participants discussed experiences of Aboriginal parents with young children in this urban area and developed initial plans for home visiting parent support, during which strategies for client engagement and topics for support were identified. For each consequent action learning set, they reviewed their goals from the last set, identifying the strengths and developing strategies for sustainable and culturally relevant improvements (INTRAC, 2012). Within each set, an education session was also facilitated by the researcher to enhance peer support worker knowledge in relevant areas such as working in partnership with families and current evidence based information on nutrition, strategies to reduce incidence of Sudden Infant Death Syndrome and identifying factors contributing to postnatal depression and anxiety. However, the intended role of the peer support worker was not to take an active treatment role. Each worker was encouraged to be a support person for parents, recognising their individual strengths and challenges in their parenting journey, praising their efforts, encouraging parents in sourcing their own solutions to parenting issues and engaging with their local community resources, and referring families to appropriate professional assistance. Data were recorded digitally and transcribed verbatim with researcher field notes also supporting the data. Thematic analysis was undertaken by the researcher (Braun & Clarke, 2006) where meanings were identified and themes developed. These themes were verified from the data by members of a senior academic research team. During action learning sets, the emerging themes were presented, discussed and accepted by participants.

3.4. Data trustworthiness

Trustworthiness of qualitative data is measured by data credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). Credibility was demonstrated through peer debriefings with academic supervisors, sustained liaison between the peer support workers and researcher, and member checks (Cohen & Crabtree, 2006; Lincoln & Guba, 1985). Peer support workers were not at ease with reviewing written data following transcription, so member checks through data summaries and reviews were undertaken during and at the end of each action learning set which assisted with data validation and their meanings.

Distinctive characteristics of individual Aboriginal population groups do not allow for universal transferability of findings across different locations. However, use of rich, thick data and verbatim participant extracts assists research consumers to make decisions on transferability to other contexts (Noble & Smith, 2015). Agreement of findings from the academic research team enhanced research dependability in addition to audit trails and a researcher reflexive journal to facilitate confirmability of findings (Cohen & Crabtree, 2006; Lincoln & Guba, 1985; Noble & Smith, 2015).

4. Results

There was one dominant overarching theme (Providing parental support) and five sub-themes within this theme (Developing client acceptance and trust, Delivering culturally relevant support, Advocating for families, Developing therapeutic engagement and communication strategies, Creating safe home visiting practices). All of the sub-themes related directly to the self-perceived ability of the peer support worker to provide parental support.

4.1. Providing parent support

The dominant overarching theme was seen as the provision of parent support in a wide range of need, amid varying psychosocial contexts. The sub-themes highlight the self-identified enabling features of this support. Peer support workers had the ability to recognise parent strengths and reinforce this to parents to build their confidence and self-esteem.

> And you know just praising them on their parenting skills and acknowledging their strengths and building their confidence up to know that they're doing the best that they can.

The following findings describe the remaining sub-themes related to providing parent support.

4.2. Developing client acceptance and trust

A key feature of Aboriginal communication is yarning, which is described as a culturally safe method of Indigenous conversation and a way of talking informally with someone to share information (Bessarab, 2012). Through their non-judgemental and yarning approach, peer support workers were able to discuss and explore family situations and parents' support ideas. Through this, they perceived that an integral part of their role was to become accepted and trusted by clients. Before this step was achieved, the workers saw themselves as being judged with families being wary and assessing their credibility.

> They're all like very guarded and they've got that wall there and they're still sussing you out. . . . they'll be thinking "what are they there for, just the money or whether they're here for us"?

They identified the inability of agencies to address long term substance and alcohol abuse as underpinning clients' wariness of their commitment to the community and ability to work with them.

> . . . in [this area] . . .there's a lot of substance abuse and a lot of alcohol because of circumstances. . . . they'll be thinking "hang on let's just stand back and wait and see what these girls are made of".

Creation of safe psychological places for talking was important to parents. Feelings of trust had to be developed and the peer support workers felt that, through authentic interactions over time, parents developed confidence in them.

She felt safe yarning and she said "there's no one else I can yarn to about the problem what I'm going through".

This was achieved through mutual understanding of parents' experiences, taking time for meaningful conversations and persistence of peer support workers when clients would not respond to phone calls or attempted home visits.

When I first started to introduce myself over the phone she would hang up on me. . . Some days she wouldn't open the door. . . But it's alright now, she's good, she opens the door and she'll let me in.

4.3. Delivering culturally relevant support

As peer support workers were Aboriginal parents living in the local community, they had empathy for families needing assistance that was both appropriate for their needs and culturally relevant. They were aware of local agency support services with the ability to offer services that recognised historical impacts how this affected their distinctive current support needs.

I think what makes it easy for me is that I know the community. . . I live and breathe in that community when I'm not working in it. So most of them [sic] services I've accessed or I know people in there.

Their role in referring parents to culturally appropriate service delivery was important for improving outcomes, especially when previous adverse experiences were present.

I always tell my clients . . .I'm not the professional, like I don't know but I can always find out try and link you up with this person that maybe can help.

I think past experiences of services is relevant. . .also discrimination concerns and that. That impacts upon families and whether they will ask for help.

4.4. Advocating for families

Advocating for families was viewed as a critical for peer support worker credibility and resolution of issues. Linking available community support services was a feature of their role as they were able to negotiate with agency staff for individual and emergency requirements. This was important for improving outcomes, especially in adverse psychosocial environments, where workers recognised the importance of a holistic approach to early years family support to develop positive long term physical and psychosocial health for children. However, barriers to their advocacy role were encountered. Social issues such as a lack of housing were frequently cited as impeding successful outcomes, causing peer support worker stress.

. . .the housing issues that a lot of families have it's just hard 'cause we can advocate on their behalf but they're wanting something. They're wanting more and that's just something that we can't do and that's very heart breaking because we know what it's like to be homeless.

'Cause she was pregnant as well and she wanted to be in a house before baby was born. . . there was also issues on priority waitlist. I said to her "I don't have a magic wand".

4.5. Developing therapeutic engagement and communication strategies

The ability to be empathic to client needs enabled peer support workers to develop a range of flexible therapeutic engagement and communication strategies, such as face to face, phone and text communication. Working in partnership and using a yarning approach with families encouraged them to identify empowering strategies, encouraging parents to engage with services themselves whenever possible.

. . .'Cause she told us that she just wanted to do it over the phone for now "cause there"s too much stress going on but then she asked us to go visit the house so [we are] . . .getting somewhere.

The individual home visiting provided opportunities for workers to tailor responses to individual client needs, with their problems able to be discussed in a confidential environment. Flexibility of meeting places, such as a local park or women's refuge, was needed at times to ensure confidentiality and safety when home was not a viable option.

We pretty much just talk about whatever she wants to talk about. Like pretty much just to be there to support her at this time 'cause she's in the refuge.

With ongoing support from reflective practice sessions, their confidence in facilitating these strategies improved.

Yeah I think I do ok, building up my confidence already. I won't go in there and just freeze on the spot, mate I'm over that barrier now.

4.6. Creating safe home visiting practices

Creating home visiting practices that were safe for peer support workers was identified as an important issue. They perceived their home visiting was valuable for parents in a range of social situations, and developed a safety strategy for two PSWs to undertake visiting in any home where there was potential for adverse events such as drug abuse and family violence. Following initial family screening by the coordinator, collective decisions regarding safe home visiting practices were made.

But we made the decision that at all times now with this client there'll be pairs going all the time. . .in regards to potential family violence.

. . . It's going to be like more harder [sic] to see her when her partner's out [of jail].

Vulnerability from out of hours contact was identified as a risk from being known community members. Development of strategies for these requests facilitated protection for themselves at physical and psychological levels.

Similarly, identifying secure visiting venues for parents was crucial. At times, the home was not a safe place due to issues such as drug or alcohol use and family violence, again necessitating peer support worker flexibility in negotiating alternate locations for client engagement such as their agency office. Findings from non-Aboriginal peer support workers' home visiting experiences have not revealed similar home safety issues, however data did not allow for comparison of psychosocial environments (Munns et al., 2016).

So I brung [sic] them into the office. They're all in that one house and they're all sort of like frightened from when grandmother goes out, gets on the slops, come back and be abusive to 'em all.

I think the best avenue is for when she touched base with the hospital again; for them to line it up to meet her there "cause there"s

family violence stuff involved and she's going from relative to rel-atives' house. So I think it's better, safer and probably a lot easier for her to talk in that environment.

5. Discussion

The peer support workers viewed their role as providing parent support through enabling strategies which developed client accep-tance and trust, delivered culturally relevant support, advocated for families, developed therapeutic engagement and communica-tion strategies, and created safe home visiting practices. The aim of this study was to explore the peer support workers' self-perceived role when working with Aboriginal families with young children and the use of participatory action research within action learning sets enabled them to articulate their lived experiences of Aborigi-nal parenting and develop culturally relevant home visiting support strategies.

The peer support workers perceived that their home visiting assisted parents in a range of psychosocial situations, recognis-ing that their role is impacted by factors both amenable to these strategies and those beyond their control. Anxieties and frustration were challenging aspects, with workers highlighting their inability to address issues arising from housing, substance abuse and fam-ily conflict. They expressed empathy for clients' situations but felt a lack of power to affect change. However, they were able to highlight their strength-based roles in provision of physical and psychoso-cial support. They perceived their role as helping parents cope with everyday life challenges, which was important before health mes-sages could be promoted which compares similarly to findings on the importance of relationships from non-Aboriginal peer support workers (Heaman et al., 2007; Jack et al., 2005). They were cog-nisant of parenting stressors, having understanding and feelings of mutuality towards parents' circumstances and feelings of distress.

Strength-based approaches to family support were identified across a range of strategies. Their ability to communicate with par-ents by phone, text and face to face was recognised as enabling for client contact. They identified that events in the lives of parents necessitated varied approaches which, in turn, developed their con-fidence in their role. Peer support workers acknowledged the need to build safe practices for visiting parents. As such, flexibility of con-tact venues was used which is supported by Walker (2010), where sometimes it was better to have contact elsewhere when home was not a safe or available option. They also visited in pairs when there was potential for lack of home safety. Overall, they were cog-nisant of the importance of supporting families in a wide range of psychosocial situations, recognising the need for mutuality and empathy in their helping role.

Peer support workers' concerns relating to challenges in addressing impacts of social determinants of health are supported by similar community and government difficulties and inequali-ties in provision of supportive services (AMA, 2013; Irvine, 2009). This contrasts with research by Walker (2010) where remote Abo-riginal peer support workers had not encountered the need for advocacy with housing and substance abuse issues apart from alco-hol. Also, findings from a recent systematic review indicated no similar adverse home visiting environments with non-Aboriginal families (Munns et al., 2016).

The self-perceived role of the Aboriginal peer support worker is comprehensively versatile. Empathy, underpinned by the lived experience of being parents of young children in the local com-munity, enabled sensitive, culturally appropriate parent support. The findings from this study have commonalities and differences with those from studies of peer support workers supporting non-Aboriginal families. Research by Munns et al. (2016) highlights home visiting peer support workers in Canada and America iden-tifying trust and the demonstration of respect between workers and non-Aboriginal parents as being central to creating supportive relationships. Additionally, enabling strategies included effective listening, being authentic, and validating their needs and strengths of their parenting abilities. However, the impact of culture on their role was not discussed, along with the associated influence on advo-cacy activities, culturally relevant communication strategies and careful home visiting practices.

6. Limitations

This study was undertaken in a specific urban Australian Abo-riginal community. Transferability of findings to other settings is limited but data can inform other contexts relating to peer led home visiting support.

7. Conclusion

As there is scarce evidence identifying the function of the Abo-riginal peer support worker, it is important that their voices in this study are able to offer insight into their developing self-perceived role. Peer support workers value their position within this com-munity and believe they are creating culturally appropriate parent support through relevant strategies. Advocacy for families encoun-tering adverse impacts of social determinants of health was both challenging and a source of self-reflection, identifying a unique part of their role as the ability to offer empathy and mutuality without necessarily being able to resolve these issues. The value of inno-vation in areas such as communication and visiting settings has not only highlighted their ability to be reflexive to clients' needs but also demonstrated their value in being able to work in partner-ship with health and family support services to establish acceptable client and family-centred approaches for program development. They are able to enhance cultural understanding between Aborigi-nal families and non-Aboriginal parent support professionals such as community child health nurses, along with the use of practical and meaningful support strategies. A further emerging feature is the ability to identify and foster self-determining and empowering support strategies for parents. As such, they are able to promote parent support embedded in Aboriginal culture, relevant to fami-lies' needs.

Peer support workers have an emerging integral role in the development of culturally acceptable support for Aboriginal par-ents. As significant members of community parent support teams, they can assist in facilitating parents' ability to cope with health and social inequalities, thereby contributing to positive lifelong health and wellness trajectories for families and children. It is recom-mended that additional research is undertaken to develop a strong evidence base by further exploring the role of peer support for Aboriginal parents, reflecting on the views of partner community agencies and participating parents. Research is recommended to determine whether peer support would be more beneficial as uni-versal or targeted programs. Strength of evidence is vital for early years parent support.

Conflict of interest

There is no known conflict of interest for any of the authors of this article.

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Author agreement

The article is the authors' original work. The article has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted. The authors abide by the copyright terms and conditions of Elsevier and the Australian College of Nursing.
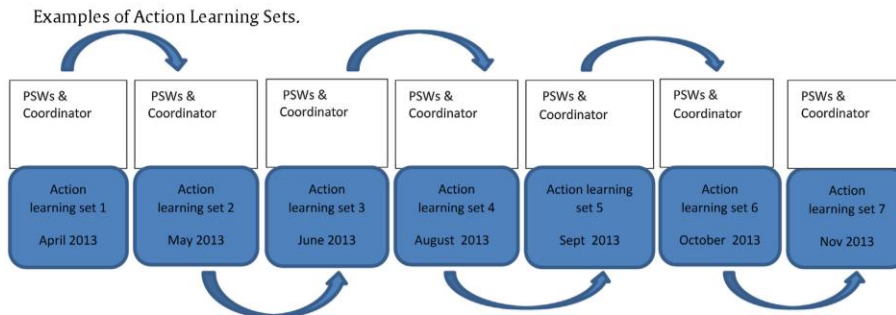
An ethical statement for all research papers

The submitted manuscript involved human research. Ethical Approval was granted for the Study as a scientific research study which was subjected to a full review by two institutional ethics committees.

Appendix A.

Examples of Action Learning Sets.

Appendix B.

Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia: Interview Questions for Peer Support Workers.

Action learning set 1: Can you tell me what it is like to be a parent with a baby or young children in Midland?

Action learning sets 2–10 (following home visiting sessions with parents):

1. Unstructured interview: Tell me about the program and how you see it is going?
2. Semi-structured interview;

   Progress, strengths and challenges

- Think about your visits – what is working well? How are these visits encouraging and supporting parents?
- What is not working well? Why do you think this is happening?
- How could you have said things differently that allowed parents time to talk and work on their ideas?
- Have you had any visits where the problems have been too hard to handle?

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4.4   Aboriginal parent support: A partnership approach

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Acknowledgements

Abstract

Aims and objectives

This study was positioned within a larger action research study relating to a peer-led Aboriginal home visiting parent support program in an urban Western Australian setting. The aims for this study component were to identify program elements, exploring participants' perceptions of the program's suitability, feasibility, acceptability and effectiveness to inform   program model recommendations and add to the body of knowledge on effective Aboriginal peer-led program models.

Background

The ability of Aboriginal parents to develop positive family environments is crucial, with parent support needing to be reflexive to local needs and socio-cultural influences. Culturally appropriate service provision needs meaningful and acceptable strategies.

Design

This study was situated within a critical paradigm supporting Participatory Action Research methodology, using Action Learning Sets as the participant engagement and data collection setting.

Methods

Within ten Action Learning Sets, focus group interviews were carried out with Aboriginal peer support workers, a non-Aboriginal parent support worker, an

Aboriginal program coordinator, an Aboriginal education support officer and non-Aboriginal program managers, (n=8), and individual interviews with parents (n=2) and community agencies (n=4). Data were analysed using thematic analysis.

Results

Five themes were derived from peer support worker and community agency cohorts: Peer support worker home visiting skills; Responding to impacts of social determinants of health; Client support and engagement; Interagency collaboration, and Issues addressing program sustainability. Parent responses augmented these themes.

Conclusions

Participants identified five key elements relating to peer-led home visiting support for Aboriginal parents. These are uniquely placed to inform ongoing program development as there is little additional evidence in wider national and international contexts.

Relevance to Clinical Practice

Engagement with communities and peer support workers to develop culturally relevant partnerships with Aboriginal families is integral to contemporary child health practice. Ongoing nurse support is needed for peer support worker role development.

Indigenous Australian peoples are people who identify as Aboriginal or Torres Strait Islander. Respectfully, throughout this paper, they will be described as Aboriginal.

Keywords

Aboriginal, Action Learning, Community Nursing, Cultural Issues, Home Visits, Models of Care, Parenting, Qualitative Approaches

What does this paper contribute to the wider global clinical community?

- Culturally relevant community child health practice with Aboriginal families and their children in the early years can be enhanced through home visiting partnerships with peer support workers.

- Key elements contributing to effective strategies include peer support worker home visiting skills, responding to impacts of social determinants of health, client support and engagement, interagency collaboration, and issues addressing program sustainability.

Introduction

The early years of life are considered to be the most important developmental phase, critical for healthy physical, emotional and social outcomes throughout the life course (WHO, 2015). Positive family functioning is integral to children's wellbeing. Strengthening the capacity of parents to proactively influence their children's health and development substantially contributes to positive lifelong outcomes. In particular, support for Aboriginal families during these early years is significant because of the considerable proportion of Aboriginal children experiencing ongoing disadvantage across a range of health and wellbeing measures (Commissioner for Children and Young People, Western Australia, 2015). The ability of families to support their children, maintaining positive parenting practices and children's developmental progress, is underpinned by comprehensive, flexible community based child and family health services (Shepherd & Walker, 2008, Munns et al., 2016). This research investigated the suitability, feasibility and acceptability and the necessary elements of a peer-led home visiting intervention as a way to support Aboriginal families and children in an urban area of Western Australia. The results will inform recommendations for a sustainable program model in this area and to add to the body of knowledge on effective Aboriginal peer-led program models.

Background and Literature Review

In presenting the need for parent support for Aboriginal families, it is important to recognise the strengths in many Western Australian Aboriginal family environments where children have culturally nurturing approaches to their care and development (Wilkes, 2014). However, it is also recognised, both nationally and internationally, that, in countries with a colonial history such as North America, New Zealand and Australia, there is a high burden of poor health and wellbeing experienced by Indigenous families and communities. Aboriginal people's health status is persistently below that of their country's whole population and access to resources and opportunities is adversely affected by historical and contemporary social determinants of health (Zubrick et al., 2014; Freemantle et al., 2007; AIHW, 2012). Unfortunately, factors such as colonisation, dispossession, institutional racism and poverty present ongoing and cumulative challenges to the role of Australian Aboriginal parents in maintaining strong families (Gray et al., 2007; Milroy, 2014; Walker & Shepherd,

2008). It is therefore important that these multidimensional historical, environmental, sociocultural and economic influences impacting on family functioning (Walker & Shepherd, 2008) are taken into consideration when developing parent support programs. Of note is their intergenerational effects on parents' feelings of self efficacy and empowerment (Bowes & Grace, 2014, Milroy et al*.,* 2014). A positive sense of social and emotional wellbeing underpins the capacity to develop enhancing and nurturing environments for children (Australian Government, Department of Health, 2013) which are linked to feelings of cultural, family and community connectedness (Government of WA, DoH, 2015). Parents need culturally relevant support services that are accessible and acceptable to strengthen their families' growth and development (Milroy et al*.,* 2014).

Without supportive interventions, childhood adversity has well established associations with toxic and chronic stress, leading to compromised life-course trajectories. Risk factors are complex, wide ranging and long standing, including poverty, recurrent physical and/or emotional abuse, chronic neglect, perinatal depression and family violence (Shonkoff et al*.,* 2009; Marriott & Ferguson-Hill, 2014). This kind of stress disrupts brain architecture, with cumulative changes inducing allostatic load, where the impact of chronic stress alters physiological and psychosocial health and wellbeing. People's behaviours shift from adaptive to maladaptive responses, frequently displayed as anger, frustration and feelings of disempowerment. There may be increased use of alcohol and illicit substances (McEwen, Nasveld, Palmer, & Anderson, 2012). These behaviours compromise developmental progress which is central to successful lifelong psychosocial and emotional adjustment and physical health (Garner, 2013; Shonkoff et al., 2009; Rogosch et al*.,* 2011). Adversity in a child's early years thus poses risks of embedding lifelong vulnerabilities with outcomes relating to family, community and politically based social determinants of health. Modifying the environments in which young children live will potentially ameliorate adversity (Bowes & Grace, 2015, Shonkoff et al*.,* 2009), a fact that highlights the need for proactive family and community based early interventions.

With families being the primary context for children's healthy development, the ability of Australian Aboriginal parents to develop family stability and positive relationships is crucial. Programs to support parents in the early years of children's lives

are designed to enhance parent-child attachment. Additionally, they aim to increase parents' knowledge of child development and their capabilities and self-efficacy in parenting competencies, thereby promoting positive coping approaches to parenting challenges (Bowes & Grace, 2014, Sanders et al., 2000, Mildon & Polimeni, 2012). A systematic review by Dudgeon et al. (2014) on effective strategies to promote Indigenous wellbeing identified seven parenting education programs designed specifically for Aboriginal families in Australia, with suggestions that they have greatest effectiveness as strength-based universal primary prevention approaches when including Aboriginal support workers. There are varying support strategies, with programs offered in a number of formats including groups and individual approaches within settings such as clinics, community venues and homes (Mildon & Polimeni, 2012). Evidence suggests that assistance for parents is most effective when reflexive to local needs, taking into account social, cultural and political influences and acknowledging familial and language groups (Walker, 2010). Recognition of both barriers and enhancing factors establishes a strengths-based approach, enabling elements of parental resilience in the form of strengths, abilities and capabilities to be incorporated into program development, also promoting active engagement and positive outcomes for parents and children (Department of Communities, Child Safety and Community Services, 2013; Tehan & McDonald, 2010; Grant & Cadell, 2009; Shepherd & Walker, 2008). Price-Robertson and McDonald (2011) further postulate that this approach ameliorates the perception of vulnerability for young parents so that they feel able to achieve positive parenting outcomes with appropriate, sustainable support. Meeting the needs of local Aboriginal parents is through a holistic approach, actively engaging in collaborative partnerships with parents and community support groups to identify unique strengths and foster strategies that are authentic and of mutual benefit.

A review of successful Indigenous programs in communities by Bowes and Grace (2014) confirms the importance of adopting a strengths-based, family-centred approach. Of note is the necessity for program flexibility and sustainability of funding and resources, along with modifications to suit the local community's context and specific requirements, which inform effective collaborative models of service. Other key elements for successful program implementation include: the employment, training and support of local community members to enable cultural guidance in program development and active involvement in service delivery, realistic expectations and requirements that accommodate community issues, avoidance of

conflict and creation of a safe, culturally secure service environment for Indigenous workers. Effective culturally competent non-Indigenous program staff are those who connect with the community, "value the trust and respect placed in them, and are able to let go of rigid western notions of time" (Bowes & Grace, 2014, p. 3).

Central to development of enhancing strategies for Australian Aboriginal parents is the recognition that, both internationally (Isajiw, 1999; Preston, 2002; Neckowaya et al., 2007), and nationally (Dudgeon & Ugle, 2014), Aboriginal cultures cannot be viewed as homogeneous. There are considerable different characteristics specific to geographical locations and social networks that need to be taken into account in program development. In Australia, notwithstanding the recognition that there is no single set of Aboriginal parenting practices, there are a number of significant commonalties influencing parenting across cultural contexts, including the value of extended family and social relationships in childrearing (Heath et al., 2011). Of additional importance is the need for acknowledgement and incorporation of Aboriginal worldviews of health and wellbeing, where cognitive, perceptual and affective awareness of these beliefs are developed and affected through social interactions and historical and cultural influences. Researchers and program developers need to work with Aboriginal parents, support workers and communities to facilitate approaches and advances that are reflective of local culture, belief systems and models of care (Hart, 2010). Cultural appreciation and understanding of parenting within reflexive models of practice are needed for non-Aboriginal health professionals engaged with Australian Aboriginal families and support workers in order to foster strong relevant family support systems (Shepherd & Walker, 2008; Munns et al., 2017).

The importance of authentic and relevant parent support are key elements of program success. Consistent with Munns and Walker (2015) and Heath et al. (2012), Price-Roberston and McDonald (2011, p. 1) proposed implementation strategies that can be used to strengthen Aboriginal parents, including:

- working with (rather than working "on") Aboriginal parents and communities;
- ensuring services are culturally competent;
- focusing on attracting and retaining the right staff;
- cultivating supportive community networks and relationships; and
- adopting an action research approach.

A key finding from a mixed methods Australian research evaluation on how to strengthen Indigenous families and communities highlighted the importance of the quality of and relationships between project staff and the communities when working to achieve positive project outcomes (Scougall, 2008). The employment of local Aboriginal support workers was considered crucial as they brought with them established community networks and understanding of local cultural issues, meaning that clients were usually able to discuss family issues with less hesitation (Scougall, 2008). An evaluation of an Aboriginal peer-led family support program in the remote Kimberley region of Western Australia had similar findings (Walker, 2010; Munns et al., 2016).

Across all Australian states and communities, these elements provide opportunities for Aboriginal parents, support workers their communities to work in partnership across dynamic cultural contexts. In contrast, there are factors impeding effective program implementation, including lack of appropriate infrastructure, human resource management issues including high incidences of staff burnout and turnover, challenging social environments with low levels of trust, participation and efficacy along with high levels of anxiety, disempowerment and mobility. Complex or "wicked" characteristics and societal issues impacting on many Aboriginal families for which there may be inadequate resources are confounding factors (Walker & Shepherd, 2008). The National Empowerment Program conducted in thirteen sites in Australia identified a number of effective strength-based responses to address problems in Indigenous communities (Dudgeon et al., 2014). In a similar Australian research evaluation on family support, it was noted that having Aboriginal support workers closely connected to a community could pose challenges where community or family conflicts arose. Recommendations for culturally appropriate services were in the primary health care context of being non-threatening, informal and low cost, being flexible in location and manner of assistance, and offering services away from formal, institutional settings such as a client's home (Flaxman et al., 2009). Reducing adverse features of parent support strategies and strengthening enhancing characteristics are challenging for program facilitators and support workers. Client centred approaches to address their self-identified needs and preferences for culturally appropriate service provision positions Aboriginal peer-led home visiting support as an appropriate form of engagement. However, this support needs further exploration

to assess program processes issues, acceptable strategies and participant meaningfulness, along with parenting and children's developmental outcomes.

In 2012, a Western Australian family support agency highlighted the need for Aboriginal parent support in a low socioeconomic urban community, following which a collaboration between a community child health nurse researcher experienced in the development of Aboriginal parent support programs was formed. An action research project facilitated by the non-Aboriginal researcher in partnership with an Aboriginal program coordinator, Aboriginal education support officer, Aboriginal peer support workers (PSWs) and community agencies supporting Aboriginal families in the local area was undertaken over a 13 month period from July 2013 to November 2014. Critical reflection on the background to the current program has been previously described along with challenges and adaptations to implementation of methods (Munns et al., 2016, 2017).

Study Methodology

Aim

In partnership with the urban community, the aim of the overall study was to investigate the self-perceived suitability, feasibility and acceptability of parent support and inform a model for a culturally secure, peer-led, home visiting model for Aboriginal families and children within this Western Australian community.

Research question

Broad research questions may be specified as study aims or goals, indicating the purpose for the inquiry rather than being stated as questions (Agree, 2009). As such, the methodological aims for this study component were to:

- Identify and examine the elements required to deliver a culturally secure Aboriginal led home visiting child health parent support program;

- Explore the self-perceived suitability, feasibility, acceptability and effectiveness of a culturally secure Aboriginal led home visiting child health parent support program; and

- Inform a model for a culturally secure Aboriginal led home visiting child health parent support program in this urban area and add to the body of knowledge on effective peer-led home visiting program models.

Ethical considerations

Approval for this research was gained from the Western Australian Aboriginal Health Ethics Committee, the Curtin University Human Research Ethics Committee, and the family support agency's research committee. Written consent for participation in the research was obtained from each participant following provision of information sheets.

Research paradigm, Methodology and Methods

This study was situated within a critical paradigm supporting Participatory Action Research (PAR) methodology, using focus groups within Action Learning Sets (ALSs) as the participant engagement and data collection setting. Elaboration of these, along with strategies for research rigour, have been previously described (Munns et al., 2016, 2017).

Demographic information was collected from all cohorts. Some anticipated data were not achievable due to personal and cultural sensitivities, services not being offered, and agency and PSW record keeping processes. For example, within the PSW group, PSW ages, specific numbers of home visits and referrals, and exemplars of brief health interventions were not available. For parents, specific numbers of home visits per family were not reliable as many visits were opportunistic and away from the home setting.

Participants

There were three participant cohorts with a total of 14 respondents, these being the family support agency's program staff consisting of Aboriginal PSWs, a non-Aboriginal parent support worker, an Aboriginal program coordinator, an Aboriginal education support officer and non-Aboriginal program managers; in addition to Aboriginal client families and Aboriginal and non-Aboriginal community agency staff.

During the progress of the research, two to four PSWs, the program coordinator, one non-Aboriginal support worker for four months, one program support educator for three months, five participants from four community agencies and two mothers contributed to the ongoing program development. PSWs were able to engage with 164 families. It was proposed to interview eight to ten families. However only two parents were available due to social and family issues, and moving from the area (Rosenthal & Khalil, 2010; Zubrick et al., 2014). Feedback from families was also reported by PSWs, indirectly contributing to program development. Ten ALSs were facilitated

over the 13 month period, with PSWs participating in every set. Clients and community agencies contributed in ALSs one, four, seven and ten. Other program staff contributed intermittently over the 13 month period.

Data collection

During focus groups with PSWs plus community agency staff, semi structured group interview processes were undertaken by the Researcher (Cohen & Crabtree, 2006). Individual unstructured interviews were conducted with Aboriginal parents using yarning as an interview technique (Bessarab & Ng'andu, 2010; Bessarab, 2012), the value of which has been previously described in Munns et al. (2016, 2017). Yarning was also intermittently used to collect data from PSWs and a community agency Aboriginal staff member. Interviews lasted approximately three hours for PSWs, program coordinator and program support educator, one hour for community agencies and twenty to thirty minutes for parents. All the data were digitally recorded and transcribed verbatim. Additionally, observational field notes were documented by the Researcher to provide additional data.

Data Analysis

Demographic data were analysed manually and will be described elsewhere. Thematic analysis, which is a flexible analytical strategy utilised across a range of epistemologies and research questions, was used to analyse qualitative data from all three cohorts. Following data transcription, data were read and coded according to significant characteristics. Themes were developed from the emerging codes, which identified important aspects of the data in relation to the research question, representing patterned responses and meanings (Table 1) (Braun & Clarke, 2006). The themes emerged as categories for analysis (Fereday & Muir-Cochrane, 2006).

Paper 5, Table 1   Phases of thematic analysis (Braun & Clarke, 2006, p. 35)

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data (if necessary), reading and re- reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic "map" of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Results

There were five themes derived from the two program staff and community agency cohorts. Peer support worker home visiting skills; Responding to impacts of social determinants of health; Client support and engagement; Interagency collaboration; and Issues addressing program sustainability. Sub-themes were also generated. Following the small number of parent interviews, these data will be presented to augment relevant themes (Table 2).

Paper 5, Table 2   Themes and sub-themes

Themes	Sub-themes

1. **Peer support worker home visiting skills**	• Peer support worker education and training needs
	• Peer support worker attributes and strategies:
	   o Capabilities, strengths and persistence
	   o Communication
	   o Safe home visiting practices
	   o Visiting flexibility
	   o Awareness of parent and child issues

2. **Responding to impacts of social determinants of health**	
3. **Client support and engagement**	• Availability of culturally relevant client support • Client engagement • Client acceptance of peer support workers
4. **Interagency collaboration**	
5. **Issues addressing program sustainability**	• Funding • Management governance

1. Peer support worker home visiting skills

This theme comprised two sub-themes: Peer support worker education and training needs; and Peer support worker attributes and strategies.

Peer support worker education and training needs

A key feature of PSW's ability to successfully engage with clients was provision of ongoing, regular education and training, including learning the process of visiting and working in partnership with families, peers and mentors. The emphasis was on having empathy for parents' individual situations, providing praise for their parenting efforts, encouraging community engagement and referring to appropriate professional support. Learning the process of visiting clients was developed over time, with PSWs gradually gaining knowledge of early years' issues along with practical skills of parent engagement.

> *After you do your first one (visit) you have an idea and then the next one you get like more of an idea then the next one after that… you want to sound professional. (PSW)*

PSWs valued training sessions on a variety of topics that were offered by the employing family support agency which supported their skill development and confidence.

> *…they are good to go to them training 'cause you're learning all different things and like it's building your confidence up. Like for speaking things you know what you're speaking about. (PSW)*

> *I just like to do all different training. So we know all different things because yeah everyone's different…it's good in case that ever comes up then we have a bit of skills in that. (PSW)*

Mentorship was important. Observing and listening alongside Aboriginal and non-Aboriginal program staff and peers developed PSW confidence for making introductory phone calls and home visits.

> *… we have a bit of a chat about it (visit) afterwards, what worked, what didn't work, what they observed, what they heard that I didn't. A little bit of follow through like that and what will you do for the second, the next visit and you know a little bit of prep time to talk about that. (Program staff member)*

I sit back and listen to (PSW) when she's ringing up. (PSW)

It's just a learning process with (mentor). I'm just getting comfortable engaging and sitting and just listening to the clients and what their parenting issues. (PSW)

Additionally, the Education Support Officer was able to offer extra learning support between the action learning sets, which enhanced continuous learning and development.

So basically just getting them prepared to start, just to think about you know how they're going to work that week and deal with their clients and what they need to do. If there's any resources that they might need and things like that. Support them in that role and then debriefing after each session. So basically what's the goal for that visit, what are we wanting to achieve on that visit. (Education Support Officer)

Exploring how to raise sensitive issues such as smoking, and child safety was identified as being important for PSWs to observe and learn, as PSWs did not want to be seen as confronting to their clients and reduce the development of trust.

I haven't really been in that in that environment to bring it (smoking) up. But I wouldn't know, I guess I'd learn off (Program staff member) 'cause you know she has been in all different situations. (PSW)

The cord was just hanging and the TV was right on the corner of the table and (Program staff member) explaining that to fix that. You can just go in there and just make it a conversation and then make it into a, not like a probing question. (PSW)

Peer support worker attributes and strategies

PSW visits to families were both planned and opportunistic. Planned visits were undertaken at parents' homes and nominated venues in addition to community agencies during their parent activities. Many booked home visits required multiple attempts by PSWs to contact clients. Opportunistic contacts were in varied locations such as the family support agency office, hospital, community agencies and shopping centres.

PSWs developed a variety of strategies to visit parents, recognising that they needed to adapt quickly to where parents were located, visiting in a variety of community areas due to convenience or necessity, such as risk of domestic violence at

home. This demonstrated their ability to be reflexive to family needs, delivering timely and effective support.

> *Because we know the mum was a still there (hospital) we thought maybe it would be a good opportunity to touch base. (PSW)*

> *Sit down with them elsewhere, some of them like just to get out of the house. (PSW)*

> *I'll be taking them to art and craft and that's our home visit there. (PSW)*

Due to their ethnicity and lived experience in the local community, the PSWs had empathy for Aboriginal families (Munns et al., 2016) which, at times, caused PSW stress.

> *They're wanting more you know and that's just something we can't do and that's very heartbreaking because we know what it's like to be homeless. (PSW)*

It was important for them to have education and training to develop suitable, realistic and acceptable parent support strategies. There were four attributes and strategies identified as important enabling elements of this support.

Capabilities, strengths and persistence

Emerging PSW confidence and capabilities progressed with time, during repeated home visiting and reflective practice during action learning sets. Early years and family support education by the child health nurse researcher enhanced their abilities and knowledge of when to refer parents to professional support services. This helped to establish confidence and self-esteem in their role of providing effective support.

> *Well I was nervous at first. Then I got up and thought here's a go, I've got to do whatever. Afterward I went "yes!", I finally got my first one. But I was really happy, oh my gosh I did it. (PSW)*

> *Well since I've been in the role I've found out that I'm very passionate about working with the community. And I love working with families. (PSW)*

> *I always say I'm not the professional but I can always link you up with this person that may be able to help. (PSW).*

Persistence in locating families was a key feature of effective PSW practice. As members of the local community, PSWs recognised influences impacting on families'

abilities to engage with services, such as transience and family issues. They understood the need to persevere with home visits, attempting to engage with parents when they were not easy to locate. Frequently government and non-government agencies had policies of ceasing contact if parents were not found after two or three attempts.

> *(Making client contact). Normally services ceased with mainstream agencies. This is pretty much the fourth time for us. (PSW)*

However, it was noted that PSW background and prior life experiences may affect their ability to work with parents.

> *How does life experience colour people's ability to interact, engage, work, trust, how to function well and find balance. How do we educate PSWs with poor prior education and adverse impacting life experiences? (Agency manager)*

Although the PSW's lived experiences as parents were considered to be a positive aspect, their employment with no prior educational parenting support skills was viewed as challenging by some of the family support agency staff.

Communication

Successfully working and connecting with families was dependent on effective communication strategies, ranging from phone, text and face to face contact. PSWs understood the importance of making connections in a variety of settings and maintaining respectful communication with clients. Persistence with client engagement remained a feature.

> *If I can't get hold of a client, I will just message and say hello, how are you going, this is me again. (PSW)*

> *Keeping in contact, we use texting and phone calls. It shows we're interested. (PSW)*

PSWs realised the importance of non-judgemental communication with parents, working from a strengths based approach. They recognised the empowering capacity of praise in their home visiting strategies.

> *It's easy to judge and assume but we are human beings. We're peer support workers and not here to judge. (PSW)*

> *When they're praised, they like that. We're making clients stronger, helping them to find their voice so they can change. (PSW)*

We're not there to point out all their negative things, we're there to praise.
(PSW)

Safe home visiting practices

An important feature was for PSWs to understand safe home visiting practices, including setting boundaries for client visiting. Proactive risk assessments were undertaken.

> *The conflict of interest is the main thing to ask about and the level of*
> *risk...that will come down to if it's a domestic violence situation or drugs*
> *or alcohol, mental health. (Program manager)*

Strategies for encouraging PSWs to identify kinship issues were essential, in addition to developing suitable communication and referral pathways when clients contacted them out of hours. This was a sensitive issue needing practice with wording during action learning sets, assisting PSWs to develop culturally appropriate and respectful ways of addressing these situations.

> *It was even hard for me to tell her, hang on sis it's after work hours. She's*
> *always had my personal phone numbers. (PSW)*

> *Is it ok if I come in or ring you if I need someone to talk to? (Parent) I said*
> *well that's fine you know I said but not after work hours. (PSW)*

Awareness of parent and child issues

Through their own parenting knowledge and the program's education topics presented by the child health nurse researcher, emergent PSW capabilities in physical and psychosocial family developmental health were developed, such as enhancing child development and safety, family relationships and attachment.

> *...how we were looking at ways parents can make their own things and*
> *how do those things, playing with those toys help with their development.*
> *(PSW)*

2. Responding to impacts of social determinants of health

Social determinants of health impacted on PSWs', community agencies' and parents' relationships, and provision of support, influencing program activities and development of client self-management and coping strategies. The dominant determinant was lack of housing, generating family stress and fragmentation.

I said the women's shelter has got a vacancy, but they can only help you (mother – not father). (PSW)

There's overcrowding (homes), lack of housing leading to homelessness and couch surfing. Then they can't get baby items as there's nowhere to put them. When housing arrives, all the baby purchases are done at the last minute and that puts a strain on the budget. (Community agency)

Legal issues, illicit substances, mental health and transport all challenged PSW practice. PSWs and community agencies understood the importance and implications of these for families without judgement.

She's a mother of five you know, partner's in jail and she just struggles. She's got the three little ones under three…and no transport. (PSW)

It's hard to do education with mums taking drugs and alcohol. They're not in a good place to take on what we say and do it. (PSW)

There's alcohol, drugs, looking after kids, proper housing, single mums, domestic violence, partners in jail. (PSW)

Yeah she's bipolar. So there's mental health issues. Depression and things like that. (PSW)

Also family violence. About 35% admit to it. It is underreported. (Community agency)

At times PSWs appeared overwhelmed by these situations, but during reflective practice sessions were able to identify their practice strengths and collaboratively develop meaningful and empathic strategies.

They're wanting more and that's just something that we can't do and that's very heartbreaking because we know what it's like to be homeless…we'll talk about it at each other's desk…we all know our strength and weaknesses and just help each other. (PSW)

Parent responses highlighted PSW understanding of the impacts of social determinants of health on families' lives. The two parents perceived the support as being suitable and effective for their needs, which was underpinned by PSWs being aware and empathetic of issues such as lack of transport impacting on parents' ability to nurture their children.

(PSW) also helping me get my driver's licence. That will be a big help. (Parent 1)

Like, kid wise, for appointments and that, they're there to help me. (Parent 2)

3. Client support and engagement

This theme highlighted three sub-themes: Availability of culturally relevant client support; Client engagement; and Client acceptance of PSWs. Various engagement strategies were necessary to provide culturally relevant client support, particularly with ongoing visiting. This issue was recognised by PSWs and agencies who collaborated whenever possible to maintain client contact.

Availability of culturally relevant client support

Agencies and PSWs identified challenges for families in providing parent support, along with issues in locating suitable community agencies to help them.

> *Parenting is tough, but depends on who parents are linked in with. (Community agency)*

> *There is lack of support from families and partners. The mothers don't know which agencies or who to go to for their needs. (Community agency)*

> *Parenting – there's a lack of role models. Clients not knowing what to expect. (Community agency)*

The availability and ability of PSWs to work with family members in a culturally appropriate manner was recognised as a strength, highlighting their ability to develop effective relationships.

> *With Aboriginal families, the family relationship is everything. The PSW's agency is committed to a culturally appropriate service. (Community agency)*

> *On our first visits, we give books. It's a question of giving stuff as a credibility issue. (PSW)*

Client engagement

The willingness and ability of PSWs to engage with parents in a variety of settings demonstrated their skills in developing flexible approaches with clients. This engagement facilitated trusting relationships shown through clients' willingness to yarn which is a feature of culturally secure practice (Bessarab, 2010).

> *(PSW) is going in to art classes at (the agency). She'll be yarning while doing this. Powerful conversations. (PSW)*

I see that PSWs are building relationships through activities. (Community agency)

We do yarning time in the car…we take her to speech therapy. She's reconnecting with services with encouragement. (PSW)

PSWs demonstrated their ability to work in partnership with community agencies to enhance client outcomes, demonstrating an effective and viable approach for the program.

PSWs can work with our clients as they have time and can reinforce what we are doing. (Community agency)

Structural and psychosocial barriers to home visiting impacted on the PSW's ability to effectively engage with parents. Frequently, clients were too busy with everyday activities such as attending government assistance meetings and family obligations.

They're busy or it's not a good day. (PSW)

Additionally, issues such as mental health influenced client planning for PSW visits or their willingness to open their doors.

Some days she wouldn't open the door. (PSW)

At times, program resources challenged their ability to effectively engage with clients.

Only one car. Often the car's not available when the clients are. This gets in the way of developing relationships with them. (PSW)

Time was needed to develop client relationships and outcomes, highlighting the need to recognise this crucial factor in program planning.

People need to realize that we can't fix things quickly. This is not a quick fix program. It's a "walk with me". (Community agency)

It takes time to build up confidence that this program is valuable. But time can be a challenge. (Community agency)

Client acceptance of PSWs

PSW attributes and strategies, along with their engagement approaches, contributed to client acceptance of their visiting support. Following initial apprehension from some

parents, a sense of trust was developed over time, indicating acceptance of the PSW support strategies.

> *They're still sussing us out, still thinking are these mob alright? (PSW)*

> *Her body language to me that morning was definitely a little bit more relaxed. She was more responsive. (PSW)*

> *I wouldn't hear anything from her and after the break I sent her a message…and she messaged me back and she was like I need some stuff. (PSW)*

This sense of trust and acceptance was confirmed in the responses from both parents, who were wary of their neighbourhoods and government agencies.

> *Some people are good, some snobby. At school some make you feel low about yourself. (Parent 1)*

> *She (neighbour) rang the police trying to get the police to take her (daughter) off me. (Parent 2)*

However, they accepted the PSWs, allowing them to come into their homes. PSW communication skills were a feature of the relationships that developed.

> *She comes around and phones. It's good to have another adult to talk to. Just talking. (Parent 1)*

> *They're both good listeners. (Parent 2)*

4. Interagency collaboration

Working together with community agencies was integral to effective parent support, with PSWs reciprocating to both refer and take referrals for clients. Maintaining interagency contact was important for program visibility, collaboration and effectiveness and to update on agency services.

> *It was a network meeting…a sharing of the information of services. Just provides us with opportunities to link. (PSW)*

> *The more the word is spread about the program, getting that voice out there again and again. You just have to become an absolute itch that someone has to keep scratching, they (agencies) have to see you. (PSW)*

Partnerships with community agencies enabled improved use of resources, effectively enhancing client and staff outcomes.

> *I can get them (PSWs) to do the home visiting and I can do the parenting over the phone. (Community agency)*

> *Three child protection cases were closed due to our workers' involvement (Program manager)*

> *You need to work together, it's too huge because you burn out. (Community agency)*

Challenges to interagency collaboration usually stemmed from service duplication, highlighting a need for clear communication processes between PSWs and agencies.

> *We just don't want to be duplicating services, I think she's involved with (other agency) again. (PSW)*

> *We tend to get double up on clients because the client doesn't tell you. (Community agency)*

5. Issues addressing program sustainability

This theme contained two sub-themes: Funding; and Management governance, which influenced program sustainability.

Funding

Ongoing sustainability of the parent support initiative was viewed as important by PSWs and community agencies and was an ever-present source of anxiety. Secure government funding over a period of time was considered essential for program development, as support services at times were costly.

> *For Indigenous families, it takes top dollar to reach them. (Community agency)*

Financial stability was an issue affecting PSW contracts, resourcing and the ability of the employing family support agency to sustain support.

> *Funding and funding cuts an issue (Community agency and program manager)*

Management governance

Management governance was also viewed as a factor of program sustainability, including staff retention. Funding for a car and child-safe car seats were budget items

in the parent support initiative, however, the car was not purchased until several months after the program commenced. PSWs were aware at commencement of employment that they were required to use their own cars, but this was not sustainable due to irregular car access, roadworthiness and petrol costs. Additionally, following the loss of the existing car seat and need for new booster seats that were safety compliant, replacements were slow to arrive. All these issues were viewed as barriers to accessibility and timely implementation of the program.

> *And now we've got the car and we've got the car seats. We've finally got the car seats now. So that took ages but finally got 'em. (PSW)*

> *Only one car. We need to look at how we can use it better. (PSW)*

As with their Aboriginal parents, PSWs are members of a vulnerable population group. Accordingly, there were cultural obligations impacting on their availability for work. There was reported and observed tension between PSWs and managers in relation to flexible work policies.

Discussion

Multiple factors, including PSW home visiting skills, responding to impacts of social determinants of health, client support and engagement, interagency collaboration and issues addressing program sustainability have been found to influence the development of Aboriginal parent support in a Western Australian urban setting. Munns and Walker (2015) have previously demonstrated key characteristics for implementing a culturally secure Aboriginal led home visiting child health parent support program in remote communities. One of the aims of this study was to work with community agencies, PSWs and Aboriginal parents in an urban setting to explore the extent to which similar and different characteristics emerged from the narratives with all participants. This paper contributes evidence from PSWs and community agencies which is supported by parent responses. These data have the potential to inform a model of practice partnership between these three groups and community child health nurses, thereby adding to the body of knowledge on effective and acceptable support programs.

Participants highlighted five themes contributing to the emerging culturally secure suitability, feasibility, acceptability and effectiveness of the home visiting program. It

was recognised that, at times, visiting and support could be more effectively undertaken in venues other than homes due to determinants such as parent and PSW safety and shared activities with other community agencies. Similarly, the importance of alternative outreach activities in isolated settings was also identified in a remote area study (Walker, 2010). Bowes and Grace (2014) highlight that program engagement is strengthened when conducted in places perceived as safe and where participants feel a sense of ownership and control.

Adverse social determinants of health and varying availability of culturally relevant client support were recognised as impacting on Aboriginal parents' abilities to nurture their families and enhance positive social and emotional wellbeing (Australian Government, DoH, 2013; Milroy, 2014) which has associations with feelings of cultural, family and community connectedness (Government of WA, DoH, 2015, Milroy et al., 2014). PSW empathy and feelings of mutuality are corroborated by Munns et al. (2016), with this insight supporting their attributes and strategies when visiting parents. These were underpinned by ongoing education and training sessions facilitated by the community child health nurse researcher (Munns et al., 2016, Walker, 2010), where acceptable capabilities, strengths and persistence in flexible home visiting approaches and communication were developed and supported by emergent PSW facilitation of physical and psychosocial family developmental health.

Client engagement was enhanced culturally with the ability of PSWs to work with all Aboriginal and non-Aboriginal family members, in addition to community agency linkage. This enabled a partnership approach to practice which was reflective of local culture and worldview belief systems, ultimately informing acceptable and relevant models of care. This was previously reported by Hart (2010) in a study of a research paradigm based within Indigenous worldviews and ways of being. Complex family, health and societal issues influenced the PSWs' liaison with parents, resulting in a scarcity of evidence based responses (Scougall, 2008; Walker & Shepherd, 2008; Shepherd & Walker, 2008). However, opportunistic and planned contact along with a range of acceptable communication strategies assisted with these issues in the current study.

Education and training needs and program sustainability influenced successful program elements and ultimately the development of an ongoing model of care. PSWs

identified the value of continuing role development support including current parenting information, learning the process of home visiting, development of communication skills and role play, with mentoring being an important aspect of putting these learnings into action (Walker, 2010).

Factors impacting on the program's implementation and maintenance have been previously recognised by Scougall (2008), including lack of recurrent program funding, infrastructure shortages, management of PSW employment and challenging social environments for both parents and PSWs. Additionally, Shepherd and Walker (2008) and Dudgeon et al. (2014) identified that racism, lack of resources and lack of cultural competence of organisations and practitioners also impact on program effectiveness. However, the five key strategies for Aboriginal parent support proposed by Price-Roberston and McDonald (2011) have been incorporated into the home visiting strategies, contributing substantially to the program's emerging suitability, feasibility, acceptability and effectiveness. These are supported by the recommendations from Flaxman et al. (2009) for culturally appropriate services. With adversity in the early years posing risks of embedding lifelong vulnerabilities (Shonkoff et al., 2009) and the effectiveness of primary prevention approaches for families being increasingly recognised (Mildon & Polimeni, 2012), there are acknowledged benefits from the perspectives of all study participants of the peer-led home visiting support.

Limitations

Due to discrete cultural differences between Aboriginal communities, there may be limitations associated with transferability of all findings to other settings. However, there is capacity for elements of the study's findings to be applied to other communities. As acknowledged in the literature, engagement issues with Aboriginal clients through problems such as mental health, mobility and family issues (Rosenthal & Khalil, 2010; Zubrick et al., 2014) reduced data that may have further informed this study's aims. Only two parents were available for interviews. However, the parents' descriptive responses are given credence as they align with data from the PSWs who are parents themselves and living on the same community as the families. Two of the criteria for employment were that the PSWs lived in the same community as the participants and were parents of young children themselves. It is acknowledged that

no one can claim complete understanding of another's lived experiences. However, every effort was made in the development and implementation of the program for PSWs to engage with parents with feelings of mutuality and respect, enhancing the ability of parents to discuss personal sensitive issues (Munns et al., 2016). We propose that the findings from this study can inform other environments relating to peer-led home visiting support for other Australian and international Aboriginal communities.

Conclusion

Parents, PSWs and community agency workers have identified positive aspects of the peer- led home visiting child health parent support. The program's suitability, feasibility, acceptability and effectiveness were described across a range of psychosocial environments by PSWs and community agencies, with supporting evidence given by a small number of parents. The key elements and challenges related to culturally nurturing support for Aboriginal families and children have been highlighted. These are crucial for ongoing program and PSW role development, ultimately informing an emerging culturally secure and meaningful model of support.

Currently, and over time, this early intervention strategy will positively enhance lifelong family environments for parents and children in this Western Australian setting and potentially other diverse settings as well as across health, education and community services sectors. Despite the importance of family functioning within government policy and reporting contexts, there remain few studies and data sources of Aboriginal programs that utilise robust and relevant Aboriginal informed measures of family functioning to inform or evaluate the effectiveness of policies and programs that aim to improve family and early child health and wellbeing outcomes.

Relevance to Clinical Practice

Although numerous challenges impact on the development and implementation of a peer-led Aboriginal home visiting parent support program, enabling factors have been identified that are facilitating culturally responsive, acceptable approaches to program development and peer support. Of note is the influence of a partnership approach between community child health nurses, PSWs, community agencies and parents or carers. Key collaborative elements for this significant child health practice role include provision of ongoing PSW role support and education, development of flexible

communication strategies for all participants and encouraging a strengths based partnership environment. It is imperative that these are underpinned by acceptable employment practices negotiated between PSWs and their employment agency, secure funding and adequate resources.

Further research is required to incorporate an integrated Aboriginal worldview to understand how to address the complex, interrelated factors influencing family wellbeing and its impacts on early child development. Aboriginal perspectives and experiences are critical in developing programs and services and more culturally relevant indicators of family functioning to measure their effectiveness. Meaningful measures of policy and program effectiveness require collection of information about positive and successful local Aboriginal-led initiatives. This, in turn, highlights the importance of using qualitative data and case studies to document the more localised and nuanced elements of successful initiatives. These processes would also facilitate the development of an evidence base of key principles and characteristics of successful programs to address complex and interrelated factors that contribute to family functioning and wellbeing in diverse Indigenous contexts. While longitudinal research is recommended to explore the impact of PSW support over a longer period and how effective program can best be supported, the qualitative case study in an urban context described here incorporate both Aboriginal family and organisational perspectives to achieve these aims.

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4.5   Conclusion

Both papers in this chapter allowed the voices of all participants to be heard in relation to the impact of the peer-led Aboriginal family support program and the self-perceived role of the peer support workers. Use of PAR methodology enabled participants' understandings, world views and opinions on peer-led parent support strategies to be considered and incorporated where possible at all stages throughout the program's development.

Innovative approaches by peer support workers demonstrated their integral role in cultivating effective partnerships with parents, community agencies and the child health nurse Researcher. Their advocacy and strength-based approaches highlighted their belief that they were able to offer meaningful help to parents to cope with everyday events impacting on their lives. Feelings of empathy, mutuality and the lived experiences of local social determinants of health underpinned their unique role in facilitating self-determining and empowering parental support strategies (Munns et al., 2016b, 2017b).

Insights into the impact of the program were drawn from the perspectives of all study participants. Their critical viewpoints on the relationships between their cultures, parenting needs and social determinants of health generated relevant proposals for program design. The relationships between program participants were enhanced by the PAR methodology, enabling them to discuss and appreciate each other's contributions and attributes in the delivery of parent support. Over time, initial hesitation by parents in relation to the peer support workers' understanding of their situations and their abilities to address complex issues settled. Development of trust led parents into engaging with peer support workers, although this process took longer for some parents than others. At times, the inability of peer support workers to resolve issues such as lack of housing was problematic for their relationships with parents. However, they employed a range of empathic communication strategies to remain in contact with parents, demonstrating their feelings of mutuality and willingness to advocate (Munns et al., 2016b, 2017a, 2017b).

Inability to affect change beyond their scope of practice was stressful for peer support workers who relied on the employing agency debriefing immediately

following family visits along with the reflective practice sessions with the Researcher during the Action Learning Sets. Unfortunately, issues with communication, role expectations and the ability to change working hours to accommodate family affairs contributed to declining relationships between peer support workers and their management team, initiating a lessening of trust and discussion of these stressors in the workplace (Munns et al., 2017a).

The ability of both Aboriginal and non-Aboriginal community agency staff to frame their support strategies through a cultural lens facilitated enabling partnerships with parents and peer support workers (Munns et al., 2017a). These collaborations heighten the potential for viable and sustainable family-centred support. The Researcher's cultural reflexivity within all interactions with peer support workers, parents and community agency staff contributed to trustful conversations within Action Learning Sets and program development which enabled insight into the community's complex physical and psychosocial environments (Munns et al., 2017a, 2017b). The reflections by all participants on processes and change established viable pathways for peer-led home visiting support for parents experiencing vulnerability and disadvantage. These interactions highlight the value of PAR approaches for community child health nurses and other health professionals when working with Aboriginal families and communities.

Chapter 5.   Discussion and Conclusion

5.1   Chapter overview

Chapter Five concludes the thesis with a summary of the major findings from the published papers. A discussion with implications of these findings and recommendations for clinical practice, policy and future research are presented. This is followed by discussion on the limitations of the study, transferability of findings and the conclusion.

This study aimed to investigate the self-perceived suitability, feasibility and acceptability of parent support and inform a model for a culturally secure, peer-led, home visiting model for Aboriginal families and children in the Midland community, WA. Five research papers investigated the aim and specific objectives, including a systematic review protocol and comprehensive systematic review, a methodology paper exploring the use of PAR facilitated by Action Learning Sets, and two papers identifying the perceptions of the research participants related to their roles and outcomes from the study.

5.2   Summary of findings

The use of PAR with Action Learning Sets facilitated a partnership approach between peer support workers, community agency staff, parents and the Researcher, enabling regular insight into their perceptions of the home visiting program and its ongoing development. These understandings were embedded within contextual influences, including social determinants of health and participants' worldviews on families, community and parenting. It is imperative that health professionals such as community child health nurses are able to work with parents and communities to collaboratively create meaningful, acceptable and effective family support. The perceptions of the peer support workers, community agency staff and parents will be outlined and discussed in relation to progressing the program.

5.2.1   Peer support workers

International evidence from the systematic review highlights peer support worker recognition of the importance of home visiting strategies for the establishment, maintenance and closure of parent collaborations. Trusting relationships with parents are established and sustained through being authentic, active listening and validating their needs and parenting skills (Munns et al., 2016a). In the study's research, peer support workers perceived their role as providing appropriate parental support for Aboriginal families. Five strategies were identified as supporting this function, these being the development of client acceptance and trust, delivery of culturally relevant support, family advocacy, development of therapeutic engagement and communication strategies and establishment of safe home visiting practices (Munns et al., 2016b). In a further study within this research, the peer support workers described the strengths of their home visiting skills with their ability to respond meaningfully to impacts of social determinants of health on families, utilise various engagement strategies to provide culturally relevant client support and maintain interagency collaboration. Issues addressing program sustainability were acknowledged as being essential to program viability, however, these related to government and the employing agency's financial and resourcing policies and were outside the scope of peer support worker influence (Munns et al., 2017b).

5.2.2   Community agencies

Community agencies confirmed the value of collaboration with the peer support workers, enabling efficient use of resources, with reciprocity being effective in improving outcomes for parents, peer support workers and agency staff. Possibilities of reduced funding affecting both the home visiting program and agency responsiveness to vulnerable parents were corroborated. The availability and ability of peer support workers to offer culturally appropriate home based support to Aboriginal families was welcomed by community agencies due to outreach activities not being within their own program scope, understaffing or not having Aboriginal employees. The agencies also highlighted the influence of social determinants of health on the families, the challenges these presented and the ability of the peer support workers to engage and work with clients within these environments (Munns et al., 2017a,b).

5.2.3   Parents

The two parents' responses augmented the findings from the peer support workers and community agencies. The parents verified the suitability, acceptability and effectiveness of the peer support workers and the home visiting program. They acknowledged the peer support worker empathy and feelings of mutuality in relation to the consequences of social determinants of health on their families and community. Both parents affirmed that the peer-led home visiting support was suitable, feasible and applicable for their needs. The continued contact of other parents not interviewed by the Researcher implied that they experienced similar viewpoints (Munns et al., 2016b; Munns et al., 2017a,b).

5.3   Discussion and implications of findings

In partnership with Aboriginal peer support workers, parents and community support agencies in Midland, WA, the aims of the study were to investigate the self-perceived suitability, feasibility and acceptability of parent support and inform a model for a culturally secure, peer-led, home visiting program model for Aboriginal families and children in the Midland community, WA. This research is particularly pertinent as, prior to the study, there was little available evidence on these innovative approaches (Munns et al., 2016a).

Five key elements were identified by peer support workers and community agencies that accounted for their self-perceived assessment of the feasibility, acceptability, effectiveness and suitability of the peer-led home visiting parent support program. These indicators were supported by distinct parent feedback and were defined as being peer support worker home visiting skills in responding to impacts of social determinants of health on families, client support and engagement, interagency collaboration and issues addressing program sustainability. These key elements, which are corroborated in the systematic review findings, were highlighted as being integral to meaningful program development and outcomes (Munns et al., 2016b, Munns et al., 2017b).

The topic relating to peer support worker home visiting skills identified two specific needs; these being peer support worker education and training needs, and peer support worker attributes and strategies. Regular sessions where current family topics are presented, along with exploration of home visiting strategies and how to work in

partnership with parents and mentors, were recognised as integral to program quality. Peer support worker attributes and strategies fostered during Action Learning Sets assist them to be both critically reflective and responsive to parents' and children's needs. Their home visiting support capabilities, strengths and persistence, communication strategies, safe home visiting practices and awareness of parent and child issues are acknowledged as being key features of effective program support (Munns et al., 2016b, Munns et al., 2017b). These five key elements allow peer support workers to work from a strength-based approach, however, regular reflective practice and education sessions during Action Learning Sets are vital for ongoing, sustainable and evidence informed skills development and proficiency (Munns et al., 2016b, Munns et al., 2017a,b).

Data focusing on client support and engagement recognised three explicit elements; these being availability of culturally relevant client support, client engagement, and client acceptance of peer support workers which are also confirmed in the systematic review findings from paper two (Munns et al., 2016a). Peer support worker availability through home visiting is a key support feature, along with their culturally appropriate engagement, communication and strategies. However, difficulties in locating community agencies with resources and a mandate to assist parents present challenges that are mostly beyond the peer support workers' control. Over time, peer support worker persistence and communication skills are seen to be significant in developing client trust and acceptance. Interagency collaboration enhances the effective use of staff and resources, allowing peer support workers to both refer clients and receive community agency requests for assistance. This collaboration enhances peer support workers' self-esteem, acknowledging their value within their local communities (Munns et al., 2016b, Munns et al., 2017a,b). Regular interagency communication is needed to ensure current information on service availability is available to both peer support workers and community agencies. This also allows for follow up information on referral outcomes.

Issues addressing program sustainability identified two further aspects relating to sustainable funding and management governance, both of which significantly affect the ability of the program to be maintained. Lack of financial stability from government funding is a source of stress for the peer support workers, participating community agencies and the family support agency managing the home visiting program. Long term

planning is hindered and maintaining peer support worker motivation when faced with possible loss of employment is challenging. Additional pressure is placed on the workers when management governance expectations differ from their own, including conditions of employment, flexibility of work hours and availability of cars for client visiting (Munns et al., 2016b, 2017b). Clear, ongoing communication in relation to work environments with regular respectful staff and management meetings would benefit work relationships and support empowerment of peer support workers. Longer-term government funding contracts are imperative for positive parent support outcomes, especially as it takes time to develop trusting and enabling relationships between peer support workers, community agencies and parents.

Responding to the impacts on families from social determinants of health affects the type of support given by peer support workers and their referrals to community agencies. The prime skills of the workers in helping parents to address the wide range of issues influencing their parenting environments are non-judgemental listening, knowledge of accessible local resources and development of meaningful, realistic and empathic strategies in partnership with their clients. Reflective practice sessions are integral for peer support workers to debrief on these family stressors as they can become overwhelmed by their inability to remedy long standing situations in addition to frequently having no referral options for the problems. These sessions within Action Learning Sets also allow the workers to collaboratively identify and develop enabling and empowering pathways for the families.

The strengths of this research were the partnership approach between study participants and the use of PAR facilitated by Action Learning Sets. Working in partnership enhances collaborative relationships of group members where all ideas are considered of equal value, based on trust and mutual understanding (WHO, 2017). This enables the views of the peer support workers, parents and community agencies to be heard and embedded in the development of a culturally appropriate peer-led home visiting support service for Aboriginal families with young children. Of note is the ability of participants to be listened to in respectful, non-judgemental environments where their worldviews on the elements of a culturally secure peer-led home visiting parent support program can be presented, explored and progressed (Munns et al., 2016b, Munns et al., 2017a,b).

Reflective practice sessions within each Action Learning Set allowed parent support strategies to be examined from the perspectives of peer support workers, parents and community agency staff in relation to feasibility, acceptability, effectiveness and ultimately suitability. The Researcher was able to facilitate Action Learning Sets, collect data on program strengths, challenges and adaptations, provide feedback to each of the participant groups, following which strategies were able to be strengthened for ongoing home visiting. This research has identified that PAR with Action Learning Sets are integral to the engagement of child health nurse researchers, peer support workers, parents and community agencies to explore the most acceptable elements for peer-led home visiting support for their unique communities (Munns et al., 2016b, Munns et al., 2017a,b).

These study findings have added to the body of knowledge needed to assist the development of a strengths-based culturally secure Aboriginal peer-led home visiting parent support model. The identified elements are: Peer support worker home visiting skills supported by peer support worker education and training needs, and peer support worker attributes and strategies; Responding to the impacts on families from social determinants of health facilitated by peer support worker non-judgemental listening, knowledge of accessible local resources and development of meaningful, realistic and empathic strategies in partnership with their clients; Client support and engagement related to availability of culturally relevant client support, client engagement, and client acceptance of peer support workers; Interagency collaboration; and Issues addressing program sustainability as identified by funding and management governance. Families are central to significantly influencing their children's physical and psychosocial opportunities. Implementation of this innovative partnership model will support parents to develop empowering culturally appropriate parenting strategies that will have lifelong health and wellbeing benefits for their children.

5.4   Recommendations for clinical practice, policy and future research

The findings from this study have added to the body of knowledge for the development of a model for a culturally secure Aboriginal peer-led home visiting child health in Midland, WA. It provides a community strengths-based approach for parents, assisting

them to develop empowering culturally appropriate parenting strategies that will have lifelong health and wellbeing benefits for their children. Recommendations for clinical practice are proposed which will inform a model for this home visiting parent support. These are followed by recommendations for policy and further research.

5.4.1   Recommendations for clinical practice

1. Recognition is needed for the role of Aboriginal peer support workers, who are able to work in partnership with parents to provide psychosocial support and community agency linkage to Aboriginal parents with young children.

2. Peer-led home visiting support needs to be offered universally to Aboriginal parents in urban, rural and remote locations in Western Australia. Targeted approaches can be perceived as stigmatising for families and universal programs offer preventative support.

3. Peer-led parent support can be undertaken in locations other than home settings. Alternative venues identified by parents may be more conducive to effective communication and other strategies for a range of personal, family or cultural reasons.

4. Peer-led home visiting parent support needs to be developed through Aboriginal and non-Aboriginal child health services in communities using Participatory Action Research with peer support workers, parents, a range of government and non-government community agencies and child health nurses. Participatory Action Research is optimally facilitated by Action Learning Sets that employ reflective practice and culturally relevant educational components.

5. The educational component preparing peer support workers for their role needs to be developed as a Certificate 11 program. This has potential for enhancing their standing in the community health and wellbeing team and giving formal recognition for their competencies in parent support.

6. Program funding should be optimally administered by a government or non-government agency that is able to be reflexive to program budgetary requirements in a timely manner in order to enhance service delivery.

5.4.2   Recommendations for policy

1. Program funding providers need to grant secure funding for a minimum of five years. This recognises the time taken to develop trusting enabling partnerships between peer support workers, parents, communities and child health nurses and

address the complex and interrelated social determinants of health adversely impacting on families.

2. Program funding providers need to develop program reporting and evaluation frameworks that recognise qualitative data as having equal importance as quantitative statistics. This would enable the views of all participants on program benefits and challenges to be known and acknowledged. These frameworks could document the more localised and nuanced elements of successful initiatives.

5.4.3   Recommendations for future research

1. The benefits of peer-led home visiting as universal or targeted support should be explored.

2. Further understanding of Aboriginal worldviews needs to be investigated in order to more optimally address the interrelationship of factors influencing parenting and family interactions with their children.

3. A cost benefit analysis of this Aboriginal peer-led home visiting program would benefit the body of knowledge and inform policy development for this area of parent support.

4. Longitudinal research for this program would be able to explore the benefits and challenges of peer support worker care for families over a longer period and how the program can be optimally supported.

5.5   Study limitations and transferability of findings

This study was undertaken in a specific urban Australian Aboriginal community. As there are distinct cultural diversities between Aboriginal communities, potential limitations exist in relation to transferability of study findings to other settings. However, the data can inform peer-led home visiting support in other cultural and geographical locations. Moreover the similarities/commonalities in the relevance of the role of peer support workers was evident in the previous work by the Researcher in the Community Families Program in Halls Creek confirming the potential relevance of both the role of peer support workers and the benefits of home visiting or outreach (Walker, 2010; Munns & Walker, 2015).

A potential methodological weakness in this qualitative study is recognised due to the small number of participants. Nevertheless, the in-depth, iterative engagement

with participants over ten Action Learning Sets enabled the Researcher to gain comprehensive and meaningful data.

Only two parents were able to be interviewed by the Researcher due to significant engagement issues as a result of the complex factors surrounding parents' lives. The detailed responses elicited valuable data that aligned with the credible responses from the peer support workers who were also parents living in the same community. While it is recognised that no person can have an entire appreciation of another's life experiences, the ability of peer support workers to communicate with mutual respect with parents on personal and culturally sensitive issues enhanced the justification for affirming the two data sets.

Objective Three from the study was designed to explore the self-perceived suitability, feasibility, acceptability and effectiveness of the program. The ability to measure effectiveness has been difficult due to the short length of time that the program has been available to the Aboriginal population in Midland. However, data obtained from all three participant cohorts demonstrates a positive progressive trend towards program value and usefulness which highlight emerging program effectiveness.

5.6   Conclusion

The study outcomes have identified innovative data, highlighting collaboration between Aboriginal peer support workers, parents, community agencies and a child health researcher to specify and examine culturally secure elements for an empowering methodology for peer-led home visiting support for parents with children in the early years. Of note is the emerging dynamic role of the peer support worker which is central to strengthening parenting environments through psychosocial support and linkage with appropriate community support. Lifelong health and wellbeing trajectories for children are enhanced through secure, positive parenting environments that are supported by culturally appropriate peer-led home visiting support.

Overall, all aims and objectives of this study have been addressed. Currently, and over time, peer-led strategies from this early intervention program will enable enduring, confident environments for parents and children in this Western Australian setting and potentially for other vulnerable population groups within diverse settings.

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APPENDICES

Appendix A is presented from the *Publications and Statement of Contributions from Others*.

Appendices B to **F** are relevant appendices selected from the four published papers and one final version manuscript that have been accepted for publication.

Appendix A   Copyright Permission Statements

A.1   Permission for Papers 1 and 2

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Email: jbi@adelaide.edu.au
Web: www.joannabriggs.org

18th April 2016

Ailsa Munns
School of Nursing, Midwifery & Paramedicine
Curtin University
GPO Box U1987 Perth 6845
Email: A.Munns@curtin.edu.au

Dear Ailsa,

Re: Permission to reproduce JBI Systematic Review in thesis.

The Joanna Briggs Institute provides permission/non-exclusive licence for you to include the JBI Systematic Reviews indicated in your thesis:

Munns, A., Hegney, D., & Walker, R. (2014). A comprehensive systematic review of the effectiveness and experiences of Indigenous families participating in peer led parenting support programs delivered as home visiting programs, and the meaning they attribute to these support programs: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 12*(3), 1-13.

Munns, A., Watts, R., Hegney, D., & Walker, R. (2016). Effectiveness and experiences of families participating in peer led parenting support programs delivered as home visiting programs and the meaning they attribute to these support programs: a comprehensive systematic review. *JBI Database of Systematic Reviews and Implementation Reports, 14*(10), 167-208.

This permission includes reproduction for examination purposes and in publically available copies of your thesis, either in hardcopy or in online format. Archiving in your institutional repository is also permitted.

Where presented in your manuscript, reference should be made to the appropriate source.

Sincerely,

Associate Professor Edoardo Aromataris
Director, Synthesis Science
Editor-in-Chief, *The JBI Database of Systematic Reviews and Implementation Reports*
The Joanna Briggs Institute

A.2   Permission for Paper 3

Taylor & Francis
Taylor & Francis Group

Our Ref: JB/RCNJ/P17/1423

14TH September 2017

Dear Alisa Munns

Thank you for your correspondence requesting permission to reproduce the following article published in our journal in your printed thesis and to be posted in your university's repository at Curtin University.

MATERIAL REQUESTED: 'Peer-led Aboriginal parent support: Program development for vulnerable populations with participatory action research' by Ailsa Munns, Christine Toye, Desley Hegney, Marion Kickett, Rhonda Marriott & Roz Walker *Contemporary Nurse* **pp. 1-18 (2017).**

We will be pleased to grant permission on the sole condition that you acknowledge the original source of publication and insert a reference to the article on the Journals website:

This is the authors accepted manuscript of an article published as the version of record in Contemporary Nurse on 2nd August 2017.
http://www.tandfonline.com/   http://dx.doi.org/10.1080/10376178.2017.1358649

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Yours sincerely

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A.3 Permission for Paper 4

A.4   Permission for Paper 5

Acceptance of Paper Five for publication. The authors' last version of the paper is presented in the thesis.

- OnlineOpen - is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see http://olabout.wiley.com/WileyCDA/Section/id-406241.html. Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at:
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After acceptance, your manuscript will appear almost immediately under the Accepted Articles section on Wiley Online Library. The manuscript will be published under the Early View section immediately after the proofs are received by the production editor. Once the paper is published under Early View, it can be considered fully published as it has a digital object identifier (www.doi.org) and can therefore be cited in other papers, listed in curricula vitae, listed in research grant applications and used in applications for promotion. As papers are gathered into cognate groups and also used at our discretion in special issues, we do not specify when the hard copy version will be published. The timeframe from acceptance to publication in print is approximately 5 months.
In accepting your paper, both JCN and Wiley give no commitment about date of publication. Therefore, while we can inform you of a likely date in the event of an enquiry, unfortunately we are unable to accommodate individual requests to have papers published at a particular time to coincide with, for example, the requirements of grant awarding bodies or promotion boards.

Please note that due to the volume of submissions received by the Journal we are unable to send out any letters of acceptance. However, please accept this e-mail, pending final submission of your paper, as proof of acceptance by JCN.

Thank you for your contribution, we look forward to your continued contributions to the Journal.

Yours sincerely,

Prof. Debra Jackson
Editor-in-Chief
Journal of Clinical Nursing

Appendix B   Ethics Committees Approval Letters

B.1   Western Australian Aboriginal Health Ethics Committee

Western Australian Aboriginal Health Ethics Committee
PO Box 8493, Stirling Street, PERTH WA 6849

15th February 2013

Dear Ailsa,

RE: HREC Reference number: 462
Project title: *Investigation of a culturally secure home visiting model for Aboriginal family and child health support in Midland community in Western Australia*

Thank you for submitting the above research project which was considered by the WAAHEC at its meeting held on *12th February 2013*.

I am pleased to advise that the WAAHEC has granted approval of this research project. WAAHEC approval is granted from *12th February 2013* pending your agreement of the following conditions:

1.   Conditions

- The WAAHEC will be notified, giving reasons, if the project is discontinued before the expected date of completion.

- The Coordinating Investigator will provide an annual report to the WAAHEC and at completion of the study in the specified format. This form can be found on the AHCWA website (www.ahcwa.org).

- The approval for studies is for three years and the research should be commenced and completed within that period of time. Projects must be resubmitted if an extension of time is required.

- Publications that arise from this research are to be provided to the WAAHEC for review prior to submission for dissemination.

- That the Aboriginal and Torres Strait Islander community are formally acknowledged for their contribution to this research project.

2.   Amendments

If there is an event requiring amendments to be submitted you should immediately contact ethics@ahcwa.org for advice.

Should you have any queries about the WAAHEC's consideration of your project please contact ethics@ahcwa.org.

The WAAHEC wishes you every success in your research.

Kind regards

Chelsea Bell
For
Tammy Prouse
Chair, WAAHEC

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.* The process this HREC uses to review multi-centre research proposals has been certified by the NHMRC.

B.2 Ngala

9 George St
Kensington
WA 6151

Ms Ailsa Munns
School of Nursing and Midwifery
Curtin University
Building 405, Room 406
GPO Box U1987
PERTH WA 6845

Dear Ms Munns,

RE: Research Project: Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia.

I am pleased to advise that the Ngala Executive have considered and accepted your research proposal: Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia.

This research project is being undertaken in partnership with Curtin School of Nursing and Midwifery and is being processed through the Curtin University ethics committee and as such I wish to acknowledge you have been granted permission to access documents and staff for the purposes of your study and support from Wade Sinclair, Manager Community Practice and Development, who can be part of the internal coordination team to;

- Assist with resource requirements and issues (which have been noted and are being addressed);
- Observe any ethical issues or conflict of interest; and
- Assist to resolve any research-based ethical concerns that may arise.

Please note, Ngala is funding this research project from Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) funding and can only provide financially based assistance whilst Ngala has this funding for engaging Aboriginal families in the Midland area.

I wish you well in the planning and undertaking of the study and look forward to reading the reports and findings from the study.
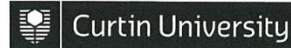
Yours sincerely

E Bennett

Elaine Bennett
Director Services, Education & Research
NGALA

28 November 2012

B.3 Curtin University Human Research Ethics Committee

Curtin University

Memorandum

To	Professor Desley Hegney, Nursing and Midwifery
From	Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval **HR 73/2013**
Date	7 June 2013
Copy	Ailsa Munns, Nursing and Midwifery Dr Marion Kickett, Nursing and Midwifery

Office of Research and Development
Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application (4469) submitted to the Human Research Ethics Committee (HREC) for the project titled "*Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia*". Your application has been reviewed by the HREC and is **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 73/2013**. *Please quote this number in any future correspondence.*
- Approval of this project is for a period of 4 years **11-06-2013** to **11-06-2017**.
- Your approval has the following conditions:
    - (i) Annual progress reports on the project must be submitted to the Ethics Office.
- **It is your responsibility, as the researcher, to meet the conditions outlined above and to retain the necessary records demonstrating that these have been completed.**

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **Progress Report** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development annually.

Our website https://research.curtin.edu.au/guides/ethics/non_low_risk_hrec_forms.cfm contains all other relevant forms including:
- Completion Report (to be completed when a project has ceased)
- Amendment Request (to be completed at any time changes/amendments occur)
- Adverse Event Notification Form (If a serious or unexpected adverse event occurs)

Yours sincerely,

Professor Stephan Millett
Chair Human Research Ethics Committee

Standard conditions of ethics approval

These standard conditions apply to all research approved by the Curtin University Human Research Ethics Committee. It is the responsibility of each researcher named on the application to ensure these conditions are met.

1. **Compliance.** Conduct your research in accordance with the application as it has been approved and keep appropriate records.
   a. **Monitoring** - Assist the Committee to monitor the conduct of the approved research by completing promptly and returning all project review forms that are sent to you.
   b. **Annual report** - Submit an annual report on or before the anniversary of the approval.
   c. **Extensions** - If you are likely to need more time to conduct your research than is already approved, complete a new application six weeks before the current approval expires.
   d. **Changes to protocol** - Any changes to the protocol are to be approved by the Committee before being implemented.
   e. **Changes to researcher details** - Advise the Committee of any changes in the contact details of the researchers involved in the approved study.
   f. **Discontinuation** - You must inform the Committee, giving reasons, if the research is not conducted or is discontinued before the expected completion date.
   g. **Closure** - Submit a final report when the research is completed. Include details of when data will be destroyed, and how, or if any future use is planned for the data.
   h. **Candidacy** - If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Faculty Graduate Studies Committee.
2. **Adverse events.** Consider what might constitute an adverse event and what actions may be needed if an adverse event occurs. Follow the procedures for reporting and addressing adverse events (http://research.curtin.edu.au/guides/adverse.cfm).Where appropriate, provide an adverse events protocol. The following are examples of adverse events:
   a. Complaints
   b. Harm to participants. This includes physical, emotional, psychological, economic, legal, social and cultural harm (NS Section 2)
   c. Loss of data or breaches of data security
   d. Legal challenges to the research
3. **Data management plan.** Have a Data Management Plan consistent with the University's recordkeeping policy. This will include such things as how the data are to be stored, for how long, and who has authorised access.
4. **Publication.** Where practicable, ensure the results of the research are made available to participants in a way that is timely and clear (NS 1.5). Unless prohibited from doing so by contractual obligations, ensure the results of the research are published in a manner that will allow public scrutiny (NS 1.3, d). Inform the Committee of any constraints on publication.
5. **Police checks and other clearances.** All necessary clearances, such as Working with Children Checks, first aid certificates and vaccination certificates, must be obtained before entering a site to conduct research.
6. **Participant information.** All information for participants must be approved by the HREC before being given to the participants or made available to the public.
   a. **University logo.** All participant information and consent forms must contain the Curtin University logo and University contact details for the researchers. Private contact details should not be used.
   b. **Standard statement.** All participant information forms must contain the HREC standard statement.

   This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 73/2013). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

   c. **Plain language.** All participant information must be in plain language that will be easily understood by the participants.

Please direct all communication through the Research Ethics Office

Curtin University   *HREC Progress Report*

The Form is to be completed and returned to *the Secretary, Human Research Ethics Committee, c/- Office of Research & Development.* hrec@curtin.edu.au

If a Form C Co-ordinator, approved your application please submit your completed form to your school Form C Co-ordinator.

Annual completion of this form fulfils researchers' obligations under section 5.5.5 of the National Statement on Ethical Conduct in Human Research.

All questions must be answered or the Form will not be processed.

Approval Number:	
PROJECT TITLE:	

1	Please confirm the project is proceeding exactly as specified in the protocol.	YES☐	NO☐

If NO, please provide details_____
(Attach additional comments on a separate sheet of paper if necessary)

2	Have any ethics related issues emerged in regard to this project since you received Ethics' Committee approval? (e.g. breach of confidentiality, harm caused, inadequate consent or disputes on these).	YES☐	NO☐

If yes, please provide details_____
(Attach additional comments on a separate sheet of paper if necessary)

3	Have any ethics related issues in regard to this project been brought to your attention by others? (e.g. study respondents, organisations that have given consent, colleagues, the general community etc).	YES☐	NO☐

If yes, please provide details_____
(Attach additional comments on a separate sheet of paper if necessary)

4	Please outline the progress made to date. (e.g. Number of participants recruited; Data collected / analysed; Papers published)	YES☐	NO☐

(Attach additional comments on a separate sheet of paper if necessary)

5	Please detail what arrangements have been made for the ongoing storage and security of the research records in accordance with the Western Australian University Sector Disposal Authority (WAUSDA). http://uim.curtin.edu.au

(Attach additional comments on a separate sheet of paper if necessary)

Investigator:		Signature:	
		Date:	
Co-Investigator:		Signature:	
School/Department:			
Head of Area: Or equivalent		Signature:	
Date:			

Office Use Only
APPROVED:_____   DATE: _____/_____/_____

Appendix C   Participant Information Letter

Curtin University

Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia.

My name is Ailsa Munns and I am a PhD student at Curtin University, working with Ngala in Midland on this study.

Why are we doing the study?
The home visiting service in Midland is a community-based family and child health support and education program for parents of young children in Midland. This program aims to draw on skills, knowledge and experience of Aboriginal parents in the community in combination with knowledge of health professionals and other service providers to improve health and development outcomes for Aboriginal children and helping parents feel stronger in their parenting. This study is important to find out about the experiences of program staff and families and whether the program is helping to change things positively for the families, children and the community.

Who is carrying out the study?
The study is being carried out by a Researcher/Child Health Nurse from Curtin University in partnership with the Aboriginal Project Coordinator and Parent Support Workers involved in the program. It is being conducted with the support of the Derbarl Yerrigan Health Service.

What will the study tell us?
The study will provide health practitioners, and program workers with greater understanding of the issues effecting Aboriginal parents through their children's early years. This information will help them to work with and assist Aboriginal families involved in the program. It will also assist program staff in making decisions about how to run this program.

What will you be asked to do if you decide to take part in this study?
You will be asked to meet with the Researcher and the Aboriginal Project Coordinator and/or a Parent Support Worker, either on your own or with family members, to talk about support you would like for parents, and your ideas about this program.

Is there likely to be a benefit to other people in the future?
The study will benefit Aboriginal families in the future because it will help health practitioners and policy makers and funders understand the sorts of things that make it important to have programs for families and their children. Your ideas and feedback will help staff to identify ways to improve the programs. It may lead resources for health practitioners and Aboriginal families.

What are the possible risks and/or side effects?
It is very unlikely that there will be any risks in participating in this study unless the stories you tell make you feel sad or unhappy. The Aboriginal interviewer/interpreter involved in your interview will make sure you are feeling okay throughout the interview. If you have concerns you will be given the option to be referred to appropriate services to assist you to come to terms with these feelings.

What are the possible discomforts and/or inconveniences?
You may not be comfortable with inviting the researcher to your home for the interview. If this is the case, the interview can be arranged to take place at another suitable location, and if required, transport can be provided for you to attend the interview location.

17

Where is your information kept?

All study information is kept in a locked cupboard in a secure building at Curtin University or on a computer that has a secure password and is kept in a locked room at Curtin University.

What about my privacy?

Your privacy is assured, and no personal information will be released to any person or organisation in a way that you could be recognised.

Who has approved the study?

The study has been approved by the WA Aboriginal Health Information and Ethics Committee and the Curtin University Human Ethics Committee and has the support of Derbarl Yerrigan Health Service.

Who to contact for more information about this study:

If you would like any more information about this study, please contact the researcher/child health nurse at Curtin University. She will be very happy to answer your questions.

Name	Title	Contact Details
Ailsa Munns	Lecturer/Child Health Nurse	Ph: 9266 2209 A.Munns@curtin.edu.au

Who to contact if you have any concerns about the organisation or running of the study?

The Human Research Ethics Committee at Curtin University requires that all participants are informed that, if they have any complaint regarding the manner in which the research project is conducted, they may contact the Human Research Ethics Committee secretary on phone 9266 2784 or hrec@curtin.edu.au or in writing c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth WA, 6845.

This project has been approved by the Curtin University Human Research Ethics Committee: Approval Number HR73/2013.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

<p align="center">THANK YOU FOR YOUR TIME</p>

<p align="center">18</p>

Appendix D   Participant Consent Form

Curtin University

FORM OF CONSENT

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND YOU CAN WITHDRAW YOUR CONSENT AT ANY TIME WITHOUT ANY UNFAVOURABLE IMPACT ON YOUR CURRENT OR FUTURE CARE.

You do not need to give any reason nor justification for such a decision. In such cases, any information collected will be destroyed, unless otherwise agreed by the participant.

I ....

Given Names   Surname

have read the information explaining the study entitled

Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia.

I have read and understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not interfere with any care or services in the program

I agree that research data gathered from the results of this study may be published, provided that names are not used.

Dated .... day of 2013

Signature ....

I, (Investigator's full name) have explained the above to the signatory who stated that he/she understood the same.

Signature ....

Dated .... day of 2013

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Appendix E   Interview Guide

Investigation of a culturally secure home visiting model for Aboriginal family and child health support in the Midland community in Western Australia: Interview Questions

Client families
Action learning set 1: Can you tell me what it is like to be a parent with a baby/young child/young children in Midland?

Action learning sets 2-10: Can you tell me about the program and the Parent Support Worker who is coming to see you?

Parent Support Workers and Project Coordinator
Action learning set 1: Can you tell me what it is like to be a parent with a baby or young children in Midland?

Action learning sets 2-10 (following home visiting sessions with parents):
  1. Unstructured interview: Tell me about the program and how you see it is going?

  2. Semi-structured interview;

        Progress, strengths and challenges
        • Think about your visits – what is working well? How are these visits encouraging and supporting parents?
        • What is not working well? Why do you think this is happening?
        • How could you have said things differently that allowed parents time to talk and work on their ideas?
        • Have you had any visits where the problems have been too hard to handle?

Community agencies
Action learning set 1: Can you tell me what it is like to be a parent with a baby or young children in Midland?

Action learning sets 2-10: Can you tell me about the program and how you see it is helping or not helping parents in Midland? Can we work together more collaboratively?

Appendix F   Action Learning Sets Schedule

5 PSW & Coord 8-10 Clients 4 CKI	5 PSW & Coord	5 PSW & Coord	5 PSW & Coord 8-10 Clients 4 CKI	5 PSW & Coord	5 PSW & Coord	5 PSW & Coord 8-10 Clients 4 CKI	5 PSW & Coord	5 PSW & Coord	5 PSW & Coord 8-10 Clients 4 CKI
Action learning set 1 Apr 2013	Action learning set 2 May 2013	Action learning set 3 Jun 2013	Action learning set 4 Aug 2013	Action learning set 5 Sep 2013	Action learning set 6 Oct 2013	Action learning set 7 Nov 2013	Action learning set 8 Dec 2013	Action learning set 9 Feb 2014	Action learning set 10 Mar 2014

CKI: Community Key Informants
Clients: Aboriginal parents/families
PSW & Coord: Parent Support Workers; Local Project Coordinator