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FINAL REPORT

ANFPP National Workforce Development Study – Informing the Way Ahead Project

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Terminology

Throughout this report, the term *Indigenous* is used to respectfully refer to both Aboriginal and/or Torres Strait Islander people. The authors of this report wish to acknowledge the fundamental diversity of both Aboriginal and Torres Strait Islander cultures, and use of the term *Indigenous* is in no way intended to diminish this diversity.

Executive Summary

This report outlines the results of Phase 2 of the *Australian Nurse-Family Partnership Program (ANFPP) National Workforce Development Study Informing the Way Ahead Project* conducted to inform ANFPP future workforce development. Phase 2 was preceded and informed by Phase 1 which consisted of a literature review (CRANAplus, 2016). The data collected for this report utilised a First Peoples-led concurrent mixed-methods design that allowed for qualitative and quantitative data to be collected and analysed simultaneously. Both data elements were integrated in the process of the interpretation of the results that were presented and discussed, with recommendations made according to 'key focus area' findings. These findings were then integrated into an overall discussion that embedded the key focus area findings and discussion with the background and literature context that formed the basis of the results.

The findings reported in the key focus areas of this report outline the fundamental and key factors influencing ANFPP workforce retention in Australia. The ANFPP is a Nurse-led home visiting program, adapted from an internationally recognised and evidence based, Nurse-Family Program (NFP). Its recent application in Australia, beginning in 2008 and currently continuing and expanding, has witnessed the licenced adaption of the NFP model to the Indigenous Australian Healthcare (IAH) context to potentially contribute to the health, development and lifecourse outcomes of Indigenous babies and children and ultimately Indigenous families and communities. The chief adaption of the NFP to this context has been the addition of a Family Partnership Worker (FPW) to work within the Nurse-led model of the ANFPP. While this adaption, inspired by the traditional role of an Indigenous Health Worker (IWH) from the Indigenous Australian Healthcare Service (IAHS) context, has been a significant and promising development for the implementation of the ANFPP in the IAHS context, further adaption of the ANFPP is required to realise the full scope of benefits, evidenced internationally, within the Indigenous Australian healthcare context.

The findings of this report outline the need for the ANFPP to more strongly align the values and aspirations of the Indigenous Australian Healthcare Context through the application of

recognised frameworks as identified in the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health and the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) (2013-2023) (*Australian Government, 2013; Commonwealth of Australia, 2016) through an approach that heightens and values Indigenous leadership and a partnership approach between the ANFPP and the IAH context. Several critical partnerships between all levels of the ANFPP and the Indigenous Australian health context are recommended in the report along with a framework of *how* the ANFPP can better and more deeply engage with the IAHS context. The critical partnership between the FPW role and the Nurse Home Visitor (NHV) role in delivering the corner-stone, 'client centred model of care' framework espoused by the ANFPP is particularly featured in the findings, and the discussion and recommendations of these findings provide guidance on how the FPW and NHV roles can work together to deliver a client-centred model of care, that not only contributes to the evidenced success of the NFP program, but that is also a key factor driving the retention of FPW and NHV.

Further findings of the report outline key recruitment strategies to ensure the best alignment of the ANFPP workforce to the IAH context. Heightened priority of experience of working in an IAH context is essential in recruitment process and procedures of support in the ANFPP and implementing IAHS implementing site. The findings also identify other desirable qualities and characteristics, such as 'being open to change', of both FPW and NHV that assist these roles to work in partnership in the ANFPP according to a client-centred model of care. The important and necessary role of the ANFPP's National Program Centre (NPC) in providing support to implementing IAHS sites has been highlighted in the findings. Their potential role in providing further support to IAHS sites in the recruitment of an appropriate ANFPP workforce, along with their role in adapting and implementing the ANFPP education package to better meet the needs of an ANFPP workforce working in an Indigenous Australian health context is critical. Closer and deeper partnerships between the NPC and the IAHS sites would assist in realising the full benefits of the support the NPC could offer and the findings of this report make specific

recommendations for this to occur, such as having one consistent and central NPC contact for each IAHS site to support the development of deeper relationships.

The adaption of the ANFPP education package to better reflect the ANFPP workforce needs to work in an IAH context is critical, in particular the adaption of the package to the recognised *Aboriginal and Torres Strait Islander Health Curriculum Framework (ATSIHCF)* (Department of Health, 2014) to improve the cultural competency of not just the ANFPP workforce, but the cultural capability of the entire ANFPP program is important. The adaption of the education package to better reflect the *training* needs of the workforce is strongly needed and again strong partnerships between the ANFPP and the IAHS sites, and specifically with FPW will ensure that the education and training needs of the ANFPP workforce are better reflected and met by the ANFPP education package. A strong need for the ANFPP education package and its delivery modes to recognise the diversity of the application of the FPW role within the different IAHS sites is essential to better align the education and training package with the IAH context.

The last findings of this report highlight specific strategies that can be implemented by the ANFPP to safeguard the retention of its workforce. The centrality of the relationship between the FPW and NHV in delivering a client-centred model of care drives job satisfaction within the ANFPP that underpins their retention. FPW and NHVs ability to deliver this model to realise and witness the successful outcomes of the ANFPP are critical as with, *their feelings of being valued* in this process. Constant organisational and program disruption from the turnover of a Nurse Supervisor (NS) threatens the job satisfaction of both the FPW and NHV and threatens the retention, specifically of NHV. The findings reported that the turnover of NS within the ANFPP is strongly influenced by IAHS support and commitment to the ANFPP reinforcing the fundamental finding of the report of better alignment between the ANFPP and IAH context to promote the joint objectives of the domains to contribute to the health, development and lifecourse outcomes of Indigenous babies, children, families and communities.

Specific support mechanisms implemented by the ANFPP, including another corner-stone of the program, 'Reflective Practice' were identified as buffering the retention of the ANFPP workforce, specifically of the NS role, however this finding sat within the broader context of the joint commitment of the ANFPP and IAH context to deliver a successful ANFPP program to contribute to the health and quality of life of Indigenous Australians. This report concludes by identifying relevant indicators and research to inform future ANFPP workforce retention and highlights the critical role that a First-Peoples led research team can contribute to providing unique insight into its results.

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List and Definition of Abbreviations

ACW	Aboriginal Community Worker *Similar to the Family Partnership Worker (FPW), a unique adaptation of the Nurse-Family Partnership program for Australia, has been specifically identified in some sites in the Northern Territory, Australia.*
ANFPP	Australian Nurse-Family Partnership Program *Encompasses all components of the ANFPP (outlined in Appendix 1: ANFPP Structure), including the Implementing Organisations (outlined in blue in Appendix 1)*
ATSIHCF	Aboriginal and Torres Strait Islander Health Curriculum Framework *The recently released Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health, 2015) provides guidance for providers of health curricula in the higher education sector to develop students' cultural capabilities.*
BPR	Broader Program Role *A role associated with the ANFPP external to the Implementing Organisations (outlined in blue in Appendix 1) that includes, but is not limited to the NPC and CaFHS*
CEO	Chief Executive Officer *Provides leadership of the Indigenous Health Service, guided by the Community Board which oversees all business of the organisation.*
CaFHS	Child and Family Health Service *Is a section within the Health Programs and Sector Development Branch of the Indigenous Health Division (Executive) within the Commonwealth Government Department of Health.*
FPW	Family Partnership Worker *A unique adaptation of the Nurse-Family Partnership program for Australia has been the inclusion of the Family Partnership Worker. Family Partnership Workers promote trust and respect between the clients and their family, the Indigenous community and health providers.*

HRM	Human Resource Management *The Human Resource Management team sits within the Indigenous Health Service and coordinates ANFPP employee recruitment.*
IAH	Indigenous Australian Healthcare *The broader national context of Aboriginal and Torres Strait Islander Community Controlled Organisations and/or Indigenous Australian Healthcare Services operated by a Commonwealth or State government department. The broader national context includes but is not limited to the historical and current political and policy environment and the key organisations, groups and individuals whom influence this environment.*
IAHS	Indigenous Australian Healthcare Service *The Aboriginal and Torres Strait Islander Community Controlled Organisation, or The Indigenous Health Service is also known as the 'Implementing Organisation' (outlined in blue in Appendix 1), 'Site' or 'Setting'.*
IHW	Indigenous Health Worker *An Indigenous health role developed within the IAH and IAHS to promote trust and respect between Indigenous clients, families, and communities and health providers.*
NFP	Nurse-Family Partnership *The ANFPP is adapted from the successful evidence-based Nurse-Family Partnership (NFP) model of home visiting developed by Professor David Olds in the USA over the last 40 years.*
NHV	Nurse Home Visitor *The Nurse Home Visitor is responsible for delivering program content (i.e home visiting guidelines) to eligible clients, with fidelity to the NFP model.*
NPC	National Program Centre *The National Program Centre provides professional support and core workforce education to the ANFPP implementing sites (outlined in dark orange in Appendix 1).*

NS	Nurse Supervisor *The role of the Nurse Supervisor is to manage the effective operation of the ANFPP, including local contracts and budgets, and supervising the local team which consists of NHV, FPW and administrative staff.*
PM	Program Manager *The Program Manager is funded and employed by the IHS to oversee the implementation of ANFPP at the IAHS.*

1.0 Introduction

1.1 Background and Literature Overview

The Australian Nurse-Family Partnership Program (ANFPP) National Workforce Development Study – Informing the Way Ahead Project aimed to gather baseline data to inform ANFPP workforce recruitment, retention and education strategies, and identify ANFPP workforce characteristics and future data collection needs. The project was comprised of two phases. Phase One was a literature review conducted by CRANAplus (CRANAplus, 2016) and presented in a separate report. Phase Two is the current data collection, which will inform the review of the *ANFPP National Workforce Development Education Strategy*, that focuses on improving long term outcomes, such as staff retention rates, and increasing the potential to contribute to ANFPP's ongoing effectiveness. This data collection also explored the significance of the FPW role to the successful implementation of the ANFPP in the IAHS context. Finally, the results of this data collection will further pave the way to inform a national research agenda for the ANFPP with priority given to examining the critical role of Indigenous cultural knowledge in delivering the ANFPP within an IAH context.

The ANFPP is a nurse home visiting program with a focus on maternal health and early childhood development, which supports women pregnant with an Indigenous baby through the first two years of the baby's life (ANFPP, 2014a). The ANFPP is a licensed program based on the successful evidence-based NFP model of home visiting developed by Professor David Olds in the USA over the last 40 years (Olds et al, 2014). Extensively researched and evaluated, including randomised control trials, the NFP has consistently shown improvements in pregnancy outcomes, maternal health, child health and development, and parental life course (Kitzman et al., 1997; Olds, Henderson, Tatelbaum & Chamberlin, 1986; Olds, 2002; Olds et al, 2014). Expansion of NFP internationally began in 2004 and there is now a total of nine countries implementing or evaluating the NFP (University of Colorado, 2016). The Australian Government committed to introducing the ANFPP as part of its 'Closing the Gap' health

strategy to address disadvantage in Aboriginal and Torres Islander families and communities (Australian Medical Association, 2013).

In light of the growing recognition of the need to balance the NFP's objectives with the context of implementation (University of Colorado, 2016), the NFP model was adapted to the Australian context in 2008 (ANFPP, 2014a). With a specific focus on Indigenous families and communities, the ANFPP was implemented at key IAHS sites in 2009 (ANFPP, 2014a). The most significant adaption to the NFP model was the inclusion of a Family Partnership Worker (FPW) role into the ANFPP team that was viewed as being integral to the success of the program within the IAH context (ANFPP National Program Centre, 2016c).

The FPW role, while a unique and developing role in the ANFPP, draws many parallels to a traditional Indigenous Health Worker (IHW) role that has operated in Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS) since their inception in Redfern, Australia in 1971 (The National Aboriginal and Torres Strait Islander Health Worker Association [NATSIHWA], 2012). These services and IHWs have an established track record of promoting and protecting the health and well-being outcomes of Indigenous communities and families over the last 40 years through the provision of culturally capable, respectful and safe care (The National Aboriginal Community Controlled Health Organisation (NACCHO), 2016). The most important aspect of the model of care provided by these services and IHWs is that they are community led and controlled (Bailey & Hunt, 2012; Martin, 2005). This is especially important given the historical impact of colonisation in Australia including the forced removal of Aboriginal children from their families that has, and continues to have, a profound impact on Aboriginal and Torres Strait Islander people in Australia (Dudgeon et al., 2014). The current inter-generational trauma and large disparities in Indigenous community and family health and well-being, are a direct result of the negative influence of such previous and current government policies (Dillon & Westbury, 2007; Fredericks & Legge, 2011; Stoneman & Taylor, 2007). To address these negative influences, Indigenous led and controlled models of care have emerged over the last 40 years to protect Indigenous

community and family health and well-being against the potentially damaging and inappropriate responses to Indigenous health disparities by externally led initiatives (Bailey & Hunt, 2012; Hayman, White, & Spurling, 2009; NATSIHWA, 2012). Given this complex sociohistorical context, there are unique challenges with implementing effective programs and policies for Indigenous peoples in Australia. These challenges include the development of trustful and respectful relationships between Indigenous and non-Indigenous people and organisations; the unclear and complicated responsibilities of government and state institutions; funding models that are often complex and inadequate and relationships between key stakeholders who often are competing for differing priorities (Lowitja Institute, 2015).

While Indigenous families are among the most disadvantaged and at risk families in Australia, child and maternal health programs have been instrumental in improving Indigenous health outcomes (Bertilone & McEvoy, 2015; Ware, 2013). Child health and maternal health programs operate in various guises within Australia, including home visiting programs where nurses work in conjunction with Aboriginal and/or Torres Strait Islander peoples to provide access to Indigenous families and communities (Australian Medical Association, 2013; Bowes & Grace, 2014; McDonald, Moore and Goldfield, 2012). Sivak, Arney and Lewig (2008) reviewed a home visiting program in South Australia where Indigenous Cultural Consultants (ICC) accompanied various health professionals, including child health nurses, on home visits to Aboriginal clients. The ICCs' ability to broker relationships and build trust were found to be imperative to the delivery and function of the home visiting program, and integral to achieving both successful engagement and outcomes for Indigenous mothers and children (Sivak et al., 2008). In the ANFPP, a key component of the FPW's role is to similarly aid in building trust and act as cultural brokers between mothers and non-Indigenous nurses (ANFPP, 2014b). In addition, their role extends to providing information, training and guidance to ANFPP team members, and to contribute to the adaption of the ANFPP model and program materials to ensure the program is delivered in a culturally capable, respectful and safe manner (ANFPP, 2012). Given the relatively recent adaptation of the NFP with the FPW role, there is a broad recognition within the ANFPP of the need to further explore the opportunities of what this role

can offer the ANFPP (ANFPP, 2016a) especially in the context of the strong track record of other similar roles such as IHWs within the Aboriginal Community Controlled context (Australian Medical Association, 2013; Panaretto, Wenitong, Button, & Ring, 2014).

A recent review of effective Australian home visiting programs (McDonald et al., 2012) identified key elements that are shared by successful home visiting programs. These key elements included a large number of visits over a longer period of time, targeted visits to at-risk families with multiple or complex problems and employing a workforce with the appropriate skills and experience to work with such families (McDonald et al., 2012). Recruiting, training and retaining an appropriate workforce is crucial to the ANFPP as a home visiting program, as its success is dependent on the ongoing development of the relationship, as a 'relationship based intervention', between mothers and home visiting team members (Korfmacher, O'Brien, Hiatt, & Olds, 1999). International research has shown that factors known to influence home visiting nurses' recruitment and retention include job satisfaction, professional development opportunities, sufficient job resources, quality support and supervision, maintenance of clinical skills, and opportunities for debriefing (Dmytryshyn et al., 2015; Lewis, 2007; Robinson, Miller, & Rickard, 2012).

The Phase 1 literature review (CRANAplus, 2016) of this study identified a range of NFP organisational and program factors influencing both nurse and FPW recruitment and retention that included opportunities for career progression and availability of alternative career opportunities; relationships with co-workers and workplace communication; and feeling valued in the workplace, such as the recognition and appreciation of effort. Recruitment and retention factors of nurses and IHW in a variety of health programs contexts, including those in which the ANFPP operates, were also investigated and it was found that decisions made by staff in choosing to leave or remain in a role are complex, as they are influenced by a mix of personal and professional factors. IHWs were established as being central to the functioning of programs involving Aboriginal and Torres Strait Islander peoples, as they contribute to the

health of their communities, facilitate entry of Aboriginal clients into programs and provide culturally safe and continuous care (CRANAplus, 2016) .

High staff turnover has been noted in the ANFPP, in particular of NHV and NS. There is also anecdotal evidence that some implementing sites find recruiting to the NS role challenging. While less turnover has occurred in the FPW role, there is a lack of information about why this is so. There is also an identified need to develop a clearer understanding of the FPW role within the ANFPP team and to examine its significance in program adaptation and implementation. Furthermore, there is also a lack of general baseline information about the ANFPP workforce, as well as the educational and workplace supports that may influence worker retention and reduce staff turnover. As a relationship-based intervention, the ANFPP's workforce recruitment and retention challenges are significant to client outcomes, as staff losses affect continued client engagement in the program and its effectiveness in meeting program objectives. In addition to the impact on program continuity, there are also recruitment costs associated with staff turnover and disruptions in the education program that equips staff with the skills needed to successfully implement the program (ANFPP, 2015; CRANAplus, 2016; Ernst & Young, 2012).

1.2 Phase 2 Objectives

This second phase of the *The Australian Nurse-Family Partnership Program (ANFPP) National Workforce Development Study – Informing the Way Ahead Project* will assist with future ANFPP workforce development planning by addressing the following objectives:

1. To collect baseline ANFPP workforce characteristics data;
2. To identify the education and support conditions that mediate staff retention and provide an understanding of how these differ between program roles;
3. To identify ANFPP workforce data that should be collected and monitored on an ongoing basis, in order to signal early changes in staff engagement and retention;

4. To identify issues affecting the current recruitment of staff to program positions; and
5. To provide a clear understanding of the FPW role activities and how these differ in each site and in relation to team dynamics/other team members.

2.0 Methodology

2.1 Design

This study utilised a First Peoples-led concurrent mixed-methods design (Centre for Research Excellence in Aboriginal Health and Wellbeing, 2009; Creswell & Plano Clark, 2007). This approach allowed for the qualitative and quantitative data to be collected and analysed simultaneously. Both data elements were integrated in the process of interpretation and reporting of the results. Importantly, this mixed method approach promotes triangulation, through the possibility of explaining outcomes from one source of data with outcomes from the other data source (Creswell, 2013; Taket 2013).

2.2 Participants

Purposive sampling was used to identify participants that could best inform the research (Creswell, 2013). In the initial phase of data collection, these were identified employees of the program from two regional and one remote IHS that had each implemented the ANFPP between the years of 2008 and 2015. Because of the identified need to explore retention factors within the ANFPP, current and former ANFPP IAHS staff were considered to take part in the research. Due to perceived risks to the ANFPP and the IAHS however, former staff were excluded from the potential participant pool. ANFPP staff from the ANFPP NPC were approached to take part in the data collection. Participants within the IAHS sites included Indigenous and non-Indigenous staff in the roles of Program Manager (PM), Nurse Supervisor (NS), NHV and FPW. Initial data collected identified the need to examine structural and higher-level factors affecting the implementation of the ANFPP, that in turn may have influenced the retention of the

program's staff. To explore these factors a snowball approach was concurrently used to identify IHS staff from higher, structural level positions, such as Chief Executive Officers (CEOs) and Human Resource Managers (HRMs). This approach was also used to identify participants from the entire ANFPP program structure (outlined in Appendix 1) that played a significant role in shaping the implementation of the ANFPP and therefore the potential factors influencing ANFPP workforce retention.

2.3 Participant Information

Quantitative On-Line Survey

Fourteen participants completed a quantitative online survey in October 2016. Of the total sample, participants were mostly FPW (n=6, 42.86%), or NHV (n=5, 35.71), with one (7.14%) PM and two (14.29%) NS also undertaking the survey. The mean age of participants was 41.14 years (SD= 10.76, range: 22-59 years) with majority of participants identifying as female (n=13, 92.86%). Participants equally identified as Aboriginal and/or Torres Strait Islander (Aboriginal: n = 4, 28.57%, Torres Strait Islander: n=2, 14.29%; Both Aboriginal and Torres Strait Islander: n=1, 7.14%) as they identified as non-Indigenous (n=7, 50%). Further participant demographic information gained from the online survey, is provided in Table 1.

Table 1: Online Survey Participant Demographic Information

Descriptive Variable	*n* (%)	M (SD) [range]
Age (years)	14 (100)	41.14 (10.76) [22-59]
Gender		
Male	1(7.14)	
Female	13 (92.86)	
Aboriginal and Torres Strait Islander Status		-
Aboriginal	4 (28.57)	
Torres Strait Islander	2 (14.29)	
Aboriginal and Torres Strait Islander	1 (7.14)	
Non-indigenous	7 (50.00)	
Role		
FPW	6 (42.86)	
NHV	5 (35.71)	
NS	2 (14.29)	
PM	1 (7.14)	
Highest Level of Education Received		
Nursing Roles		
Non-tertiary level	0 (0)	
Tertiary undergraduate level	2 (33.33)	
Tertiary postgraduate level	3 (50.00)	
Other	1 (16.67)	
FPW Role		
Non-tertiary level	4 (66.67)	
Tertiary undergraduate level	2 (33.33)	
Tertiary postgraduate level	0 (0)	
Other	0 (0)	
Qualifications		
Child Health	2 (14.28)	
Family Health	1 (7.14)	
Midwifery	3 (21.42)	
Nursing	8 (57.14)	
Aboriginal and/or Torres Strait Islander Health Worker	6 (42.85)	

Qualitative In-depth Interviews and Focus Groups

Thirty interviews (30) and two (2) focus groups were conducted, with 30 participants and 6 participants undertaking each, respectively. Further information about participants who engaged in interviews and focus groups is provided in Table 2.

Table 2: Number and role of participants who engaged in interviews or focus groups (n= 36)

	Site One		Site Two		Site Three		Other		TOTAL
	Interview	**Focus Group**	**Interview**	**Focus Group**	**Interview**	**Focus Group**	**Interview**	**Focus Group**	
PM	1	-	1	-	1	-	-	-	**3**
FPW	1	3	2	-	2	-	-	-	**8**
NHV	3	-	2	-	2	-	-	-	**7**
NS	1	-	1	-	1	-	-	-	**3**
CEO of IAHS	-	-	1	-		-	-	-	**1**
HR of IAHS	-	-	1	-	1	-	-	-	**2**
Other	-	-	-	-	-	-	9	3	**12**
TOTAL	**6**	**3**	**8**	**0**	**7**	**0**	**9**	**3**	**36**

2.4 Methods

Qualitative and quantitative data collection occurred concurrently at individual IAHS site visits over a one-month period in October-November 2016. All potential ANFPP participants at the IAHS sites were invited to partake in the quantitative online survey using the *LimeSurvey* platform prior to each sites' visit by the lead investigator. Completion of the online survey was considered implied consent to participate. Participants were then invited to partake in in-depth, semi-structured interviews which were either individual or in a focus-group setting as dictated by

participants. Participants who engaged in the interviews or focus groups were counselled in plain English about the research project and gave full informed consent prior to participation.

Participants selected using the aforementioned snowball approach (e.g. CEOs and HRMs) were invited to participate in in-depth, semi structured interviews only, as were other participants from the ANFPP structure (outlined in Appendix 1). Data relating to specific attrition and retention rates was outside the scope of this project and thus, was not collected.

2.5 Data Collection

Quantitative Data Collection

A survey produced from the results of the literature review conducted in Phase One of the *Australian Nurse-Family Partnership Program (ANFPP) National Workforce Development Study* (CRANAplus, 2016) was provided to the research team. This survey was then adapted for use in the IHS to allow for the exploration of factors specifically relevant to this context. Examples of these adaptations included expanding the responses to questions to include personal motivations for working in the IAHS context (Hunt, 2013; Dudgeon & Ugle, 2014; Duthie, King & Mays, 2013) and including extra questions related to prior knowledge and training in Indigenous health to prepare workers for their role (West et al., 2017). The final survey consisted of 46 questions and was separated into four parts:

Part 1: Demographic details, including education, knowledge and qualifications;
Part 2: Prior education and experiences of the participant;
Part 3: Recruitment and retention into the program; and,
Part 4: Current role within the program, including barriers and enablers in undertaking roles successfully and motivation to stay within individual role/s.

Qualitative Data Collection

The semi-structured interviews were also informed by the Phase One literature review (CRANAplus, 2016) and adapted to the IAHS context to explore the factors influencing the recruitment and retention within the ANFPP workforce and the scope of the FPW role within the ANFPP. All interviews, including design, framing and delivery of questions, were conducted according to the national standards for research with Aboriginal and Torres Strait Islander Peoples: *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (National Health and Medical Research Council [NHMRC], 2003) and *Guidelines for Ethical Research in Indigenous Studies* (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2002) and were conducted by the lead investigator, an Aboriginal Nurse and Professor with strong cultural, professional and academic expertise. This ensured that participants felt supported in a culturally safe environment which valued mutual respect and created opportunities for meaningful dialogue and negotiation with participants (NHMRC, 2003). Questions for PMs, NSs, NHVs and FPWs included: "What are the positive aspects of your role?", "What are the challenging aspects of your role?", "What are some of the ways you have support in the program personally, culturally, professionally and clinically?" and "What is the significance of the FPW role for the ANFPP?". Questions for the other participants broadly focussed on factors that influence the recruitment and retention within the ANFPP workforce such as "What are some of the factors that you think influence nurse turnover?", "What are the formal and informal factors that support the ANFPP team personally, culturally, professionally and clinically?", "What is the significance of the FPW role for the ANFPP?", and "What other factors have a significant influence on the ANFPP implementation and effectiveness"? Open and explorative questioning employed throughout the interviews and focus groups, while aiming to explore the factors influencing retention, was also used to cross-check assumptions and competing explanations among participants (Streubert and Carpenter, 2011).

2.6 Analysis

Quantitative Data Analysis

Quantitative data from the online survey were downloaded from the LimeSurvey platform in a de-identified format, with participants given a unique identification number. As questions in the survey were specific to the roles of the PMs, NSs, NHVs and FPWs, only data from these participants was utilised in the analysis. Data was entered and analysed in *IBM Statistical Package for Social Sciences (SPSS) Version 20*. Items ranged from binary yes/no responses, to multiple response answers and 5-point Likert scale responses. All categorical data was summarised using counts and percentages. For descriptive data that was continuous, means and standard deviations were used. All Likert scales were on a five-point scale, with responses reported as means and standard deviations. For descriptive purposes, mean cut-off points for Likert scale items were: 0-1.50 = very low; 1.51-2.5 = low; 2.51-3.50 = average; 3.51-4.50 = high; and 4.51-5.0 = very high.

Due to a small sample size only descriptive analyses were undertaken. Additionally, due to the small cohort and potential identifiability of data, measures were taken to report all outcomes in a group format where appropriate. Where stratification by role occurred, outcomes were reported only where n=>5.

Qualitative Data Analysis

Qualitative data from in-depth and semi-structured interviews and focus groups were transcribed verbatim and uploaded into the qualitative software program *NVivo Version 11*. A thematic qualitative data analysis approach (Castro, Kellison, Boyd & Kopak, 2010) was undertaken in the following steps:

1. A research team of predominantly First Peoples academics initially worked collectively to openly code data from selected interviews and defined overarching themes and sub-themes to form the initial coding structure.
2. A single member of the research team continued to code all interviews, focus groups and other sources (e.g. follow up email communication from participant interviews/focus groups) expanding on the initial coding structure.
3. The research team intermittently re-convened to cross-check and neutralise the assumptions and biases of the single member of the research team in the developing coding structure to assist in the validity and trustworthiness of data (West, Foster, Stewart and Usher, 2016).
4. After the completion of the coding, a core group of the research team convened to produce six overarching themes that reflected the completed coding structure.

For the purposes of data integration according to a mixed-method, concurrent approach (Castro et al., 2010), the analysis of quantitative and qualitative data were initially analysed simultaneously. After the results of each method were produced, the qualitative results formed the dominant framework of the overall findings and the quantitative results were used to confirm and explain the qualitative results further (Moffatt, White, Mackintosh, & Howel, 2006).

2.7 Ethics

Ethical clearance was provided by the Griffith University Human Research Ethics Committee prior to the commencement of the data collection (GU Ref No: 2016/670). The data collection, analysis and reporting of results adhered to the *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Researc*h (NHMRC, 2003) which includes key values and ethical principles for research with Aboriginal and Torres Strait Islander communities: reciprocity; respect; equality; responsibility; survival and protection and spirit and integrity. Data collection, analysis and reporting was further guided by the Lowitja Institute's approach to research for Aboriginal and Torres Strait Islander people namely, the five

key research principles: Beneficence, Leadership, Engagement, Workforce development, and Measurement of health impacts (Lowitja Institute, 2016). To reflect this guidance, the lead investigator had extensive interaction with the CEOs of each IAHS site to ensure the data collection was conducted in a culturally and ethically sound manner.

3.0 Key Focus Area 1 - Indigenous Australian Healthcare (IAH) Context

3.1 Key Focus Area 1 - Results

The implementation of the ANFPP in the IAH context fundamentally influenced IAHS organisational commitment to the program that ultimately impacted on ANFPP workforce retention.

Despite the significant evidence base, decades of successful outcomes and the potential the ANFPP has to bring generational change for Indigenous Australians, the mismatch between the ANFPP as a Nurse led program conflicts with that of the IAHS settings where programs are IHW led. This fundamental mismatch impacts on the successful implementation of the program and results in ANFPP staff within the IAHS, not being as well integrated or supported in the broader IAHS organisation that ultimately affects their job satisfaction and retention.

To better integrate the ANFPP within the IAH context and IAHS sites, a change of the ANFPP title to Family Partnership Program (FPP), as illustrated by the following quotes, is a better reflection the partnership approach, namely between the FPW and NHV to deliver the client-centred model of the ANFPP, that places the family at the centre of the program.

"In the UK they had a lot of push back from the nurses, interestingly enough, around the focus... is on the family so why is the nurse first in the title? So they flipped it, so they called it the, "Family Nurse Partnership Program". And so we thought that that made perfect sense, and it actually is a better way of saying it because it really, it is problematic when you say "nurse" first because it makes it look like the nurses are the pivotal part of the

program. And yes, it's a nurse-led intervention, but the family is the core of it…. and then in the Australian context, why does the nurse get preferenced over the FPW… so there would be very much openness to a name change. The only thing that we really do require and it's part of the branding process, is some visual use of the original Nurse-Family Partnership logo. But countries can call it whatever makes sense for them, like in the Netherlands they call it something that does not translate into Nurse-Family Partnership at all…but I think if there's a better name for it...I would say it's absolutely possible, absolutely" (Broader Program Role)

"That's always the first question that comes up. So, I think we can reframe the program in that, so our approaches are around wellbeing and stuff first, you mention about the nurse in the title and stuff...I definitely think, that should not be in the title and I think it should be something else" (Broader Program Role)

"[It's called] FPP or Family Partnership Program. We do have a [community] interpretation of that. I haven't heard it widely used in the community. The FPWs may hear it more because they know that language... and it's easier to say FPP than ANFPP" (Family Partnership Worker)

A lack of recognition of the partnership between the FPW and NHV in delivering the ANFPP deeply impacts on the integration of the ANFPP into the IAHS sites and can result in the isolation of the program leading to its lack of perceived value as shown by the following quote:

"We lose value within the organisation, and other services forget ...the less contact we have with them and the less conversations we have with other services within the organisation, the less they're going to understand about our program, and the less they're going to value it. So I think that's a real, that's a risk that we take if we do become siloed" (Nurse Supervisor)

This lack of integration of the program within the broader IAHS was further supported by the quantitative data which investigated the factors that influence the workforce of the ANFPP. Outcomes showed that the majority of participants (69.23%) expressed that the integration of the ANFPP within the IHS was either below average or average.

Strong and enabling Indigenous leadership and presence within the ANFPP were identified as key factors that influenced and promoted alignment between the ANFPP and IAH context. Indigenous leadership within the NPC as well as at the IAHS site level, shown by the following quotes are instrumental in ensuring the perceived value of the ANFPP to the IAH context:

> *"Someone strong's got to lead it … people like (Indigenous leader) and (Indigenous leader), they've been involved all the time but, whilst they were always there, they probably were never empowered enough to be given significant roles in shaping the program..." (Broader Program Role)*

> *"We still hadn't got that it was an indigenous program, and needed really strong presence, and a fully informed by indigenous peoples program" (Broader Program Role)*

> *"So I hope that being an Aboriginal nurse does, I don't know, it does bring more value to the role and how people work within this team in particular…there's certainly a different perspective that I bring, and I think I feel like it's quite respected and I feel like if I do say something because of my Aboriginality it is heard, and it's valued" (Nurse Home Supervisor)*

In addition to Indigenous leadership, the development of strong partnerships and clear communication pathways are critical to upholding the perceived value of the ANFPP in the IAH context.

The development of deeper partnerships and engagement between the ANFPP and the IAHS, especially their Community Boards was essential to ensuring the organisational commitment to the ANFPP. Having a central point of contact within the NPC, for the IAHSs was also viewed as facilitating the development of deeper partnerships and engagement through offering clear communication pathways as illustrated in the following quote:

"I find with the NPC is that everyone has a different, there's no set communication channels with the sites. So there's no person, there's no person who's the primary contact. So there is not one person in the NPC...there's no set process" (Broader Program Role)

Extending clearer communication pathways throughout ANFPP and the IAHS more generally was further identified as benefiting the implementation of the ANFPP in the IAH context. The particular benefits of the generation of research evidence about the implementation of the ANFPP in the IAH context was important for ensuring the ongoing perceived value of the ANFPP and is shown in the following quote:

"There's not a lot of experience operationalising those sort of programs into the Australian – that as a job is a rare thing. Some people are really skilled at it. I think that there hasn't been that communication, the leadership group's role and how they feed into it...and having those conversations actually go from us here into that realm, evidenced you know this is the issue, this is what our evidence is, this is the way we think we should move forward, and this is the benefits that are going to come. I think that's really not very active, and it needs to be much more active because there's a whole range of things that we've identified that need to go up to that level, so that it takes the pressure off artificial performance measures that we may not need...but that we're meeting a whole heap of other things" (Broader Program Role)

3.2 Key Focus Area 1 - Discussion

Commitment to Indigenous health values, leadership, workforce and research, as identified by these findings, are known factors to the provision of culturally capable, respectful and safe health services (Australian Government, 2013; Bainbridge et al, 2015; Commonwealth of Australia, 2016; Department of Health, 2014; Thomas, Bainbridge & Tsey, 2014). The *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* and the *National Aboriginal and Torres Strait Islander Health Plan (2013-2023)*, provide a guide for embedding Indigenous values, leadership, workforce and research throughout the ANFPP and the IAHS. The University of Colorado (University of Colorado, 2016) further supports these findings by its growing acknowledgement of the need to honour the context of NFP implementation internationally. Its review of the application of NFP program fidelities (University of Colorado, 2016) presents an opportunity to strengthen the ANFPP fidelities with Indigenous values, leadership, workforce and research, to form the basis of a research agenda into the effectiveness of the ANFPP in an IAH context in Australia. This research agenda would also ideally provide further opportunity to inform more accurate ANFPP data and monitoring points of ANFPP workforce retention currently being considered by ANFPP (ANFPP NPC, 2016c; ANFPP NPC, 2017).

Indigenous leadership and influence in the implementation of the ANFPP in the IAH context, as demonstrated in the findings, is critical to ensure the close alignment between ANFPP and IAHS values (Australian Government, 2013; Bailey & Hunt, 2012; Hunt, 2013; Ware, 2013). Encapsulated within Indigenous leadership is a commitment to Indigenous health workforce development. In particular, and in response to the incongruent nature of a Nurse led program versus an IHW led program, is to prioritise increasing Indigenous Nurses in the ANFPP program and the development of pathways for FPW into nursing roles within the program (Alford, 2015; Power et al., 2015).

As witnessed in the Aboriginal Community Controlled Health Service (ACCHS) context over the last 40 years, Indigenous led and controlled programs have been the key aspect of the effectiveness of health programs and health service delivery in promoting and protecting the health and wellbeing of Indigenous families and communities (Aboriginal Health & Medical Research Council [AHMRC], 2015; Bailey & Hunt, 2012; Hunter et al., 2005; Panaretto et al., 2014). It is this 'community control' that was further illustrated in the findings through Community Board and organisational commitment for the ANFPP. It is necessary to distinguish between the literature surrounding the influential role of Community Boards in the IAH context and other 'Community Advisory Boards' that are proposed within the NFP applications internationally (NFP, 2010; NFP, 2016). As demonstrated in the literature, Community Boards provide leadership and organisational commitment to programs which impact their communities (Bailey & Hunt, 2012; Burton, 2012; Couzos & Murray, 2007; Martin, 2005). As elected representatives, they are practical representations of the local Indigenous community and their 'control' and therefore ownership and responsibility of the ANFPP are pivotal to its successful endorsement and implementation. In the IAH context, established Community Boards direct IAHSs and through their fundamental leadership structures they work to ensure organisational commitment to programs (AHMRC, 2015; Bailey & Hunt, 2012; Burton, 2012; Couzos & Murray, 2007). Aligning the ANFPP Communication and Engagement Strategy (ANFPP NPC, 2016b) with the communication and engagement strategies of the IAHS sites, focussing on the joint objectives of the client-centred model of care will promote Community Board and IAHS organisational commitment. Organisational 'readiness tools' which aid in ascertaining organisational commitment to program evaluation and implementation (Commonwealth of Australia, 2016; Ernst & Young, 2012) can also assist in ascertaining commitment for the ANFPP.

The development of strong partnerships and clear communication pathways were identified in the findings as crucial to the success of the ANFPP and confirmed by the literature (Australian Government, 2013; Commonwealth of Australia, 2016; Couzos & Murray, 2007; Department of Health, 2014, Panaretto et al., 2014), however, the literature also extends the identification of

these partnerships to broader structures such as international agreements and conventions, and federal and state government policy (AHMRC, 2015; Bretherton, 2014). This has particular relevance to the ANFPP with respect to applying stronger partnerships and communication between the NFP (International Team), Child and Family Health Section, Department of Health (CaFHS) (outlined in Appendix 1) and the NPC, with Indigenous internal and external partners through a multifaceted and coordinated approach (Australian Government, 2013; Commonwealth of Australia, 2016; Department of Health, 2014). Important Indigenous partners in this domain include the National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak body representing Aboriginal Community Controlled Health Services (ACCHS) across the country on Aboriginal health and wellbeing issues and the Indigenous Health and Health Workforce sectors (National Programme Delivery, Deputy Secretary) of the Commonwealth Government.

3.3 Key Focus Area 1 - Recommendations

To better align the ANFPP with the IHS values, leadership, workforce and research, it is recommended that:

1.1 The name of the ANFPP, be adapted to the 'Family Partnership Program' (FPP) to reflect the joint ANFPP and IAH context values of a client centred model of care, in conjunction with consideration of the licensing requirements such as the need to identify the NFP logo on program materials. This recommendation would also provide benefits for facilitating partnerships and engagement with the IAH context more generally.

1.2 The ANFPP and IAHS apply the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health and the National Aboriginal and Torres Strait Islander Health Plan* (2013-2023), including alignment with the ANFPP Cultural Respect Framework.

1.3 An Indigenous leadership position to adjoin the ANFPP Director role within the ANFPP NPC organisational structure be established and roles and responsibilities identified within the

ANFPP and IAHS, for example, the Indigenous leadership position in conjunction with the NS, oversee the application of the Cultural Respect Frameworks (ANFPP, 2016b; Commonwealth of Australia, 2016), at the NPC and IHS levels, respectively.

1.4 Promote a commitment to Indigenous health workforce development and priority of increasing Indigenous Nurses in the ANFPP through integrating this commitment and priority in a review of the ANFPP Workforce Development Plan (ANFPP, 2016a)

1.5 All ANFPP program fidelities (University of Colorado, 2016) be strengthened with Indigenous values, leadership, workforce and research as a part of the NFP Model Elements Review Process (University of Colorado, 2016).

1.6 The impact of the application of the ANFPP program fidelities with Indigenous values, leadership, workforce and research to form the basis of a national research agenda including the formulation of indicators and a methodology for determining the impact of the Cultural Respect Frameworks (ANFPP, 2016b; Commonwealth of Australia, 2016) on ANFPP effectiveness and workforce retention.

1.7 Review existing arrangements between partners to assist in the development of deeper partnerships and engagement between the ANFPP and IAH and IAHS internal and external partners at all governing levels including between the CaFHS and ANFPP NPC with NACCHO and the Indigenous Health and Health Workforce sectors (National Programme Delivery, Deputy Secretary, Commonwealth Government), and between CaFHS and ANFPP NPC and the IAHS.

1.8 Review existing arrangements between partners to assist in the development of clearer communication pathways include identifying one central point of contact within the NPC for each IAHS as opposed to a different contact for a different matter; clearer communication pathways within ANFPP and the IHS regarding the sharing of data collection and monitoring

processes and the continuation of the ANFPP annual conference and monthly communities of practice meetings.

1.9 Promote Community Board and IAHS site organisational commitment through alignment of ANFPP and IAHS communication and engagement strategies that focus on joint objectives, such as the model of client-centred care.

1.10 To use an organisational 'site readiness' tool (Department of Health, 2014) to assess Community Board and IAHS readiness including commitment to deliver the ANFPP, and similarly to also consider the use of these tools for ANFPP readiness to apply the Cultural Respect Frameworks (ANFPP, 2016b; Commonwealth of Australia, 2016).

4.0 Key Focus Area 2 - Family Partnership Worker

4.1 Key Focus Area 2 - Results

The Australian adaptation of the NFP is unique in employing FPW with the intent to work in partnership with the program's NHV to ensure culturally safe service delivery. Currently there is limited information about how these positions were implemented at individual IAHS sites, the specific support needs of these workers and how they work within the ANFPP team. While the adaption of the ANFPP with the FPW role is perceived to be critical for the success of the program, there is a general perception that the FPW role is not as valued as the NHV which undermines the NHV and FPW partnership and influences job satisfaction and retention for both roles.

The perception that the FPW role is not as valued as the NHV role is largely perpetuated by the nature of the ANFPP program. The name of the program, identified as a Nurse led program, and focus of the NHV in the role and education structures of the ANFPP neglect to acknowledge, and inadvertently devalue the role of the FPW. In addition to this, the lack of acknowledgement of the history and role of the IHW in the IAH context undermines the full scope of skills and expertise that the FPW role, drawn from the IHW role, could offer. The quotes below by FPWs

and a broader program representative attempt to illustrate the complexity of these factors that influence the perception of value of the FPW role within the ANFPP.

"When they first started ANFPP, they didn't know how the FPW role was going to roll out. I mean, all the training, everything, was based around the nurse, - you'd get really cut because there was, like, no value for our role" (Family Partnership Worker)

"But over years of conversations and things like that, we, sort of, developed a PD, I guess, for the FPW role... It's much better. It probably could still have more, you know, done to it. Still improve. Because it's still - yeah, I mean, they're still trying to work out exactly what we do...We're not just there to go out with the nurse, or we're not, like, security or anything. We're not bodyguards. I mean, that's what in the beginning it, sort of, was like that" (Family Partnership Worker)

"We're there for the cultural needs for the client, you know, sometimes it's an interpreting service. Sometimes you know, we don't just do visits with the nurse, there's visits that we can do outside of contact visits and that, family visits where we just, you know, check in with them to see what's going - and sometimes girls don't always say - when they're with their own mob - our mob, we talk different, you know. And they'll come out with things they feel comfortable. I mean, a lot of times when clients ring up, they don't always ring up for the nurse, they always ask for the FPW. You know? And that message will go - then we'll talk to the nurse or whatever… and there's no fidelity around that...there's no fidelity around the FPW position… and there should be…" (Family Partnership Worker)

"I think when it goes to new sites, or whatever, people shouldn't just come in and change what we've already been working on for years. They should roll with it… and the informal visits are valuable...because sometimes - you know, I don't know if it's just, like, around respect or whatever, they don't always, you know, they might not be there for the visit, and we'll say, you know, if the nurse is there, whatever, you know, 'Are you still interested in being on the program?' It's just when we go out and talk to them it's different, it's like we're aunties talking with … a different relationship. And the girl will - or you know, if

you yarn to them, we just know how to get it out of them, I guess...how to talk to them about different things" (Family Partnership Worker)

"Especially in a lot of their [ANFPP] writing that you read, it's like, you know, "The nurses do this, the nurses do this, the nurses do this." And it's sort of like, "Well, what's the partnership worker do" (Family Partnership Worker)

"I want to get out and yes, build those relationships..but there are certain things where we could be able to deliver that content. I don't know, there are some things that you want to deliver, and you want to talk about with your girls, because you know they're not going to talk to a nurse...so there should be scope for us to be able to deliver culturally appropriate content like that, but at the moment there's not" (Family Partnership Worker)

"At the moment we're just there. We don't really do nothing. We don't deliver content, we don't do nothing. We haven't had that chance to build a relationship like the nurse would have over those two and a half years. And we got told it is nurse led, it is a nurse led relationship program. But at the end of the day you can't have a successful program with Aboriginal people if you don't have Aboriginal workers" (Family Partnership Worker)

"People are still going, "Ah, what's their [FPW] role? We need role clarification." I'm going, "You know, it's actually that we won't let anyone practise, within their scope, and allow them to do their job." (Broader Program Role)

Further defining and clarifying the broad scope of the FPW role was perceived to be imperative for the ANFPP. FPWs largely built the cultural capability of other staff, including providing formal orientation to NHV and FPW; they serviced the cultural needs of clients including acting as a 'cultural broker'; they were a communication conduit between the client and the NHV; they delivered content culturally appropriately to clients including leading home visits and in some instances, they led the ANFPP site team as shown by the following quote:

"And I think an FPW would be good as a team leader, not Nurse Supervisor, because you're out there in the community, you know what the mums want, that approach and all that sort of stuff. At the end of the day we're still supporting nurses. Or sometimes we're even leading on those visits, even though, yeah, we're not supposed to, but sometimes you are"(Family Partnership Worker)

The need for further role clarification around the FPW role is specifically supported by quantitative data that shows that participants had an average level of understanding surrounding the roles and responsibilities of the FPW (mean = 3.38, SD = 1.26), which was a lower understanding than the roles and responsibilities of the NHV (mean = 4.00, SD = 0.82) and NS (mean = 3.77, SD = 1.01) (Figure 1.). Additionally, results showed that almost half (n=6, 46.15%) of participants reported that the roles and responsibilities of all team members were not clearly defined upon commencement with the ANFPP.

Figure 1. Participant understanding of roles and responsibilities of ANFPP team members (n=14).

The qualitative results showed that FPW's broad scope of work was influenced by the needs of the Indigenous mothers and community; the diverse needs of the IAHS site; the previous

experience, skills and qualifications of the FPW, along with their own definitions of their role as illustrated by the following quotes from a Nurse Supervisor:

"What the community accepts, and what women actually want at visits is very different at each site, in terms of having a cultural brokerage and having someone come along on the visits and that kind of stuff. So it was interesting, in our context it just didn't work. So women weren't interested in having, well, pretty much usually it's a family member come along and talk about all this stuff. So for us there had to be a different kind of vision for that role" (Nurse Supervisor)

"I think for each site it needs to be something that is, you know, there is a structure there and there's training there, but I think that the vision for the role and how it plays out needs to be something that's defined by the FPWs themselves. Because they're the people who work in this community and work with the community" (Nurse Supervisor)

"So we were surprised that the FPW, that it just hasn't been something that women want. But that doesn't mean that their role is any less valuable. Like that cultural brokerage, that support, that having family on the team, so the role is really important in this context. But it's hard to define it and to set roles and responsibilities that work for every team, yeah, so I think the role needs to have still, even at this stage of rollout ... a lot of flexibility around allowing FPWs to identify what their role is and what that's going to look like, but then making sure at recruitment, making sure that you have someone with a proven study record, or a proven kind of ability to move forward, be interested in ...professional development, like a proven kind of someone who's going to be proactive in that for themselves" (Nurse Supervisor)

While there were no specific qualifications that the FPW were required to have to fulfill their role within the ANFPP site team, there was a wide diversity of responses in the qualitative data about the qualifications, if any, that were needed to fulfill the FPW role. Some participants acknowledged the constraints of recommending a minimum qualification for the FPW role with regards to recruitment, specifically for candidates with community, cultural and personal

knowledge and attributes suited to the FPW role, but who did not have a formal qualification. Other participants who recommended a qualification for the role perceived the value it could add to enhancing the FPW role particularly, at a minimum, for understanding professional behaviours and boundaries in an IAH context. In any case, as illustrated by the quote below, the IAHS organisational support and pathways offered to local Indigenous staff according to the policies and procedures of the IAHS were the most significant aspect in assisting skills and qualifications to be obtained:

"[This role] might be just what someone wants at this stage in life. They mightn't want much more. But if those pathways were set down and supported, then that might be a perfect avenue for someone who's feeling "Oh, I don't want to do anything else, I don't want to do more". But if those pathways were supported and really valued, it could be a different story" (Nurse Supervisor)

4.2 Key Focus Area 2 - Discussion

The results of key focus area (KFA) 2 build on the results of KFA 1, further illustrating the need to embed the ANFPP into the IAH context though deeper translation of the key adaption of the program, the FPW role into the ANFPP program to assist in ANFPP workforce job satisfaction and retention.

As demonstrated in the findings of KA1, the results of KA2 confirmed a greater emphasis on the partnership between the NHV and FPW delivering client-centred care in the name of the ANFPP, would assist in recognising the value and contribution of the FPW role to the program. Similarly reinforced, the need to have a greater acknowledgement of the contribution of the FPW role to the NFP fidelities. Building on this acknowledgement in KFA1 is the need to undertake research of an NFP fidelity model strengthened with Indigenous values, leadership, workforce and research with respect to the FPW role. A report undertaken by Ernst & Young in 2012 of a preliminary evaluation of ANFPP also pointed to the need for such research specifically related to the diversity of the FWP in the IAHS implementing sites (Ernst & Young, 2012).

Again confirming the results of KFA1, was the finding in KFA2 of the need to broadly acknowledge the IAH context, and in particular, recognise and learn from the role of the IHW that has developed in the IAH context over the last 40 years (NATSIHWA, 2012; Panaretto et al., 2014). While acknowledging that the FPW role is different to the IHW role, there are strong fundamental parallels to both the IHW and FPW in that they are both purposefully tailored to the IAH context. The strongest parallel between these roles is in the skills and expertise that both the IHW and FPW demonstrate in leading health programs, where this need has been identified by the local Indigenous community (Bowes & Grace, 2014; Fredericks & Legge, 2011; McDonald et al., 2012). While this finding is at odds with the current ANFPP program structure (ANFPP, 2014b; ANFPP, 2014c), it represents a critical insight into how the ANFPP can translate in the current program context, in applying a client centred model of care, for example, to meet the needs of clients in the Indigenous community. A further example of this translation are the differences in the FPWs' roles during home visits (ANFPP, 2014b), where in the findings of KFA 2, their home visiting arrangements, either solely or with the NHV, are in response to the needs of the Indigenous clients, according to a client centred model of care, and/or in response to the needs of the IAHS organisational policies and procedures. Having such flexibility in program models to respond to the program context, specifically in relation to client-centred care models is widely confirmed by the literature (Bailey & Hunt, 2012; Australian Government, 2013; Bainbridge et al., 2015; McCormack & McCance, 2006)

The importance of recognising the diversity in the application of the FPW role between IAHS sites, identified in these findings has been previously identified by Ernst & Young (2012). These findings in KFA 2 expand on the findings of the Ernst and Young (2012) report by identifying a broader scope of the FPW role that is currently accommodated by the ANFPP program structure. A further insight provided by these findings in KFA 2 was the need to acknowledge and honour the differences in the FPW role at each site as a function and response to the ANFPP client centred care model, and to acknowledge the central role of the FWP in defining their role at each site. These results are confirmed by others in the literature who propose that when the roles of the Indigenous health workforce are locally shaped, they more adequately meet client needs, the

needs of the local IAHS, and the needs of the Indigenous communities (Bretherton, 2014; Burton, 2012; Raymond, McDonnell & Wilson, 2012). In addition to acknowledging the diversity of application of the FPW role in IHS sites, the findings of KFA 2 identified a broad scope of activities of the FPW role. Although the literature confirms these activities as related to an IHW or similar role such as that of an Indigenous Cultural Consultant (ICC) (Bowes & Grace, 2014; Panaretto et al., 2014; Rose, 2014, Sivak et al., 2008), given the strong parallels between IHWs and FPWs, the activities identified in the findings could be formalised into ANFPP program structures, in collaboration with the FPWs at each site. It is important to acknowledge at this point that the FPW role definition challenges experienced by the ANFPP are not unique and that similar issues with regards to IHW are experienced across the country (Abbott, Gordon, & Davidson, 2008; Hooper, Thomas, & Clarke, 2007; Mills et al., 2010).

The recognition of the diversity in the IHS sites additionally relates to the development of qualifications to support the Indigenous health workforce roles within these IAHS organisations and communities (Bretherton, 2014; Mason, 2013; Ware, 2013). The development of local IAHS organisational support structures and pathways to build a local Indigenous workforce is a strategy widely used in the IAH context and is confirmed by the literature (Bretherton, 2014; Dudgeon et al., 2014; Kildea, Kruske, Barclay & Tracy, 2010). Fostering affiliations with professional organisations is another strategy identified in the literature to build workforce capacity (Bretherton, 2014). Professional organisations are guided by a corresponding set of regulatory agencies, associations and licensing boards which work to define the broad scope of job role boundaries through client safety and legal indemnity principles (Australian Health Practitioner Regulation Agency, 2017; Australian Medical Council Limited, 2017; Australian Nursing and Midwifery Accreditation Council, 2016; NATSIHWA, 2012). The key professional organisation of IHWs is the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA), and alignment with NATSIHWA would give FPWs opportunities to gather with other professionals, share information and experiences about preferred practice techniques, compare strategies to preserve high standards of culturally appropriate client care, and discuss the day-to-day challenges associated with IHW work (Bailey & Hunt, 2012;

NATSIHWA, 2016). Affiliation with this organisation has further benefits for FPWs including consolidation of their role identity, professional recognition, and establishing professional boundaries which shape job responsibility, which in turn contributes to skills development, long term career development, and pathways to develop collegial supports and Indigenous leadership (Bretherton, 2014; Burton, 2012; Ware, 2013).

4.3 Key Focus Area 2 - Recommendations

To ensure a deeper translation of the key adaption of the ANFPP, the FPW role into the ANFPP, it is recommended that:

2.1 The NFP program fidelities, model elements 5-15 and 18 (University of Colorado, 2016) be strengthened with the contribution of the FPW role, for example, element 5 could be adapted to "Client is visited according to their preferences and IAHS organisational policies" and could include being "visited one-to-one with one NHV or one FPW, or both the NHV and FPW"

2.2 The impact of the NFP program fidelities strengthened with the contribution of the FPW role to form a significant focus of a national research agenda including the formulation of indicators and methodology for determining the specific impact of the FPW role on ANFPP program effectiveness and workforce retention.

2.3 In collaboration with the FPW at each IAHS site, the broad scope of activities of the FPW role accommodating flexibility based on a client and IAHS organisational policies and procedures be formalised into ANFPP program structures, for example a review of the ANFPP Home Visiting Guidelines (University of Colorado, 2014) be conducted to allow flexibility in home visiting according to client's needs.

2.4 The diversity of application of the FPW role in the IAHS sites be accommodated in research designs to determine the full effectiveness of the ANFPP, for example, experimental research

designs could measure the effectiveness of the ANFPP in different IAHS sites attributing program outcomes to different applications of the FPW role in each site.

2.5 The ANFPP seek advice and guidance from the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) regarding the qualifications for FPW to ensure that they align with IAH context and IAHS organisational requirements and for example, contribute to local IAHS site support structures and pathways already in place to build a local Indigenous workforce.

2.6 The ANFPP additionally seek advice and guidance from NATSIHWA in processes of defining the broad scope of activities of the FPW role to be formalised into ANFPP program structures, for example a workshop of FPW with NATSIHWA could translate the ANFPP program structures into the FPW role at each site and contribute to a newly developed FPW role description.

5.0 Key Focus Area 3 - Recruitment

5.1 Key Focus Area 3 - Results

The alignment of the characteristics of the ANFPP workforce with the joint values of the ANFPP and the IAH context, along with associated recruitment processes promoted job satisfaction and retention within the ANFPP.

Strong Indigenous leadership and presence within the ANFPP and IAHS is achieved through the fundamental priority of the recruitment of an Indigenous health workforce, and especially at the implementing IAHS site, a *local* Indigenous health workforce who are a direct reflection and link to the local Indigenous clients and community. Additionally important are the recruitment processes used that link to local IAHS site support structures and pathways that build a local Indigenous health workforce. The processes in place for building an Indigenous health

workforce are illustrated in the following quotes for the FPW role and how these additionally link to the NHV and NS roles:

"There are five Aboriginal staff under the [IAHS] area, including one of the FPW that have now completed their Certificate II in Aboriginal and Torres Strait Islander Primary Healthcare. So two of them were drivers, two of them were Aboriginal Liaison Officers, and one a receptionist. So that gives us the ability to be able to backfill when it's planned [FPW] leave...I think we should be looking at developing them professionally. And it doesn't have to be degrees, necessarily, little steps, and inspiring and encouraging staff to undertake training...so we were able to adapt that program to suit our working environment, so it was a very flexible program where we could say "Okay, we want our staff to go [do training] every Friday", and then just release them from their work to be able to do it" (Program Manager)

"It would be good to focus on local people, whether the program could potentially look at growing our own Aboriginal nurses, for example. So there's no reason why an FPW at one of the sites couldn't aspire to be a Nurse Home Visitor. At least you know that they're not going anywhere. I'm really comfortable that our current Nurse Supervisor is going to be staying around, just looking at some strategies around that longer term...our strategic plan is looking at training or upskilling and qualifying Aboriginal people into professional roles, but even people, Aboriginal people that hold the lower level positions within the organisation, offering them training opportunities too, because not everybody aspires to have a degree or postgraduate qualification. Yeah, so they've got KPIs around the percentage of Aboriginal staff that are employed within the organisation, and then at different levels, for example they're offering cadetships next year, and nursing and midwifery is listed as options for that" (Program Manager)

The recruitment of Indigenous nurses generally, along with processes to support and grow an Indigenous nursing workforce are equally important strategies to ensure this Indigenous workforce is available to meet the growing demands of the ANFPP and IAHS. Partnerships with tertiary institutions to support the education and attraction of Indigenous nurses into the ANFPP

were identified as specific strategies to promote the alignment of the ANFPP workforce characteristics with the IAH context to safeguard job satisfaction and retention.

The quantitative results expand on the understanding of ANFPP workforce characteristics, that illustrate personal and professional characteristics that promote congruence between values of the ANFPP and the IAH context, but that also identify needs for further alignment. The quantitative results showed that 71.43% (n=10) of participants demonstrated a commitment to improving the health outcomes of mums and bubs in their community. The majority of participants 71.43% (n=10) also valued the importance of the work and was viewed as a chance to work with a holistic approach to health (n=8, 57.14%); in a primary health care model (n=8, 57.14%) and in partnership with the Indigenous community (n=8, 57.14%). In spite of these results however, only 50% (n=7) cited that a willingness to work in Indigenous health, including within a community based program (n=7, 50%) and a willingness to work with their community (n=6, 42.86%) were important factors in undertaking their role within the ANFPP. These data illustrate a separation between the personal and professional desire to achieve health outcomes for mums and bubs with the professional willingness to work within an IAH and IAHS community context. These results however can be explained by other characteristics of the ANFPP workforce, that showed that just under half (n=6, 42.86%) of all participants reported no experience working in a relevant service prior to commencing with the ANFPP where 'relevant' services included: Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHS) (in remote, rural or urban settings); ACCHSs non-government organisations; IAHSs within government organisations; health organisations in discrete Indigenous communities; community health home visiting programs (in a remote, rural or urban settings), and/or other maternal and child health programs (remote, rural or urban settings).

Valuing not only the professional willingness to work in an IAH and IAHS community context but more importantly, the *previous experience* of working in a relevant service represents an important need to fulfill to form the basis of recruitment processes to align the ANFPP with the IAH context.

Other specific qualities and attributes that assist in the alignment of the ANFPP and the IAH context specific to the NHV and FPW roles were revealed by the qualitative results. The ability for both roles to "change their glasses" to view a situation from the perspective of the client was a powerful analogy for the effectiveness of these roles in providing client-centred care. This analogy is illustrated by the quote below:

> *"You require lots of fluidity, patience, and you have to be prepared to see their lives through [the client's] glasses. I mean you have to change your glasses to see through [theirs]. I used to hear some nurses who will quickly judge, they only see the top of the iceberg… there's just so much underneath … and the family partnership worker even they don't see through the mother's glasses...and too quickly dismiss" (Nurse Home Visitor)*

NHVs who specifically could "put themselves in the shoes of the client"; could "relocate their power position" and who were "open to change" were also identified as important attributes that facilitated their ability to work in an IAH and IAHS context, as shown below:

> "*It comes back to a person's characteristics, they've got to understand what a partnership approach is, and they've got to want to work in that space and understand what that means for their own identity. If they want to be the expert then this is not the program. You go and work where you can be the expert*" *(Broader Program Role)*

Along with a professional willingness and previous experience of working in an IAH and IAHS context, prioritising these additional qualities and attributes in recruitment processes, such as NPC recruitment support provided to IAHS sites and IAHS position descriptions assists the alignment of the ANFPP with the IAH context. Reflecting these collective workforce characteristics in the position descriptions for all the NHV, NS and FPW role is important, as shown the following quote:

"I would look at how the PDs fit with the program and I would make sure that the Aboriginal family partnership PD was given as much thought and consideration that any other PD was given, and that they were sold as equal partners in the program" (Human Resource Manager)

Recruitment processes could also consider broader strategies to attract appropriate staff such as the ANFPP supporting IAHS to develop partnerships with local tertiary institutions to capture and mould a workforce aligned to ANFPP and IAH context values as suggested in the following examples:

"Yeah, and certainly the nurses that are less than five years out of university are less indoctrinated into Australia's nursing context, they're far more adaptable, they're much more flexible" (Broader Program Role)

"I'm finding the newer ones, the young, I've got a new one now, she's only two years out, we can mould and shape her to just be the beautiful home visitor nurse we need" (Program Manager)

5.2 Key Focus Area 3 - Discussion

These findings in KFA 3 build on the findings of KFA 1 and 2. The congruency of the ANFPP and IAH context and the need to build Indigenous leadership and a local IAHS workforce, shown in KFA 1 and 2 was confirmed by the results of KFA 3. The results of this KFA expanded on previous findings by identifying the importance of fostering, specifically, an Indigenous nursing workforce, and identified other specific strategies to reflect ANFPP and IAH context values in recruitment processes.

Since 1997, a lot of the focus on building Indigenous Nursing workforce capacity, particularly Indigenous nurse leadership, has been fostered nationally by the professional organisation of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the peak organisation of Indigenous Nurses and Midwives who provide guidance for the growing of an Indigenous nursing workforce and the prioritising of Indigenous nurse leaders (CATSINaM, 2015). Tertiary institutions have also been active in building an Indigenous nurse workforce through different strategies such as employing Indigenous nurses as academics within the Schools of Nursing and Midwifery (West, 2012); the establishment of scholarships for Indigenous nursing students (Australian College of Nursing, 2017a; James Cook University, 2017); Indigenous nursing cadetships (Australian Catholic University, 2017; Australian Government, 2016; New South Wales Government, 2016); and undergraduate and graduate placement opportunities, specifically in rural/remote health and IAH contexts (Spiers & Harris, 2015; Australian College of Nursing, 2017b; Webster et al., 2010). Similar strategies can, and have been, used to support non-Indigenous nurses into specific areas of work, and such strategies could also be applied in the ANFPP (Australian College of Nursing, 2017b; CRANAplus, 2017; New South Wales Government, 2017).

Further strategies to reflect ANFPP and IAH context values in recruitment processes were in the results of this KFA 3. The prioritisation of previous experience in an IAH context and other identified qualities and attributes shown by these results, as confirmed by the Ernst & Young (2012) report, are fundamental to selecting the 'right' staff from the outset that demonstrate not only the professional qualifications required but the personal skills and attributes necessary to work within the IAH context. Hunt (2013) expanded on these attributes by identifying good communication skills; an understanding of Indigenous culture; an ability to work independently and within a team environment; the ability to develop relationships, and a commitment to improving the health of Indigenous communities as critical success factors when working in an IAH context (Hunt, 2013). The results of this KFA further demonstrate not only the importance of these qualities and attributes but the priority need for having had experience in applying these in an IAHS context.

The results of this KFA also identified the importance of reflecting this previous IAHS experience and other qualities and attributes in recruitment processes, which was also confirmed by the Ernst & Young report (2012). Both the results of KFA3 and the report (Ernst & Young, 2012) and other literature (Humphreys et al., 2009a; Duraisingam et al., 2011; Brunettoa et al., 2014; Tourangeua et al. (2009) confirm the importance of reflecting this experience, qualities and attributes in position descriptions and marketing used in recruitment processes. The Ernst and Young (2012) report further identified deeper partnerships between the ANFPP and the IAHS sites would assist in developing IAHS sites' understanding of the ANFPP and staff requirements, and recommend supporting interview panel members' capacity to define roles and responsibilities and have a working knowledge of the ANFPP and IAHS context. Other literature has pointed to the value of structured orientation and induction programs, performance management and mentoring to facilitate ongoing career development (Humphreys et al., 2009a; Duraisingam et al., 2011; Brunettoa et al., 2014; Tourangeua et al. (2009).

5.3 Key Focus Area 3 - Recommendations

To align of the characteristics and recruitment processes of the ANFPP workforce with the congruent values of the ANFPP and the IAH context it is recommended that:

3.1 ANFPP program and recruitment structures and processes recognise and build upon local IAHS training, support and pathways for the recruitment of a local Indigenous workforce into local ANFPP IAHS positions including priority for Indigenous NHV and NS roles, for example, supporting FPW to undertake nursing qualifications for NHV roles and supporting Indigenous NHV into NS roles.

3.2 Liaise with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) to seek guidance for supporting FPW to undertake nursing qualifications and for supporting Indigenous NHV into NS roles.

3.3 Engagement with the tertiary sector occur to promote potential pathway options for Indigenous nurses, such as the pre-negotiation of credit for the ANFPP education package, the establishment of Indigenous nursing cadetships and scholarships for Indigenous nursing students and undergraduate and graduate placement opportunities within the ANFPP.

3.4 ANFPP to support and IAHS to engage with local tertiary institutions to promote potential pathway options for Indigenous and non-Indigenous nurses, such as the pre-negotiation of credit for the ANFPP education package, the establishment of ANFPP cadetships and scholarships, the availability of undergraduate and graduate placement opportunities within the ANFPP and the general promotion of the strengths of ANFPP IAHS positions, for example that offer strong job satisfaction, good remuneration, work hours and conditions and professional development.

3.5 ANFPP to review the NHV and FPW position descriptions to reflect the priority of previous experience in an IAHS context and other identified qualities and attributes as opposed to formal qualifications and experience, and ANFPP and support the use of the revised position descriptions within the IAHS sites, for example through closer partnerships between NPC and IAHS HRM services.

3.6 ANFPP to support IAHS sites with other recruitment strategies, such as supporting interview panel members' capacity to define ANFPP IAHS roles and responsibilities and supporting structured orientation and induction programs, performance management and mentoring to facilitate ongoing career development.

3.7 ANFPP to collect data and monitor on an ongoing basis, about staff recruited with previous experience in an IAHS context and monitor IAHS uptake of NPC support strategies such as the use of revised position descriptions and acceptance of offers of support for interview panel members.

6.0 Key Focus Area - 4 ANFPP Education Program

6.1 Key Focus Area 4 - Results

The ANFPP education package which is a key feature of the ANFPP contributed to job satisfaction and retention through offering professional development opportunities for the ANFPP workforce and through supporting the FPW and NHV partnership to deliver a client centred model of care.

While FPW and NHV were generally very satisfied by the opportunity to gain skills and expertise through the professional development opportunities provided by the ANFPP education package there was a general consensus that this package needed to translate into other forms of professional recognition to promote the transferability of the skills and expertise gained. The following quotes illustrate the need for the ANFPP education package to be more formally recognised to promote transferability and general career development for both FPW and NHV:

"Well, I thought we were going to get certificates and that out of it, which we didn't...that way it shows, like if you finish this job and want to go to another, you've got it all in front of you....so it's sort of going somewhere" (Family Partnership Worker)

"I feel like my professional development has been huge, occasionally I do feel worried about kind of moving into the next phase of my life where hopefully I'll be starting a family, and I feel like clinical nursing is really good in that way, because you can just go and work a shift here and there, and this [ANFPP] job doesn't really lend itself quite as easily in that way to less intense options around that. ...But yeah, I don't know what's after FPP, like it doesn't feel like there's a clear kind of pathway after that...I definitely think that [the skills you learn in ANFPP] they're as valuable, they're just not necessarily transferable" (Nurse Home Visitor)

Participants suggested a number of qualifications that the ANFPP education package could contribute to including a Certificate 11 or 111 in Aboriginal and Torres Strait Islander Primary Health Care for FPW and a Graduate Certificate or Diploma in Child and Maternal Health for NHV.

These qualitative results also reinforced the importance of the provision of professional development opportunities of the ANFPP education package for *both* the NHV and the FPW, to recognise the partnership between the two roles in delivering a client centred model of care, where previously in the history of the ANFPP these professional development opportunities were provided only for the NHV. While participant responses varied for the professional development needs of FPW, which were largely determined by the varied FPW role at each IAHS, there was a general consensus that the FPW role needed to have at least a basic level understanding of all of the current concepts of the ANFPP education package to enable accurate and appropriate communication of these concepts to clients in accordance with a client-centred model of care delivered in a culturally safe way.

In addition to this basic knowledge, the ANFPP education package needed to accommodate the differences in the FPW role at each IHS site, for example in remote communities the education and training needs of FPW related to the translation of ANFPP education package into appropriate traditional language and cultural concepts whereas in more regional communities FPW education and training needs focussed more on how the FPW could share the delivery of content, for example, processes of communication between FPW and NHV to negotiate who and how to deliver content before a client visit and then reflect on this process after a visit.

While there is general satisfaction about how the ANFPP education package is currently delivered for FPW and NHV, for example face to face and through a central location, this does not necessarily meet the needs of FPW in remote communities who prefer to have greater flexibility in the options to receive this education face to face, including one-on-one, in their local communities. Having the ANFPP education package on-line was also identified as being

advantageous for NHV in remote communities in terms of time management to enable NHV to start the education package while waiting for the face to face training to occur.

Similarly, while there is general satisfaction with the current content of the ANFPP education package a number of improvements were recommended including an overwhelming need to provide more Indigenous health education and specifically training as illustrated in the following quote:

> *"I want to make a recommendation to include a training program focused on cultural safety. Interactive ochre the online cultural learning package is not enough!!" (Broader Program Role)*

Participants also suggested that an increased focus of the ANFPP education package on the localisation and contextualisation of ANFPP education package content to the IAHS context would assist in balancing the ANFPP's needs with the implementing IAHS site's organisational needs. Particular attention to the implementing IAHS site's home visiting policy and procedural processes, especially with the mitigation and management of risk to staff safety; the balance of professional and cultural boundaries and more content on domestic violence and child protection were specific topics recommended to be included to enhance the application of the ANFPP education package into the IAH and IAHS context.

These qualitative results are confirmed by the quantitative results where most participants (n=10, 76.92%) reported that there was education which had not been provided in the ANFPP education package which would have been useful for them to undertake their role successfully. A lack of cultural capability education was demonstrated in these results that found that many ANFPP participants had no prior cultural awareness training (n=6, 42.86%). The majority of participants also had no previous experience of Aboriginal and Torres Strait Islander health education (n=10, 71.43%) and no prior education on racism (n = 12, 85.71%) (Table 3). Further, of the six participants (46.15%) who completed cultural awareness training within the IAHS on commencement with the program, only three (23.08%) felt the cultural awareness training

received was enough to prepare them for working in their role. This results are outlined in Table 1.

Table 1. Prior experience reported by participants (n=14)

Prior Experience	*n* (%)	
	Yes	No
Prior cultural awareness training	8 (57.14)	6 (42.86)
Prior education on racism	2 (14.29)	12 (85.71)
Prior mandatory state and/or territory workplace cultural awareness program	4 (30.77)	9 (69.23)
Prior Indigenous health education	4 (28.57)	10 (71.43)

In addition to the ANFPP education package, the importance of revisiting the educational concepts of the package through processes of continuous professional development were important reinforce concepts, as is illustrated by the quote below:

"Some of the skills that were required around negotiation, professional boundaries, emotional intelligence, conflict resolution, team building, those sorts of skills are covered in the training but "How often do you revisit them? And are they contextualised to the day to day, rather than just in the units?" (Broader Program Role)

6.2 Key Focus Area 4 - Discussion

These findings in KFA 4 build on the findings of KFA 1, 2 and 3 and develop further the understanding of how the ANFPP education package can contribute to the job satisfaction and retention of the ANFPP workforce.

The results of this KFA reinforce the findings of the CRANAplus literature review (CRANAplus, 2016) that identified the importance of professional development opportunities for job satisfaction for both FPW and NHV. The results reported here expand on this understanding by identifying the importance of having the professional development of the ANFPP education package professionally recognised to contribute to the overall career prospects of FPW and NHV. This professional recognition to promote long term career objectives for the Indigenous health workforce has been confirmed by others (Bretherton, 2014), and has been reported elsewhere for the general nursing workforce specifically as a means for attracting nurses into particular roles (Humphries et al., 2008; Keane, Lincoln & Smith, 2012; West, 2013). Personal communication with the ANFPP (A. Bermudez Ortega, January 25, 2017) has revealed that a body of work (ANFPP NPC, 2017b) is in progress to map the contribution of the ANFPP education package to qualifications for FPW. As identified in the results of KA 2, obtaining guidance from NATSIHWA to ensure the outcomes from this body of work (ANFPP NPC, 2017b) align to the long term career objectives of the Indigenous health workforce more generally, is recommended. If necessary, leadership and direction can also be sought from other bodies such as CATSINaM, the Nursing and Midwifery Board of Australia, and the Office of the Chief Nursing and Midwifery Officer.

The results of this KFA also reinforce the findings of KA2 that the provision of professional development opportunities for FPW, through attendance at the delivery of the ANFPP education package, acknowledges their role in the FPW and NHV partnership in delivering a client centred model of care. The results of this KFA additionally identified the unique ANFPP education package and training needs of the FPW role, such as a basic level understanding of the concepts of the package. As demonstrated in the education literature (Krakouer, 2015; Tilley et al., 2007; Wilson & Devereaux, 2014), learning outcomes of the ANFPP education package, could be scaffolded as required for each of the FPW and NHV roles. Learning outcomes that have been adapted from Bloom's revised teaching taxonomy for example, follow progressive stages of skill development, from a novice level (remembering, comprehending), intermediate level (applying,

analysing), through to an entry to practice (evaluating, creating) (Department of Health, 2015, Sweet, Blythe & Carpenter, 2016).

In addition to adapting the content of the ANFPP education package for the FPW role, the results of this KFA acknowledge the need to tailor the education package to the specific and diverse needs of the FPW role among the different IHS sites. This has been achieved previously at a 2 day professional development workshop held predominantly for FPW, but also attended by some NHV and NS at Fitzroy Island in 2012 (ANFPP, 2012), and could form the basis of possible content and a structure of how to address the ANFPP education and training needs of the FPW role. As identified in the results of KA2 and confirmed by others (Bailey & Hunt, 2012; Bretherton, 2014; Burton, 2012; Raymond, McDonnell & Wilson, 2012), collaboration with the FPW and IHS at each site is critical to ensure the full scope and diversity of needs are reflected in the provision of ANFPP education and training.

The needs for more Indigenous health content in the ANFPP education package identified in this KFA is critical and builds on the results of KA1 to increase cultural respect within all levels of the ANFPP program structure. Adopting the Aboriginal and Torres Strait Islander Health Curriculum Framework (ATSIHCF) (Department of Health, 2014) is one way of ensuring a high quality, evidence-based cultural capability curriculum framework is embedded. ATSIHCF provides guidance to health education providers on the development of curricula related to cultural capabilities (Department of Health, 2014). ATSIHCF specifies five key cultural capabilities: "respect, communication, safety and quality, reflection, and advocacy" that relate tangibly to practice, and contribute to the provision of culturally safe care (Department of Health, 2014, p. 8). Cultural capabilities require participants to engage actively in learning and reflection, (Snook, Nohria, & Khurana, 2011) and involve life-long learning processes (Health Workforce Australia, 2014). Importantly the impetus of 'Reflective Practice' (RP) as part of this ATSIHCF framework aligns with the impetus of RP similarly within the ANFPP (ANFPP, 2014b; ANFPP, 2014c)

In addition to adopting the ATSIHCF to address the cultural capability needs of the ANFPP education package, this framework builds on the results of KA1 by providing guidance on how

to build the cultural capability of the entire ANFPP program including directing future research and data and monitoring points to measure the cultural capability of the program and ANFPP workforce (Department of Health, 2014). Program level indicators of cultural capability include aspects such as the recognition of Australia's colonial history and its impact on Indigenous health in program structures, such as consistent acknowledgement of country in ANFPP program welcomes and documentation and workforce level indicators such as the inclusion of this content in the ANFPP education package. The use of 'Cultural Capability' tools (West et al., 2017) to measure cultural capability of the ANFPP workforce can be used to monitor the growth of cultural capability in the workforce over time and can represent an important data and monitoring tool for the ANFPP program.

The results of this KFA showing the further need to embed the concepts of the ANFPP education package into continuous professional development are confirmed by others (Humphreys et al., 2009a; Duraisingam et al., 2011; Brunettoa et al., 2014; Tourangeua et al. (2009). Ongoing professional development that is flexible, responsive and sustainable has been identified as contributing to workplace retention as it enhances employee confidence to achieve their work, leading to a feeling of 'value' within the workplace (Humphreys et al., 2007). In relation to the IAH context, seeking opportunities for ongoing professional development may also include linking the ANFPP workforce to attend evidence-based research conferences such as those of the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA), Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and the Maternal, Child and Family Health Nurses of Australia (MCaFHNA).

A review of ANFPP documentation (ANFPP, 2014b; ANFPP, 2014c), currently identifies the application of RP as a cornerstone of the ANFPP in fulfilling the needs for continuing professional development for staff at the IAHS site, and is the responsibility of the NS to successfully implement. The importance of RP to professional development, however, was not identified by participants in this KFA. RP is a recognised critical approach to consolidating learning and increasing education outcomes across a number of health fields (Knott & Scragg, 2016; Boud & Walker, 2006; Redmond, 2006) and specifically for offering skills and techniques

for health professionals to work in cross-cultural contexts (Dudgeon, Milroy, & Walker, 2014). The process of RP allows health professionals to interrogate their own political, social and cultural positioning and is a powerful tool for the production of new knowledge. Significantly, critical RP has the potential to improve social justice outcomes for Indigenous peoples and communities (Dudgeon et al., 2014) and has been identified by the ANFPP as a crucial component and success factor for the program (ANFPP, 2014b; ANFPP, 2014c; Ernst & Young, 2012). The lack of identification of RP by participants as contributing to ongoing professional development in this KFA can be partially explained by factors related to the results discussed further in KFA 5 and 6.

6.3 Key Focus Area 4 - Recommendations

To increase the contribution of the ANFPP education package to the job satisfaction and retention of the ANFPP workforce it is recommended:

4.1 To promote broader professional recognition of the ANFPP education package, collaborate with NATISHWA, CATSINAM, Nursing and Midwives Council/Board and the Chief Nursing Officer to align the package with relevant qualifications and standards of practice for FPW and NHV, for example by initially assessing the ANFPP education package against the Australian Quality Framework (AQF).

4.2 In collaboration with FPW and IAHS sites, review the ANFPP education package content with greater attention to aspects of training and application to the IAHS context, in particular, build on the outcomes of the *Report of the FPW/ACW Unit 2 Training* (2012) and trial FPW training based on a 'novice' level understanding of ANFPP education package; accommodate the diverse training needs of the FPW role at different sites, and trial different delivery modes of the ANFPP education package (eg. localised, face to face and online) to meet the specific needs of remote communities.

4.3 ANFPP and IAHS sites apply the ATSIHCF to the ANFPP education package and other ANFPP and IAHS program and organisational structures and integrate this framework with the broader application of the *Cultural Respect Framework 2016-2016, National Aboriginal and Torres Strait Islander Health Plan (2013-2023)* and ANFPP Cultural Respect Framework (outlined in Recommendation 1.2).

4.4 The integration of the ATSIHCF should contribute to the basis of a national research agenda (outlined in Recommendation 1.6) to formulate indicators and methodology for determining the impact of this framework on ANFPP program effectiveness and workforce retention and could, for example, include the use of the Cultural Capability Tool (CCT) (West et al., 2017) to monitor cultural capability of the ANFPP workforce.

4.5 In accordance with the ATSIHCF, a discrete 'Cultural Capability' unit be trialled in the ANFPP education package and be undertaken by all ANFPP and IAHS site staff and be embedded within continuous professional development structures, for example, performance management plans of ANFPP and ANFPP IAHS staff.

4.6 Support additional role based, continuous professional development of FPW and NHV for example, through encouraging attendance at conferences of NATSIHWA,CATSINaM and MaCHFNA to additionally assist in the implementation of ANFPP education package into the IAHS site.

4.7 Promote and monitor the uptake of RP as a core model element in all aspects of the ANFPP education package and program.

7.0 Key Focus Area - 5 Retention

7.1 Key Focus Area 5 - Results

Job satisfaction and retention of the ANFPP workforce were specifically influenced by a range of factors featured by a FPW and NHV commitment to a client centred model of care and FPW and NHV feeling valued within their role.

The qualitative results revealed that all participants interviewed were committed to the client centred care model of the ANFPP, the program outcomes and potential for future program outcomes. FPWs and NHVs were especially committed to this model through witnessing the 'real life' benefits of the program, however different aspects of the client centred model motivated different roles' retention in the program. For FPWs, their mostly intrinsic connection and obligation to the Indigenous community, and specifically Indigenous mothers and babies drove their job satisfaction and ultimately their retention. For NHVs, a close alignment of their personal and professional interests and experience with a client centred care model, promoted their job satisfaction and retention. NHV having a specific passion for working with Indigenous mothers and babies was identified by FPWs as being important. The following quotes illustrate these factors that influence job satisfaction and retention:

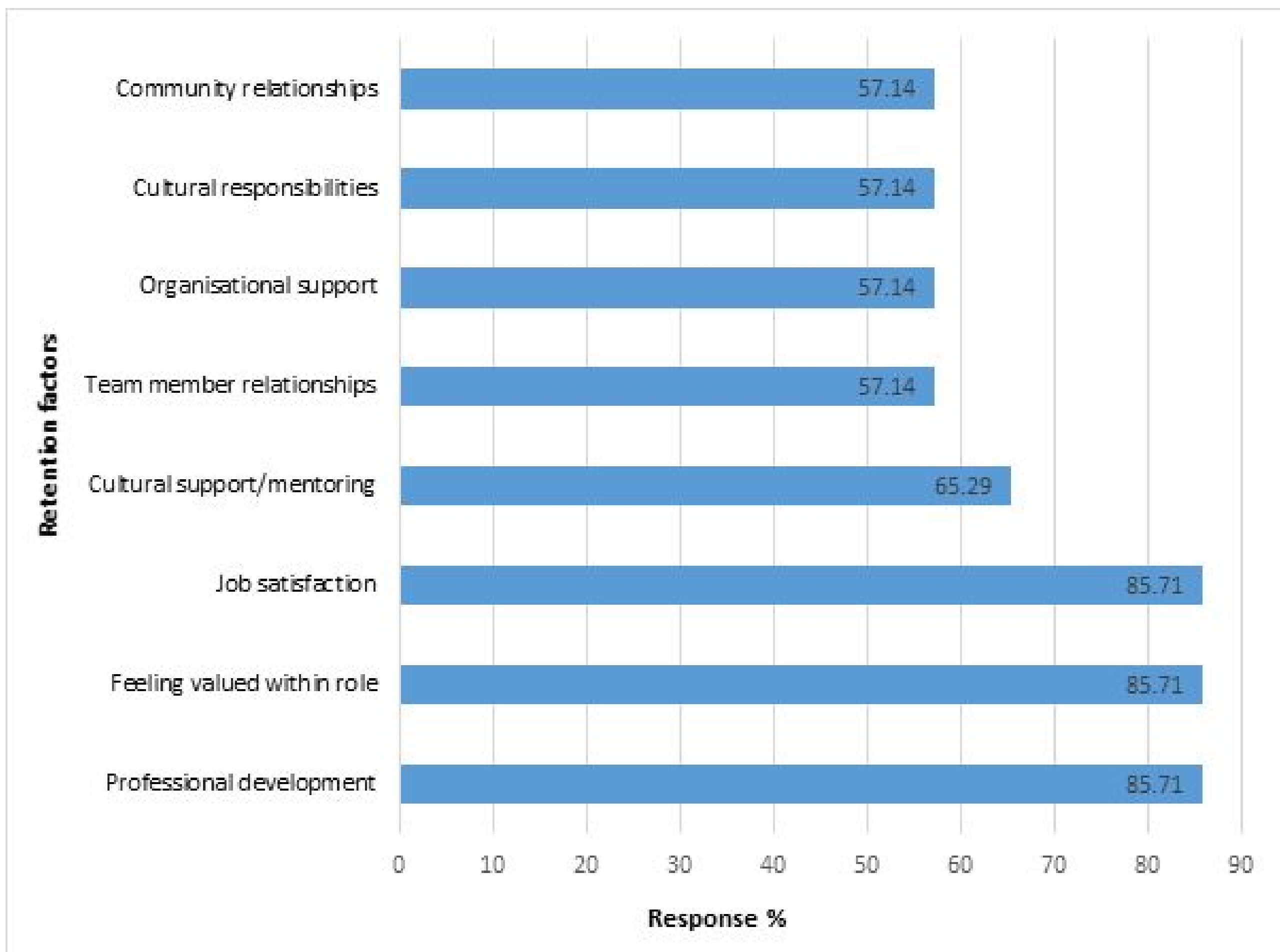
"We just talk about the job that we're doing ... you know, the day to day thing...if anything really, it's just more about working with our clients, with our people. No, we don't sort of worry about what our wages are and all that sort of thing....No, because we're from here, you see, we don't care what money we're on, because we're still going to help them" (Family Partnership Worker)

"You've got to have nurses that really have, are interested in closing that gap. That want to make a difference for Aboriginal people who are not just here for the money. Or just to

get the training and go whatever, something to put on their CV. They've got to be, yeah, passionate about it. And want to make a difference" (Family Partnership Worker)

FPW and NHV job satisfaction translated in these roles' feelings of being *able* to and *feeling valued* in the process of delivering a client-centred model of care. These qualitative results are illustrated further by the quantitative results in Figure 2. showing job satisfaction (n=12, 85.71%), feeling valued within their role (n=12, 85.71%), professional development opportunities (n=12, 85.71%) and strong cultural support/mentoring (n=9, 65.29) as strong factors in safeguarding ANFPP workforce retention.

Figure 2: Factors that influence participants remaining in their role (n=14).



The qualitative results gave further insight into the factors that influenced perceptions of FPW and NHV feeling valued within their role related to their processes of delivering a client-centred model of care. Within the context of the equal value of the FPW and NHV role as contributing to the partnership of delivering this model, processes of delineating roles and responsibilities, leading to role clarity, especially for FPW were particularly important as illustrated by the following quotes:

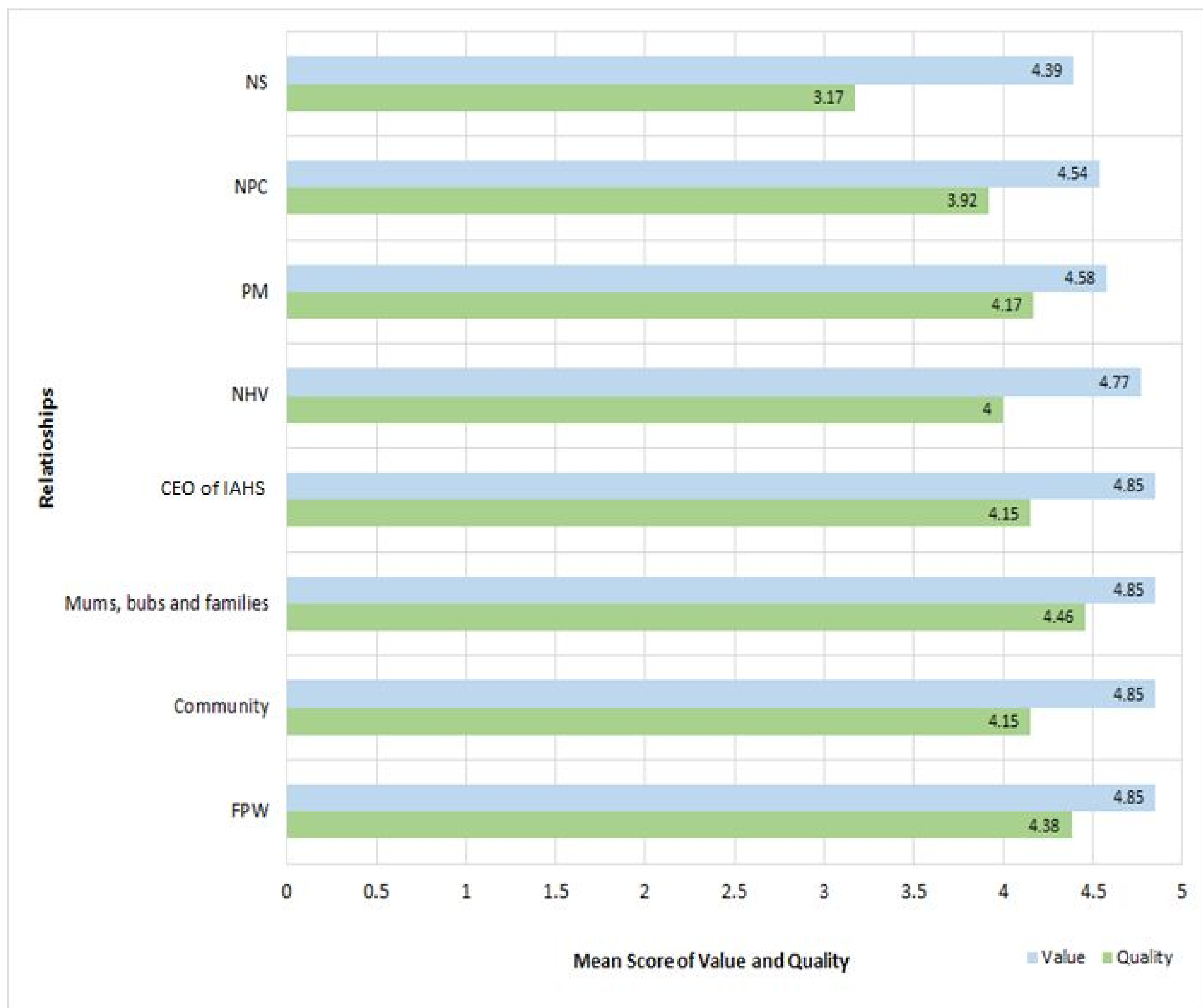
> *"It comes back to what's right and wrong within the roles and responsibilities and also around delegation, you know, whether the nurse home visitors up here and the family partnership worker's down here...because I see them both having key roles. But then it comes back to the question that we're asking and the issue that I had before, you know, when they go out on visits, unless they understand their roles and how they link together, you're always going to have issues. Because one's going to think, "Well, I know this family", the Aboriginal family partnership [worker], "I know this family, this is the way we do things." But then if it's not in line with process, you know. Or again, you know, you get a big noting home visitor nurse saying, "Well, you know, I'm qualified and we've done this and that", but then it's not around process" (Chief Executive Officer).*

> *"I want it to be mutual… it should be that we both know what's going to happen within the visit on the day. And I personally would like to know what's going to happen a week prior to it so I can read up, research, get my head around it, so then when the client does answer, I can say, "Well yes, I know that answer. I will talk about that." (Family Partnership Worker).*

To further explore the qualitative factors influencing perceptions of being valued in their role, quantitative data was analysed to explore the role of 'Relationships', specifically the perceptions of the value and quality of relationships within ANFPP that allowed participants to undertake their role successfully.

The most important relationships were reported as being between the participant and: the FPW (mean = 4.85, SD =0.38), the community (mean = 4.85, SD =0.38), mums, bubs and families (mean = 4.85, SD = 0.38) and CEO of the IAHS (mean = 4.85, SD = 0.38). Despite the identified high importance of these relationships, a lower quality of relationships with team members and key stakeholders was generally reported. The highest quality relationship was reported as being with mums, bubs and families (mean = 4.46, SD = 0.97), the FPW (mean = 4.38, SD = 0.96) and the PM (mean = 4.17, SD = 1.40). The largest discrepancy between value and quality was reported with the NS relationship, as indicated in Figure 3.

Figure 3: Perceptions of value and quality of relationships within the ANFPP team and with key stakeholders (n=14).



The discrepancy between the value and quality of relationship with the NS was partially explained by the qualitative results that identified a high turnover of the NS generally across IAHS sites influenced the relationship dynamics from the organisational change of ANFPP practices, roles and responsibilities with the arrival of each new NS. Interestingly, the high turnover of NS in these sites, among other factors, also inadvertently affected the application of RP within the IAHS sites, giving rise to what some participants termed 'informal RP' as an important relationship maintenance tool for FPW and NHV as illustrated by the following quote:

> *"If the program manager is not very supportive or really understands what our program is, I know staff have sort of tried to go externally, to get an external person to say do that RP, but unfortunately it gets fed back to the supervisor, and then it affects that relationship… so that's why we tend to look after ourselves. Well, that's what's happened. That's why we've ended up looking after ourselves… I think that [reflective practice] can be done on the fly and just even in a team environment, group environment. And we love to talk so we're always unpacking. And we know about every single client, because when we come back we talk and we say, "Oh, this client did really really well", or, "I had this problem" (Nurse Home Visitor)*

These qualitative results are confirmed by quantitative results that showed that while participants reported a high understanding of the need for reflective practice within both the context of Indigenous health (mean= 3.79, SD = 0.58) and the ANFPP (mean = 3.86, SD = 0.66), it still didn't, in its formal application, appear to be an influential factor on staff remaining in their current role (n=4, 28.57%).

7.2 Key Focus Area 5 - Discussion

The results of this KFA reinforce the results of other KFA, specifically KFA 2 and KFA 4 and develop further the understanding of the range of factors that influence job satisfaction and retention of the ANFPP workforce.

Job satisfaction is a well renowned determinant of workforce retention (Baernholdt & Mark, 2013; Maqbali, 2015; Molinari & Monserud, 2008). The results of this KFA confirmed the importance of job satisfaction to the ANFPP, FPW and NHV roles and furthered the understanding of factors that influenced their job satisfaction in their role. The emergence of the client-centred care model as a joint factor influencing the job satisfaction and retention of the FPW and NHV is an important finding. Research has consistently demonstrated that client-centred care models require the formation of therapeutic relationships between professionals, clients and their significant others, and that these relationships are built on mutual trust, understanding and the sharing of collective knowledges (Bainbridge et al., 2015; Kildea et. al, 2010; McCormack & McCance, 2006). While a client-centred care model was an important commonality for the NHV and FPW partnership in this KFA, this partnership was undermined by a general perception of the unequal value of roles, as identified in KFA 2 and fuelled especially for the FPW, a lack of clarity of their role. These aspects of the recognition and appreciation of effort as important retention factors for NHV and FPW have been noted by others in the literature (McDonald et al., 2012; Rickard, 2012; Robinson et al., 2012), along with the importance of clearly defined roles for the retention of FPW (CRANAplus, 2016).

The importance of other retention factors for FPW and NHV in the quantitative results such as access to professional development opportunities confirms this finding in KFA4 and is equally supported in the literature (CRANAplus, 2016; McDonald et al., 2012; Robinson et al., 2012). The identification of the importance of cultural mentoring and support however represents a new insight into the retention for FPW and NHV and points towards the integration of this aspect into ANFPP program structures as a strategy to retain ANFPP staff. Cultural mentoring and support have been identified by others in the literature, as a retention and professional development strategy specifically for IHW and an Indigenous health workforce (Chong et al., 2011; Downing, Koral & Paradies, 2011; NATSIHWA, 2013), however, the findings of this KFA point towards offering this support to NHV as well. While this cultural mentoring and support may be currently undertaken by FPW within the ANFPP this may need to be strengthened through formalisation in their role and within other ANFPP and IAHS structures. The other factor of organisational support identified in the quantitative results was also identified by participants as

influencing their retention, albeit not as strongly as other factors. This represents an interesting result that builds an understanding of the role of organisational support in the retention of the ANFPP workforce, as while it has been identified as a fundamental factor underpinning a cascade of other factors influencing retention throughout KFA1 and the other KFA, it was not strongly or directly perceived to affect retention in this KFA. These results point towards the influence of organisational support and/or commitment as being an *indirect* influence on ANFPP workforce retention rather than a direct influence of it.

Similarly, while the role of 'relationships' and 'cultural responsibilities' relative to other retention factors did not feature strongly, further quantitative investigation of these results still provided insight into areas of possible need to be addressed, specifically in terms of the relationship with the NS in IAHS sites and specifically how the turnover of this role impacts on relationships as well as other important aspects of the ANFPP program such as RP. The integrity of RP, as a proven strategy of working in maternal and child visiting programs (Dmytryshyn et al., 2015; Gill et al., 2007; Lewis, 2007; Robinson et al., 2012) and in an IAH context (Best & Fredericks, 2013; Kuipers et al., 2014; Paul, Allen, & Edgill), is important to be protected, and the identification of 'informal RP' described by participants in this KFA can threaten this integrity (A. Bermudez Ortega, January 25, 2017). The processes of 'informal RP' as described by participants in this KFA align more closely to processes of 'informal peer support' and 'debriefing' which, while have been established as important factors in the literature as contributing to relationships (Hillier, 1998; Manthorpe & Baginsky, 2015; Dmytryshyn et al., 2015; Robinson et al., 2012) need to be distinguished from RP practice that is identified as contributing to quality practice in a client centred model and especially in an IAH context (NFP, 2010; University of Colorado, 2016; Beam et al., 2010). Further research in this area is warranted to delineate the role and influence of RP on ANFPP workforce retention and other forms of practice, such as 'informal peer support' and 'debriefing that contribute to safeguarding relationships within the ANFPP.

7.3 Key Focus Area 5 - Recommendations

To promote general job satisfaction and retention of the ANFPP workforce it is specifically recommended that:

5.1 More flexibility be promoted at the IAHS site to respond to client needs, balanced with the program needs and IAHS policies and procedures, for example, the consideration of home visiting conducted by the NHV and/or the FPW as determined by the client (as outlined in Recommendations 2.1 and 2.3)

5.2 The contribution and equal value of each role to the NHW and FPW partnership be formalised throughout the ANFPP, for example, through established processes of communication to occur between the NHV and FPW before a visit to determine the role that each partner will play and after a visit to reflect and establish learnings for future visits

5.3 Cultural mentoring and support be formalised into ANFPP and IAHS structures, for example, be formalised as a part of the FPW role (linked to Recommendation 2.5) and be included in ANFPP education and training (link to Recommendation 4.2) and other support structures to assist FPWs to undertake this role

5.4 Delineate formal RP practices from other forms of informal peer support and debriefing practice in all aspects of the ANFPP education package and program

5.5 Conduct further research and data reporting to investigate the influence of RP in ANFPP to job satisfaction and ANFPP workforce retention.

5.6 Ongoing data and monitoring indicators be collected, at 3 month intervals for example, to reflect key factors of and signal early changes in staff retention, such as:

- Job satisfaction of ANFPP workforce, specifically of the NS, NHV and FPW;
- Application of a client centred care model, specifically qualitative indicators from FPW and NHV such as questions of 'Do you feel you are able to deliver client-centred care to your clients?' and 'Do you feel valued in your role?' and qualitative indicators from clients such as client satisfaction with FPW and NHV care
- Perceptions of being valued, specifically qualitative indicators from FPW, NHV and NS such as questions of 'Do you feel valued in your role, why/why not?' and 'Do you feel valued in your role by: FPW? Community? Mums, bubs and families? CEO of IHS? NHV? PM? NPC? Or NS, why/why not?
- Quantitative indicators of the value and quality of relationships, from FPW, NHV and NS, specifically the quantitative indicators of 'value and quality of relationships' used in the on-line quantitative survey of the described data collection procedures.
- Availability of, access to and satisfaction with professional development opportunities for FPW, NHV and NS, specifically:

➢ Quantitative indicators of the availability of a range of professional development opportunities such as in a central or local location and on-line;

➢ Quantitative indicators of the access to a range of professional development opportunities such as in a central or local location and on-line;

➢ Qualitative indicators of facilitators and barriers to the availability and access of professional development opportunities for example, 'What are the facilitators and barriers to receiving professional development?'

➢ Quantitative and qualitative indicators of satisfaction with professional development opportunities such as questions of 'On a scale of 1 - 5 how satisfied are you with professional development opportunities provided by ANFPP' and 'Are you satisfied with the professional development opportunities provided by ANFPP, why/why not?'

- Availability of, access to and satisfaction with cultural mentoring and support for FPW, NHV and NS, specifically:

➢ Quantitative indicators of the availability of a range of cultural mentoring and support such as from NPC, the IAHS or other sources (eg. community or external);

- ➢ Quantitative indicators of the access to a range of cultural mentoring and support such as from NPC, the IAHS or other sources (eg. community or external);
- ➢ Qualitative indicators of facilitators and barriers to the availability and access to cultural mentoring and support for example, 'What are the facilitators and barriers to receiving cultural mentoring and support?'
- ➢ Quantitative and qualitative indicators of satisfaction with cultural mentoring and support such as questions of 'On a scale of 1 - 5 how satisfied are you with cultural mentoring and support provided by ANFPP' and 'Are you satisfied with the cultural mentoring and support provided by ANFPP, why/why not?'

- Availability of, access to and satisfaction with opportunities for debriefing and obtaining informal support from peers for FPW, NHV and NS, specifically:

- ➢ Quantitative indicators of the availability of a range of opportunities for debriefing and obtaining informal support from peers such as from NPC, the IAHS or other sources (eg. community or external);
- ➢ Quantitative indicators of the access to a range of opportunities for debriefing and obtaining informal support from peers such as from NPC, the IAHS or other sources (eg. community or external);
- ➢ Qualitative indicators of facilitators and barriers to the availability and access to opportunities for debriefing and obtaining informal support from peers for example, 'What are the facilitators and barriers to receiving opportunities for debriefing and obtaining informal support from peers?'
- ➢ Quantitative and qualitative indicators of satisfaction with opportunities for debriefing and obtaining informal support from peers such as questions of 'On a scale of 1 - 5 how satisfied are you with of opportunities for debriefing and obtaining informal support from peers provided by ANFPP' and 'Are you satisfied with opportunities for debriefing and obtaining informal support from peers provided by ANFPP, why/why not?'

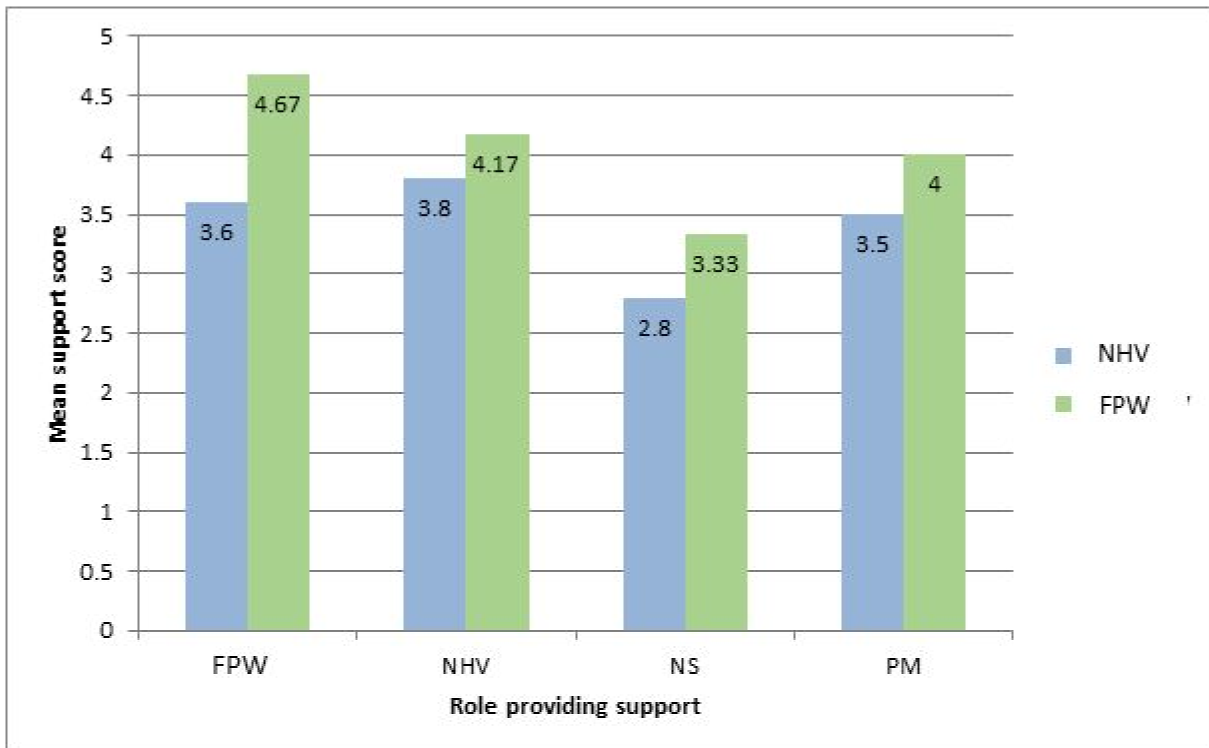
8.0 Key Focus Area - 6 Support

8.1 Key Focus Area 6 - Results

Multiple mechanisms of support within the ANFPP and IAHS contributed to job satisfaction and retention within within the ANFPP. Support provided to and received by the FWP and NHV featured as a strong support mechanism as well as support provided to and received by the NS. A lack of support mechanisms especially for the NS, jeopardised their retention and influenced the turnover of this role causing organisational disruption that ultimately affected the job satisfaction and retention of FPW and NHV.

When assessing self-reported received support, the quantitative results showed FPW reporting a very high support score both amongst their peers (mean = 4.67, SD = 0.52) and from the NHVs within their team (mean = 4.17, SD = 1.17). Although generally lower than the FPW, the NHVs also reported a high level of support amongst their peers (mean = 3.80, SD = 0.84) and from the FPW within their team (mean = 3.60, SD = 0.89). FPW and the NHV reported their lowest level of peer support as being received from the NS (mean = 3.33, SD = 1.37; mean = 2.80, SD = 0.84 respectively). Figure 4. illustrates the level of received support of NHV and FPW, outlined by the blue and green bars respectively, provided by each of their ANFPP team member roles. Interestingly, as illustrated by the green bars, FPW reported receiving a generally higher level of support from all of their ANFPP team member roles than the NHV, illustrated by the blue bars.

Figure 4: *Self-reported received support of NHVs and FPWs provided by their ANFPP team members (n=11)*



NB: Results from PM/NS not reported as n <5

These quantitative results can be explained further by qualitative results. FPW give and receive support to and from each other as a function of cultural obligation as well as general satisfaction with receiving support from the newly developed support structures provided by NPC for FPW. NHV similarly felt generally supported through the ANFPP, including through the NPC and the IAHS. The mechanisms of support provided are illustrated in the following quotes:

"I think it's good now with NPC, with - well, with [Broader Program Role] in particular. Like, we have the meetings - I think it's once a month, and we have another one that's, like, once a fortnight. There's two different ones where we just have a catch up and then...just to talk about any...not just anything, but talk...and then we have the actual FPW meeting

where all sites...you know, we give updates and whatnot, and get to really talk about our role properly and what's happening, yeah… they are really valuable.. because there's better support in one for each - each other, each site" (Family Partnership Worker)

"Yeah, we are very well supported. We attend different learning sessions which all really ties in nicely to this program… the trainings...and yeah, I feel well supported through the organisation, through my team and the Brisbane [NPC] team. I'm very satisfied" (Nurse Home Visitor)

The overall lower level of support received by the NHV, as identified in the quantitative results, could be explained by the qualitative results of a complex interaction of a variety of factors influencing NHV perception of *receiving* support, the type of support being provided to the NHV by FPW and the IAHS and lack of ANFPP communication processes between FPW and NHV, specifically about their roles in regards to the delivery of content during the home visits. The following quotes attempt to highlight the complexity of these factors and identify cross cultural communication challenges and strategies, such as informal and formal communication and clarification of roles and responsibilities to promote perceptions of support between the NHV and FPW:

"At a team level it's communication, which can be difficult depending on people's backgrounds again, and differing levels of skill and comfort around communicating ... there's always that undercurrent. And it's hard. I mean, I talk a lot about the parallel process rupture, and here you're going to have ruptures if you have these frank discussions. You're going to have that rupture within the relationship, but then it's about that repair work and coming back together, working through it, and resolving it. And I guess when you look at that kind of stuff, it's why it's so important to have even cohesiveness between the nursing training and the partnership worker training. Because if you're going to be talking to Partnership Workers about communication skills and if you think there's an issue, how do you have those conversations with your nurse, you need to be talking to your nurses about the importance of taking on board that feedback, and valuing that feedback and working with the Partnership Worker to come to a solution. So it's a two way street. It can't be seen in isolation. And that's that line between Partnership

Workers and nurses has got to go. We're a partnership program, it's not just nurses working in partnership with families, it's you're working in partnership with each other" (Nurse Home Visitor)

"So sometimes they [NHV] listen, sometimes they don't. I think sometimes they think that I just like to hear myself talk, when in actual fact I'm trying to protect them. Because I find that when they don't listen and then, you know, it all goes south, then they're like, "Ah", and then realise that they should have listened. So when I'm giving them like, you know, little eye contacts or like look at them and going, like that sort of thing when the client can't see me, they're sort of like, "Oh", and then continue doing their work, and I'm like, "I've picked up something that you haven't. Therefore then I'm the Aboriginal worker telling you we need to leave this environment now." And then when we don't, bad things have been happening...sometimes then when we're in the car, when it's just myself and the nurse, sometimes we can have that one-on-one [conversation]. Other times, it's just like dead silence because it's sort of like a shock of, "What just happened?" And it's just that you just want to get away from that place. And sometimes like the straight talk we use can happen a couple of days later, when it's all calmed down and emotions aren't running high and stuff like that" (Family Partnership Worker)

"So you and I know what each other does. You and I know how we work together. You and I know what the communication is, who's responsible for what. We know that. They don't. And I think that that's the starting place. And consult with them. I wouldn't impose a PD on them. They've been in the roles for too long. Consult with them. Invite them in. Sit down and say "Let's talk about what it is you do and let's talk about what it is nurses do. Let's talk about how we can get a partnership happening here" (Human Resource Manager)

The support provided to and received by the NS had a powerful influence on their retention and consequently the job satisfaction of FPW and NHV and retention specifically of NHV. IAHS organisational support and commitment to the ANFPP, along with effective RP were identified as key factors that influenced the retention of the NS in the context of this role being described as a 'lonely position', belonging neither to the executive structure of the IAHS, or due to the supervisory nature of the position, the ANFPP IAHS site team.

The high turnover of the NS influenced job satisfaction of both the NHV and FPW and the retention of NHV through new NSs changing policies and procedures of the ANFPP within the IAHS site affecting the roles and responsibilities of NHV and FPW and especially where their ability to deliver a client centred model of care was particularly jeopardised. The impact of the turnover of the NS is illustrated below:

> *"The biggest challenge has been lack of continuity with our nurse supervisor, nurse supervisors, on average, last just under a year, so with 7 years being here, I've had 7 nurse supervisors and a couple of acting people in the position in a team leader role. So it's very, very difficult in those terms because when you get new nurse supervisors, have never had experience with the program, so then they have to do their training, they have to understand what it is we do...it's very complex what we do so it takes a long time for people to wrap your head around it. I know with the nurse home visitor, it takes a good 12-18 months to really be competent and feel confident in the role. So when you've got a nurse supervisor who's lasting less than 12 months, they don't really get it, they kind of challenge a little bit as to why we do things a certain way. Some have come in and they've wanted to completely change how we've done things and how we operate, so it's difficult" (Family Partnership Worker)*

Organisational support for the ANFPP by the IAHS played a critical role in the support perceived by the NS role that contributed to their retention, along with RP that was formally and informally organised, external to the IAHS. These protective support factors for NS retention are illustrated by the following quotes:

> *"I feel supported by the organisation. And I feel valued by the organisation, not just myself, but I feel that the program is valued by the people who need to value them. There are others that certainly don't value the program and question it. But I take that back to maybe their lack of understanding of where we fit in this" (Nurse Supervisor)*

"I think it has to come down to the support that I've got from [CEO]. If I didn't have [CEO]'s support I wouldn't be here…" (Nurse Supervisor)

"[External RP provider] kept me sane...when I was thinking, I had my back up against the wall, and the world was against me, [they'd] be that person, "Let it go, we'll hold up, let's look at this, let's look at the principles". [They] are very, very good at what [they] do" (Nurse Supervisor)

"I seek external RP, I meet previous colleagues. And we discuss, I guess I give them reflective practice and they give me at the same time … [but] it's not a [formally organised] practice, no" (Nurse Supervisor)

In addition to these factors, other strategies demonstrated in the quote below that supported NS were time for them to prepare for their positions, including undertaking site visits before managing their team and having more time to understand their role and the ANFPP.

"In terms of the nurse home visitors, they have more time in terms that they can sit down and read through the manuals, and go out and do shadow visits, and have that exposure as well as the training, before they be allocated clients. So they might have that eight to 12 weeks where they actually, learn the program...where with nurse supervisors, they don't have that, it's not afforded to you, because you do have to hit the ground running, you do have to monitor everything else as well as marry the [organisational] policy, into the program" (Nurse Supervisor)

8.2 Key Focus Area 6 - Discussion

These findings in KFA 6 reinforce the findings of KFA 1, 2 and 3, 4 and develop further the understanding of how the mechanisms of support within the ANFPP and IAHS contribute to job satisfaction and retention of the ANFPP workforce.

The link between 'support' and job satisfaction and retention is well established in the literature (CRANAplus, 2016; Eisenberger, 2002; Humphries et al., 2009; Maqbali, 2015) and is confirmed by the findings of this KFA. A supportive workplace, opportunities for collaboration with professional peers, and relationships with co-workers, are all regarded as mechanisms that supported team members to stay in their positions (CRANAplus, 2016; Dmytryshyn et al., 2015; Harden, 2010; Korfmacher et al., 2008). The results reported here particularly showed the importance of the FPW and NHV supportive relationship both with their professional peers (eg. FPW with other FPW and NHV with other NHV) and with each other. The results also identified the role of cross cultural communication in translating the perceptions of support between the FPW and NHV and acknowledged informal and formal processes of communication, such as processes of communication before and after a home visit, in addressing cross cultural communication challenges. The role of the NPC in providing education and training, professional support, material adaption and development and monitoring data (Ernst & Young, 2012) may also be able to integrate cross cultural communication techniques into its support systems and build on the application of the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health,* (Commonwealth of Australia, 2016), *NATSIHP, 2013-2023 (*Australian Government, 2013) and *ATSIHCF* (Department of Health, 2014), identified in KA1 and KA4.

The role of IAHS organisational support and commitment to the ANFPP, as shown in the results of KA1 was also identified in this KFA as a key supporting factor influencing NS retention. As similarly identified and discussed in KA1, there must be stronger partnerships between the ANFPP and the IAHSs to improve integration and organisational support for the ANFPP program (Burton, 2012; Hunt, 2013). Support from the IAHSs is absolutely critical to the continuing success and viability of the ANFPP and this was most evident in the support offered to the NS role. The NS position is crucial to the function of the ANFPP (Beam, O'Brien & Neal, 2010) and yet suffered most from a perceived lack of support from the broader health care team and organisation, influencing the turnover of the position and therefore the job satisfaction of the FPW and NHV and turnover of the NHV. Professional and cultural support delivered at an IAHS

organisational and local level has been shown to improve both job satisfaction and retention of NSs in similar programs (Dmytryshyn et al., 2015; Robinson et al., 2012) and could be applied as a strategy to provide further localised support for the NS in the IAHS sites.

In addition to the role of organisational support and commitment, RP was identified in this KFA as a support mechanism that influenced the retention of the NS. While RP has been widely identified as a supportive mechanism to alleviate the stress of delivering a client-centred model of care for NHV and other NFP professionals (Dmytryshyn et al., 2015; Gill et al., 2007; Lewis, 2007; Robinson et al., 2012) less has been identified for the NS role, these results for this KFA representing a development in the literature. The significance of this finding for the NS is particularly heightened also given its indirect influence on the retention of NHV and FPW. The results of this KFA further revealed the importance of formally and informally organised, *external* RP, and highlight the need for a range of options of RP to be available. This finding builds on the trends noted internationally for the provision of external RP (Dmytryshyn et al., 2015; Robinson et al., 2012; Schwartz, 2015). RP, nonetheless, as a support and survival tool for health professionals working in cross cultural contexts cannot be underestimated (Dudgeon et al., 2014). The NS is pivotal to implementation of RP for the rest of the ANFPP IAHS site team and must be actively supported by both the IAHS and the ANFPP for this important practice to continue.

8.3 Key Focus Area 6 - Recommendations

To strengthen mechanisms of support within the ANFPP and IAHS to contribute to job satisfaction and retention of the ANFPP workforce it is recommended that:

6.1 NPC strengthen current support mechanisms for ANFPP roles by integrating cross-cultural communication techniques into the ANFPP education package and training, particularly for NHV and FPW and other program structures, such as the formalisation of informal and formal

communication processes between NHV and FPW before and after a site visit (linked to Recommendation 5.2).

6.2 Support from the implementing IAHS sites be sought for the ANFPP through alignment and application of ANFPP and IHS communication and engagement strategies, for example that focus on joint objectives, such as the model of client-centred care (linked to Recommendation 1.9).

6.3 More localised and cultural and professional support mechanisms be put in place for the NS role, for example an established cultural mentor from the IAHS.

6.4 Recognition of the importance of external RP, organised either formally or informally as an important tool for the NS and continue to promote and monitor the uptake of RP for FPW and NHV.

6.5 ANFPP and IAHS to provide more time for the NS to prepare for position including on site visits and time to understand the ANFPP education package and training.

6.6 Ongoing data and monitoring indicators be collected, at 3 month intervals for example, to reflect key factors of and signal early changes in staff retention, such as:

- Engagement with current NPC support mechanisms such as NHV and FPW attendance of communities of practice meetings and the annual conference.
- Engagement with ANFPP education and training and application of cross communication techniques, including the NHV and FPW use of informal and formal communication processes before and after a site visit
- Alignment and application of ANFPP with IAHS communication and engagement strategies and level of organisational support and commitment to the ANFPP, ascertained through the use of a 'site readiness' tool to assess Community Board and IAHS readiness to deliver ANFPP
- The the use of formally and informally organised, external RP processes, especially for NS

- The uptake of RP as a core model element in all aspects of the ANFPP, especially for FPW and NHV

6.7 Undertake further research and reporting of specifically identified factors that influence RP uptake in the ANFPP program including the development of a 'reflective practice culture' where reflective practice could be applied through all ANFPP program structures.

9.0 Discussion and Conclusions

This report aims to assist future ANFPP workforce planning by identifying a range of factors that influence ANFPP workforce retention. To understand these factors adequately, a consideration of the broad Australian policy context historically and currently, specifically as experienced by Indigenous Australian families and communities is necessary.

While the ANFPP program has a long and established track record and research in Nurse-led home visiting programs (Kitzman et al., 1997; Olds et al., 1986; Old et al., 2002; Olds et al., 2014), the IAH context also has an equally long and established track record of IHW-led programs, albeit not as heavily evidenced according to the research of a Western knowledge system (Bailey & Hunt, 2012; Baba, Brolin, & Hill, 2014; Liaw et al., 2011; Peiris et al., 2009). Bringing the strengths of the two domains of the ANFPP and the IAH context closer together is critical for the successful implementation of the ANFPP for the benefit of better realising the outcomes that have been evidenced in countries all over the world (Lee et al.,2012; Miller, 2015; Miller & Levy, 2000; Mejdoubi et al., 2014) for Indigenous Australian families and communities.

What is specifically unique about the IAH context compared with other comparable western colonised nations such as the United States, Canada and New Zealand where the NFP model is implemented, is the current policy and legislative context response to the historical policies that

have affected Indigenous Australians. In particular, there is a lack of legislation and coherent policy to recognise the fundamental rights of Indigenous Australians, as afforded to other Australians, and that has been developed in countries such as the United States, Canada and New Zealand (Australian Human Rights Commission, 2010; Howse, 2011; Watson, 2007). This fundamentally affects initiatives such as the ANFPP through generalised perceptions of suspicion and mistrust of initiatives outside of the realm of Indigenous leadership and self determination. An example of how this could currently affect the ANFPP is a consideration of the current Australian policy response to the historical policies of the 'Stolen Generation' in Australia where Indigenous babies and children were forcibly removed from their families (Calma, 2007; McCallum, 2007; Wilkie, 1997; Zambas & Wright, 2016) by institutions and importantly the role some non-indigenous nurses played in this era (Forsyth, 2007). These same historical trends occur in the current health service policy context where non-Indigenous nurses are often responsible for collecting and reporting information, according to a western knowledge and belief system and lack of necessary cultural capability, that may contribute to the removal of Indigenous babies and children from Indigenous families and communities. These current policy contextual forces strongly influence Indigenous Australian perceptions of and interactions with initiatives where Indigenous leadership and self determination is limited or absent (Gajjar, Zwi, Hill, & Shannon, 2014; Hayman et al., 2009; Kelaher et al., 2014; Mazel, 2016). As such, in order for the ANFPP to closer align to the IAH context, Indigenous leadership and self determination leading to a partnership approach to implement the ANFPP in the Australian context is critical.

This report provides a framework for how Indigenous values, leadership, workforce and research can inform the ANFPP and identifies critical frameworks such as the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health,* (Commonwealth of Australia, 2016), *NATSIHP, 2013-2023 (*Australian Government, 2013) and *ATSIHCF* (Department of Health, 2014) and leadership and partnership approaches enable this to be applied. The report discusses the central role of the major NFP adaption to the IAH context, the FPW role and provides specific recommendations to how a partnership approach can be applied.

Firstly through the ANFPP title being changed to the ‘Family Partnership Program’ (FPP) to reflect the FPW and NHV partnership approach and the centrality of a client centred model of care and secondly through the strengthening of the NFP fidelity items to recognise the contribution and role of both the FPW and NHV in providing this client-centred model of care.

Adapting the name of the ANFPP to the ‘Family Partnership Program’ and strengthening the fidelity items will have flow on effects throughout the ANFPP model. An acknowledgement and re-orientation of the program to a partnership approach will allow easier engagement and working relationships generally between the ANFPP and the IAH context. It also forms the framework for desirable characteristics, qualities and attributes to recruit an appropriately aligned ANFPP workforce that match the joint values of the ANFPP and IAH context. Additionally, it re-orients the ANFPP education package, and further retention and support strategies to safeguard the retention of the ANFPP workforce. This report provides specific recommendations, supported by evidence, to enable the ANFPP to undertake these important tasks.

This report provides further recommendations for how the ANFPP can collect ongoing data to monitor ANFPP workforce retention and provides recommendations to inform future research including the establishment of a national research agenda to test a revised ANFPP model based on a closer alignment with the IAH context, with the implementation of the recommendations of this report. While a plethora of data was collected to inform this report, the reporting of this data was limited by the scope of the research objectives. An excess of rich and insightful data collected for the purpose of this report is still in existence and could be used to provide further insights for the ANFPP program, specifically in the areas of the role of the FPW and the dynamics of RP within the ANFPP model. This report was further limited by data collected by research tools and methods inherited by the research team that could be strengthened in future research to better reflect the joint research objectives of the ANFPP and the IAH context. Similarly, any future research conducted in this area should reflect the joint values of the ANFPP and IAH context to support an Indigenous led, partnership approach as has occurred for the

conduct of the data collection, analysis and reporting of results for this report. The usual implementation challenges associated with research, such as small sample sizes and response rates have affected the data collection processes that have informed this report, however these have been addressed and overcome by a mixed method approach that has provided an insightful report, according to a First Peoples approach to guide the workforce retention of the ANFPP.

10.0 References

Abbott, P., Gordon, W., Davison, J. (2008). Expanding roles of Aboriginal health workers in the primary care setting: seeking recognition. *Contemporary Nurse, 27*(2), 66–73. https://dx.doi.org/10.5555/conu.2007.26.1.66

Alford, K. (2015). *A cost-effective approach to closing the gap in health, education and employment: Investing in Aboriginal and Torres Strait Islander nursing education, training and employment*. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Canberra, Australia.

Australian Catholic University. (2017). The Aboriginal Nursing and Midwifery Cadetship for ACU Students. Retrieved from http://www.acu.edu.au/about_acu/faculties,_institutes_and_centres/health_sciences/about_the_faculty/news_and_events/news/the_aboriginal_nursing_and_midwifery_cadetship_for_acu_students

Australian College of Nursing. (2017a). *Available Scholarships*. Retrieved from https://www.acn.edu.au/available-scholarships

The Australian College of Nursing. (2017b). *NAHSSS Remote Clinical Placement Scholarships*. Retrieved from https://www.acn.edu.au/nahsss_rural_and_remote

Australian Government. (2013). *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf

Australian Government. (2016). *Indigenous Cadetship Support*. Retrieved from https://www.ics.employment.gov.au/

Australian Health Practitioner Regulation Agency. (2017). *What we do: The National Registration and Accreditation Scheme*. Retrieved from http://www.ahpra.gov.au/About-AHPRA/What-We-Do.aspx

Australian Human Rights Commission. (2010). *Taking stock of Australia's human rights record: Submission by the Australian Human Rights Commission under the Universal Periodic Review Process*. Retrieved from http://www.humanrights.gov.au/sites/default/files/content/upr/AHRC_UPR_guide.pdf

Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS]. (2002). *Guidelines for Ethical Research in Indigenous Studies*. Retrieved from http://aiatsis.gov.au/sites/default/files/docs/research-and-guides/ethics/gerais.pdf

Australian Institute of Health and Welfare [AIHW]. (2012). *Australian Institute of Health and Welfare 2014, Health Expenditure Australia 2011–12: Analysis by Sector*. Canberra, Australia: AIHW.

Australian Medical Association. (2013). *Aboriginal and Torres Strait Islander Health Report Card, 2012-2013. The Healthy Early Years – Getting the Right Start in Life*. Retrieved from http://ccde.menzies.edu.au/sites/default/files/AMA%20Report%20_irp_2013_final%5B1%5D.pdf

Australian Medical Council Limited. (2017). *Accreditation and recognition*. Retrieved from http://www.amc.org.au/accreditation

Australian Nurse-Family Partnership Program [ANFPP]. (2012). *Report of the FPW/ACW Unit 2 Training 5-9 November 2012*. Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program. (2014a). *About ANFPP*. Retrieved from http://www.anfpp.com.au/about-anfpp

Australian Nurse-Family Partnership Program. (2014b). *ANFPP Family Partnership Workers/Aboriginal Community Workers Unit 1 Training Manual*. Canberra, Australia: Department of Health.

Australian Nurse-Family Partnership Program. (2014c). ANFPP *Nurse Home Visitors: Unit 1 Training Manual.* Canberra, Australia: Department of Health.

Australian Nurse-Family Partnership Program. National Program Centre. (2015). *National Annual Data Report: 1 July, 2014 to 30 June, 2015*. Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program. (2016a). *ANFPP National Program Centre National Workforce Development and Education Strategy, 2015-201*8. Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program. (2016b). *ANFPP Cultural Respect Framework.* Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program National Program Centre [ANFPP NPC]. (2016a). *ANKA Project Plan.* Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program National Program Centre. (2016b). *ANFPP National Quality Framework, 2016*. Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program National Program Centre. (2016c). *Communications and Engagement Strategy, 2016*. Brisbane, Australia: ANFPP National Program Centre.

Australian Nurse-Family Partnership Program National Program Centre. (2017a). *ANFPP Data Collection System: Systematic Review Report*. Brisbane, Australia: ANFPP NPC.

Australian Nurse-Family Partnership Program National Program Centre. (2017b) *ANFPP Workforce Development Project Report*. Manuscript in preparation.

Australian Nursing and Midwifery Council [ANMC], (2010). *Standards and Criteria for the Accreditation of nursing and Midwifery Courses: Re-entry to the register standards Registered Nurses*. Retrieved from file:///C:/Users/s2135885/Downloads/Standards-and-Criteria-for-the-Accreditation-of-Nursing-and-Midwifery-Courses-Re-Entry-to-the-Register-Standards-Registered-Nurses.PDF

Baernholdt, M., & Mark, B. A. (2013). The nurse work environment, job satisfaction and turnover rates in rural and urban nursing units. *Journal of Nursing Management, 17*(8), 994-1001. doi:10.1111/j.1365-2834.2009.01027.x

Bainbridge, R., McCalman, J., Clifford, A., & Tsey, K. (2015). *Cultural competency in the delivery of health services for Indigenous people*. Issues paper no. 13. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Retrieved from

http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2015/ctgc-ip13.pdf

Bailey, S., & Hunt, J. (2012). Successful partnerships are the key to improving Aboriginal health. *NSW Public Health Bulletin, 23*(3–4), 48–51. doi:10.1071/NB11057.

Beam, R. J., O'Brien, R. A., & Neal, M. (2010). Reflective Practice Enhances Public Health Nurse Implementation of Nurse-Family Partnership. *Public Health Nursing, 27*, 131–139. doi:10.1111/j.1525-1446.2010.00836.x

Bertilone, C., & McEvoy, S. (2015). Success in Closing the Gap: favourable neonatal outcomes in a metropolitan Aboriginal Maternity Group Practice Program. *The Medical Journal of Australia, 203*(6), 262.e1-e7. Retrieved from https://www.mja.com.au/system/files/issues/203_06/10.5694mja14.01754.pdf

Best, O., & Fredericks, B. (2013). *Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care*. Port Melbourne, Australia: Cambridge University Press

Boud, D., & Walker, D. (2006). Promoting reflection in professional courses: The challenge of context, *Studies in Higher Education, 23*(2), 191-206. doi:10.1080/03075079812331380384

Bowes, J., & Grace, R. (2014). *Review of early childhood parenting, education and health intervention programs for Indigenous children and families in Australia*. Issues paper no. 8. Produced for the Closing the Gap Clearinghouse. Canberra, Australia: Australian Institute of Health and Welfare & Melbourne, Australia: Australian Institute of Family Studies.

Bretherton, T. (2014). *Shifting Gears: Identifying drivers of career development for Aboriginal and Torres Strait Islander workers in the health sector.* Melbourne, Australia: The Lowitja Institute.

Brunettoa, Y., Shacklock, K., Teoc, S., & Farr-Wharton, R. 2014. The impact of management on the engagement and well-being of high emotional labour employees. *The International Journal of Human Resource Management, 25*(17), 2345–2363. doi.org/10.1080/09585192.2013.877056

Burton, J. (2012). *Opening doors through partnerships: practical approaches to developing genuine partnerships that address Aboriginal and Torres Strait Islander community*

needs. Melbourne, Australia: Secretariat of National Aboriginal and Islander Child Care. Retrieved from http://www.snaicc.org.au/toolsresources/fxlistresources.cfm?loadref=5&initsearch=1&searchbyterm=opening+doors&txnid=1246&txnctype=resource&txncstype=document

Calma, T. (2007). *Indigenous health: real solutions for a chronic problem – social and emotional wellbeing*. Retrieved from http://www.humanrights.gov.au/news/speeches/indigenous-health-real-solutions-chronic-problem-2007

Castro, F. G., Kellison, J. G., Boyd, S. J., & Kopak, A. (2010). A Methodology for Conducting Integrative Mixed Methods Research and Data Analyses. *Journal of Mixed Methods Research*, *4*(4), 342–360. http://doi.org/10.1177/1558689810382916

Centre for Research Excellence in Aboriginal Health and Wellbeing. (2009). Centre for Research Excellence in Aboriginal Health and Wellbeing annual report 2011. *From marginalised to empowered: transformative methods for Aboriginal health and wellbeing*. Perth, Australia: Telethon Institute for Child Health Research. Retrieved from http://aboriginal.telethonkids.org.au/media/286956/cre_2011_annual_report_final.pdf

Chong, A., Renhard, R., Wilson, G., Willis, J. & Clarke, A. 2011, Improving Cultural Sensitivity to Indigenous People in Australian Hospitals a Continuous Quality Improvement Approach. *Focus on Health Professional Education: A multi-disciplinary Journal, 13*(1), 84–97. Retrieved from https://www.lowitja.org.au/sites/default/files/docs/ICHP%20Timeline-WEB.pdf

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives [CATSINaM]. (2015). *What Do We Do*. Retrieved from http://catsinam.org.au/about-us/what-we-do

CRANAplus. (2016). *Australian Nurse-Family Partnership Program Workforce Study: Literature Review*.

CRANAplus. (2017). *Scholarships and Grants*. Retrieved from https://crana.org.au/membership/scholarships

Creswell, J. W. (2013). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Los Angeles: SAGE.

Commonwealth of Australia. (2016). *Cultural Respect Framework 2016-2016 For Aboriginal and Torres Strait Islander Health, A National Approach to Building a Culturally Respectful Health System.* Canberra, Australia: Commonwealth of Australia.

Couzos, S., & Murray, R. (2007). *Aboriginal Primary Health Care: An evidence based approach*. South Melbourne, Australia: Oxford University Press.

Department of Health. (2014). *Aboriginal and Torres Strait Islander Health Curriculum Framework*. Canberra, Australia: Commonwealth of Australia.

Dillon, M. C., & Westbury, N. D. (2007). *Beyond humbug: transforming government engagement with Indigenous Australia*. West Lakes, South Australia: Seaview Press.

Dmytryshyn, A. L., Jack, S. M., Ballantyne, M., Wahoush, O., & MacMillan, H. L. (2015). Long-term home visiting with vulnerable young mothers: an interpretive description of the impact on public health nurses. *BMC Nursing, 14*(12), 1-14. Retrieved from http://bmcnurs.biomedcentral.com/articles/10.1186/s12912-015-0061-2

Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care, 23*(3), 247–57. doi:10.1093/intqhc/mzr008.

Driscoll, D. L., Appiah-Yeboah, A., Salib, P., & Rupert, D. J. (2007). Merging Qualitative and Quantitative Data in Mixed Methods Research: How To and Why Not. *Ecological and Environmental Anthropology, 3*(1), 19-28. Retrieved from http://digitalcommons.unl.edu/icwdmeea/18

Dudgeon, P., Milroy, H., & Walker, R. (Eds.). (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Barton: Commonwealth of Australia. Retrieved from http://aboriginal.telethonkids.org.au/media/699863/Working-Together-Book.pdf

Dudgeon, P., & Ugle, K. (2010). Communication and Engagement: Urban Diversity. In: N. Purdie, P. Dudgeon, R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (pp. 257-267). Canberra, Australia: Commonwealth of Australia.

Duraisingam, V., Roche, A.M., Trifonoff, A., & Tovell, A. 2010. Indigenous AOD Workers' Wellbeing, Stress, and Burnout: Findings from an online survey. *National Centre for Education and Training on Addiction (NCETA)*, Flinders University, Adelaide SA.

Retrieved from: http://nceta.flinders.edu.au/files/8013/3291/0487/EN440_Duraisingam_2010.pdf

Duthie, D., King, J., & Mays, J. (2013). Raising awareness of Australian Aboriginal peoples reality: Embedding Aboriginal knowledge in social work education through the use of field experiences. *The International Education Journal: Comparative Perspectives, 12*(1), 197–212. Retrieved from http://openjournals.library.usyd.edu.au/index.php/IEJ/article/viewFile/7446/7802

Eisenberger, R., Stinglhamber, F., Vandenberghe, C., Sucharski, I. L., & Rhoades, L. (2002). Perceived supervisor support: Contributions to perceived organizational support and employee retention. *Journal of Applied Psychology, 87* (3), 565-573. http://psycnet.apa.org/doi/10.1037/0021-9010.87.3.565

Ernst & Young. (2012). *Stage 1 Evaluation of the Australian Nurse-Family Partnership Program: Final report*. For Department of Health and Ageing. Canberra, Australia: Ernst & Young Australia.

Farrelly, T., & Lumby, B. (2009) A Best Practice Approach to Cultural Competence Training. *Aboriginal & Islander Health Worker Journal, 33*(5) p 14-22.

Forsyth, S. (2007) Telling stories: Nurses, politics and Aboriginal Australians, circa 1900-1980s. *Contemporary Nurse*, 24, p. 33-44.

Fredericks, B. (2008) The need to extend beyond the knowledge gained in cross-cultural awareness training. *The Australian Journal of Indigenous Education, 37*, p81-89.

Fredericks, B., & Legge, D. (2011). *Revitalizing Health for All: International Indigenous Representative Group Learning from the Experience of Comprehensive Primary Health Care in Aboriginal Australia—A Commentary on Three Project Reports*. Melbourne, Australia: The Lowitja Institute.

Gajjar, D., Zwi, A. B., Hill, P. S., & Shannon, C. (2014). A case study in the use of evidence in a changing political context: an Aboriginal and Torres Strait Islander health service re-examines practice models, governance and financing. *Australian Health Review 38*, 383-386. http://dx.doi.org/10.1071/AH13221

Gill, S., Greenberg. M. T., Moon, C., & Margraf, P. (2007). Home visitor competence, burnout, support, and client engagement. *Journal of Human Behavior in the Social Environment, 15*(1), 23-44. doi:10.1300/J137v15n01_02

Halcomb, E. J., Peters, K., & Davies, D. (2013). A qualitative evaluation of New Zealand consumers perceptions of general practice nurses. *BMC Family Practice, 14*(26). Retrieved from http://www.biomedcentral.com/1471-2296/1414/1426.

Hayman, N. E., White, N. E., & Spurling, G. K. (2009). Improving Indigenous patients' access to mainstream health services: the Inala experience. *Medical Journal of Australia, 190*(10), 604-606. Retrieved from https://www.mja.com.au/journal/2009/190/10/improving-indigenous-patients-access-mainstream-health-services-inala-experience

Health Workforce Australia. (2014). *Developing Aboriginal and Torres Strait Islander cultural capabilities in entry to practice health graduates: A review of the literature.* Canberra, Australia: Department of Health.

Hillier, Y. (1998). *Informal practitioner theory: eliciting the implicit*. Retrieved from http://www.leeds.ac.uk/educol/documents/000000723.htm

Hooper, K., Thomas, Y., & Clarke, M. (2007). Health professional partnerships and their impact on Aboriginal health: an occupational therapist's and Aboriginal health worker's perspective. *Australian Journal of Rural Health, 15*(1), 46-51. https://dx.doi.org/10.1111/j.1440-1584.2007.00849.x

Howse, G. (2011). *Legally Invisible – How Australian Laws Impede Stewardship and Governance for Aboriginal and Torres Strait Islander Health*. Carlton, Australia: The Lowitja Institute.

Humphreys, J. S., Wakerman, J., Wells, R., Kuipers, P., Jones, J. A., & Entwistle, P. (2008). "Beyond workforce": a systemic solution for health service provision in small rural and remote communities. *Medical Journal of Australia, 188*(S8), S77-S80. Retrieved from https://www.mja.com.au/system/files/issues/188_08_210408/hum11124_fm.pdf

Humphreys, J., Wakerman, J., Wells, R., Kuipers, P., Jones, J., Entwistle, P., & Harvey, P. (2007). *Improving primary health care workforce retention in small rural and remote communities: how important is ongoing education and training? Report*. Australian Primary Health Care Research Institute. Retrieved from:

http://aphcri.anu.edu.au/projects/network/improving-primary-health-care-workforce-retention-small-rural-and- remote

Humphreys, J., Wakerman, J., Pashen, D., & Buykx, P. (2009). *Retention strategies & incentives for health workers in rural & remote areas: what works?* Report.:Australian Primary Health Care Research Institute. Retrieved from: http://files.aphcri.anu.edu.au/research/international_retention_strategies_research_pdf_10642.pdf

Hunt, J. (2013). *Engagement with Indigenous communities in key sectors. Resource sheet no. 23. Produced for the Closing the Gap Clearinghouse*. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Retrieved from http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs23.pdf

Hunter, P., Mayers, P., Couzos, S., Daniels, J., Murray, R., Bell, K.,... Tynan, M. (2005) *Aboriginal Community Controlled Health Services in General Practice in Australia 2004*. Canberra, Australia: Australian Government Department of Health and Ageing.

Jackson, D., Brady, W., Stein, I. (1999). Towards (re)consiliation: (re)constructing relationships between Indigenous health workers and nurses. *Journal of Advanced Nursing, 29*(1), 97–103. Retrieved from http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1999.00866.x/full

James Cook University. (2017). *Thelma Myers Memorial Aboriginal and Torres Strait Islander Nursing & Midwifery Scholarship*. Retrieved from https://www.jcu.edu.au/scholarships-@-jcu/search/thelma-myers-memorial-aboriginal-and-torres-strait-islander-nursing-and-midwifery-scholarship

Jones Harden, B. (2010). Home Visitation with Psychologically Vulnerable Families: Developments in the Profession and in the Professional. *Zero to Three 30*(6): 44– 51.

Keane, S., Lincoln, M., & Smith, T. (2012). Retention of allied health professionals in rural New South Wales: a thematic analysis of focus group discussions. *BMC Health Services Research, 12*:175. doi:10.1186/1472-6963-12-175

Kelaher, M., Sabanovic, H., La Brooy, C., Lock, M., Lusher, D., & Brown, L. (2014). Does more equitable governance lead to more equitable health care? A case study based on the implementation of health reform in Aboriginal health Australia. *Social Science & Medicine, 123*, 278-286. http://dx.doi.org/10.1016/j.socscimed.2014.07.032

Kitzman, H, Olds, D. L., Henderson, C.R. Jr., Tatelbaum, R., McConnochie, K. M., Sidora, K., …Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: a randomized controlled trial. *JAMA, 278*(8), 644–652. Retrieved from http://jamanetwork.com/journals/jama/fullarticle/418043

Kildea, S., Kruske, S., Barclay, L., & Tracy, S. (2010). 'Closing the Gap': How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women. *Rural and Remote Health, 10*:1383, S1-S18. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_1383.pdf

Knott, C., & Scragg, T. (2016). *Reflective Practice in Social Work*. London, United Kingdom: Sage.

Korfmacher, J., Green, B., Staerkel, F., Peterson, C., Cook, G., Roggman, L., Faldowski, R., & Schiffman, L. (2008). Parent Involvement in Early Child Home Visiting. *Child You Care Forum, 37*(4): 171– 96.

Korfmacher, J., O'Brien, R., Hiatt, S., & Olds, D. (1999). Differences in program implementation between nurses and paraprofessionals providing home visits during pregnancy and infancy: A randomized trial. *American journal of Public Health, 89*(12), 1847-1851. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1509014/pdf/amjph00012-0061.pdf

Krakouer, J. (2015). *Literature review relating to the current context and discourse on Indigenous cultural awareness in the teaching space: Critical pedagogies and improving Indigenous learning outcomes through cultural responsiveness*. Melbourne, Australia: Australian Council for Educational Research.

Kuipers, P., Harvey, D., Lindeman, M., Stothers, K. (2014). Aboriginal and Torres Strait Islander health practitioners in rural areas: credentialing, context and capacity building. *Rural and Remote Health, 14*: 2897. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_2897.pdf

Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes*. Olympia, United States: Washington State Institute for Public Policy.

Lewis, J. (2007). Colorado nurses and the NFP: Feedback from those working in the nurse-family partnership may help retain nurses. *American Journal of Nursing,107*(11), 69-72. Retrieved from: http://www.nursingcenter.com/upload/static/747975/Coloardo%20NFP.pdf

Liaw, S. T., Lau, P., Pyett, P., Furler, J., Burchill, M., Rowley, K., & Kelaher, M. (2011). Successful chronic disease care for aboriginal Australians requires cultural competence. Australia New Zealand Journal of Public Health, 35(3), 238–248. doi: 10.1111/j.1753-6405.2011.00701.x.

Lowitja Institute. (2015). *Program 3: Health policy and systems*. Retrieved from http://www.lowitja.org.au/health-policy-systems

Lowitja Institute. (2016). *Approach to Research: Key principles*. http://www.lowitja.org.au/research

Ma Rhea, Z. (2012). Partnership for improving outcomes in Indigenous education: relationship or business? *Journal of Education Policy, 27*(1), 45-66. Retrieved from http://www.tandfonline.com/doi/full/10.1080/02680939.2011.621030?src=recsys

Manthorpe, J., & Baginsky, M. (2015). *Reflective Practice* [Presentation]. London, Great Britain: King's College London.

Maqbali, M. A. A. (2015). Factors that influence nurses' job satisfaction: A literature review. *Nursing Management (2014+), 22*(2), 30. doi:http://dx.doi.org/10.7748/nm.22.2.30.e1297

Martin, D. F. (2005). Rethinking Aboriginal community governance. In: P. Smyth, T. Reddel & A. Jones (Eds). *Community and local governance in Australia* (pp. 108-125). Sydney, Australia: University of New South Wales Press.

Mason, J. (2013). *Review of Australian Government Health Workforce Programs*. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf

Mazel, O. (2016). Self-Determination and the Right to Health: Australian Aboriginal Community Controlled Health Services. *Human Rights law Review, 16*(2), 323-355. https://doi.org/10.1093/hrlr/ngw010

McCallum, D. (2007). Informal powers and the removal of aboriginal children: Consequences for health and social order. *International Journal of the Sociology of Law, 35*(1), 29-40. doi:10.1016/j.ijsl.2006.11.003

McCormack, B., & McCance, T. V. (2006). Development of a framework for person centred nursing. *Journal of Advanced Nursing, 56*(5), 472-479. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17078823

McDonald, M., Moore, T., & Goldfield, S. (2012). *Sustained home visiting for vulnerable families and children: A literature review of effective programs*. Prepared for Australian Research Alliance for Children and Youth. Parkville, Victoria: The Royal Children's hospital Centre for Community Child Health, Murdoch Children's Research Institute. Retrieved from http://www.rch.org.au/uploadedFiles/Main/Content/ccch/resources_and_publications/Home_visiting_lit_review_RAH_processes_final.pdf

Mejdoubi, J., van den Heijkant, S. C., van Leerdam, F. J., Crone, M., Crijnen, A., Hirasing, R. A. (2014). Effects of nurse home visitation on cigarette smoking, pregnancy outcomes and breastfeeding: A randomized controlled trial. Midwifery, 30(6), 688–695. doi:10.1016/j.midw.2013.08.006

Miller, T. R. (2015). Projected outcomes of Nurse-Family Partnership Home Visitation During 1996-2013, USA. *Prevention Science, 16*(6), 765-777. doi: 10.1007/s11121-015-0572-9

Miller, T. R., & Levy, D. T. (2000). Cost-outcome analysis in injury prevention and control: Eighty-four recent estimates for the United States. *Medical Care: 2000, 38*(6), 562–582. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10843309

Mills, J. E., Francis, K., Birks. M., Coyle, M., Henderson, S., & Jones, J. (2010). Registered nurses as members of interprofessional primary health care teams in remote or isolated areas of Queensland: Collaboration, communication and partnerships in practice. *Journal of Interprofessional Care, 24*(5), 587-596. http://dx.doi.org/10.3109/13561821003624630

Moffatt, S., White, M., Mackintosh, J., & Howel, D. (2006). Using quantitative and qualitative data in health services research – what happens when mixed method findings conflict? *BMC Health Services Research*, *6*, 28. http://doi.org/10.1186/1472-6963-6-28

Molinari, D. L., & Monserud, M. A. (2008). Rural nurse job satisfaction. *Rural and Remote Health, 8*(4): 1055. http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=1055

Nakata, M. (2007). The cultural interface. *The Australian Journal of Indigenous Education, 36*(S1), 7-14. Retrieved from http://c.ymcdn.com/sites/www.weraonline.org/resource/resmgr/symposiamembermeetings/2010-siep-marti__nakata_ajie.pdf

National Aboriginal and Torres Strait Islander Health Worker Association [NATSIHWA]. (2012a). *The Aboriginal and Torres Strait Islander Health Worker Professional Practice Framework, July 2012*. Retrieved from http://natsihwa.org.au/sites/default/files/publications/NATSIHWA-Aboriginal-and-Torres-Strait-Islander-HW-Prof-Practice-Framework_FINAL%20DRAFT_July%202011.pdf

National Aboriginal and Torres Strait Islander Health Worker Association. (2012b). *A unique profession*. Retrieved from http://www.natsihwa.org.au/content/unique-profession

National Aboriginal and Torres Strait Islander Health Worker Association. (2013). *Cultural Safety Framework.* Retrieved from http://www.natsihwa.org.au/sites/default/files/publications/NATSIHWA-Cultural%20Safety-Framework%20Summary.pdf

National Aboriginal Community Controlled Health Organisation [NACCHO]. (2016). *NACCHO History. Introduction - The need for NACCHO*. Retrieved from http://www.naccho.org.au/about-nacho/naccho-history/

National Health & Medical Research Council. (2003). *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. Retrieved from https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e52.pdf

New South Wales Government. (2016). *NSW Aboriginal Nursing and Midwifery Cadetship Program*. Retrieved from http://www.health.nsw.gov.au/nursing/aboriginal-strategy/Pages/aboriginal-cadetships.aspx

New South Wales Government. (2017). *2017 Rural Undergraduate Scholarships*. Retrieved from http://www.health.nsw.gov.au/nursing/scholarship/Pages/rural-undergrad.aspx

Nurse-Family Partnership [NFP]. (2010). *Implementation Overview & Planning: A guide for prospective Nurse-Family Partnership Implementing Agencies*. Retrieved from https://www.nursefamilypartnership.org/assets/PDF/Policy/HV-Funding-Guidance/NFP_Overview_Planning

Nurse-Family Partnership. (2016). *Nurse-Family Partnership Community Advisory Board*. Retrieved from https://static1.squarespace.com/static/575b3e7b2eeb8186ef29638b/t/57b49321e6f2e189cfb2a699/1471456553997/CAB-Recruitment-1pger.pdf.pdf

Olds, D. L., Henderson, C. R., Tatelbaum, R., Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: a randomized trial of nurse home visitation. *Pediatrics,77*, 16-28. Retrieved from http://pediatrics.aappublications.org/content/77/1/16

Olds, D. L., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of Home Visiting by Nurses on Maternal and Child Mortality: Results of a 2-Decade Follow-up of a Randomized Clinical Trial. *JAMA Pediatrics, 168*(9), 800–806. http://doi.org/10.1001/jamapediatrics.2014.472

Olds, D. L., Robinson, J. A., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., … Talmi, A. (2002). Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial. *Pediatrics, 110*(3), 486-496. DOI:10.1542/peds.110.3.486

Panaretto, K. S., Wenitong, M., Button, S., & Ring, I. T. (2014). Aboriginal community controlled health services: leading the way in primary care. *The Medical Journal of Australia, 200*(11), 649-652. doi:10.5694/mja13.00005

Paul, D., Allen, C., & Edgill, P. (2011). Turning the corner assessment: a key strategy to engagement and understanding in Indigenous health. *Focus on Health Professional Education: a Multi-Disciplinary Journal, 13*(1), 52–64. http://search.informit.com.au/documentSummary;dn=348841783319907;res=IELAPA

Peiris, D. P., Patel, A. A., Cass, A., Howard, M. P., Tchan, M. L., Brady, J. P., … Brown, A. D. (2009). Cardiovascular disease risk management for Aboriginal and Torres Strait Islander peoples in primary health care settings: findings from the Kanyini Audit. *Medical Journal of Australia, 191*(6), 304-309. Retrieved from https://www.mja.com.au/system/files/issues/191_06_210909/pei10138_fm.pdf

Power, T., Sherwood, J., Geia, L. K., & West, R. Indigenous leadership in nursing: Speaking life into each other's spirits. In J. Daly, S. Speedy & D. Jackson (Eds.), *Leadership and Nursing: Contemporary perspectives* (pp 141-148). Sydney, Australia: Elsevier.

Raymond, I., McDonnell, C., & Wilson, G. (2012). NSW Aboriginal Health Promotion Program: lessons learned and ways forward. *NSW Public Health Bulletin, 23*(3–4), 57–58. doi:10.1071/NB12067b.

Redmond, B. (2006). *Reflection in Action: Developing Reflective Practice in Health and Social Services*. Burlington, United States of America: Ashgate.

Robinson, D., Miller, L., & Rickard, C. (2012). *The Family Nurse Workforce: A Study for the Family Nurse Partnership National Unit*. (IES Report 500 Year 2013). Retrieved from http://www.employment-studies.co.uk/sites/default/files/500summary.pdf

Rose M. (2014). *Knowledge is power: Aboriginal Healthworkers' perspectives on their practice, education and communities (Unpublished Doctoral Dissertation).* University of Technology, Sydney, NSW.

Rural Health West. (2013). *Critical success factors for recruiting and retaining health professionals to primary health care in rural and remote locations: Contemporary review of the literature*. Retrieved from http://www.ruralhealthwest.com.au/docs/publications/rhw_uwa_cucrh-contemporary-review-of-the-literature-f-lr.pdf?sfvrsn=2

Sivak, L., Arney, F., & Lewig, K. (2008). *A Pilot Exploration of a Family Home Visiting Program for Families of Aboriginal and Torres Strait Islander Children*. Retrieved from http://w3.unisa.edu.au/childprotection/documents/fhv.pdf

Snook, S. A., Nohria, N., & Khurana, R. (2011). *The handbook for teaching leadership: knowing, doing, and being*. Thousand Oaks: Sage.

Spiers, M. C., & Harris, M. (2015). Challenges to student transition in allied health undergraduate education in the Australian rural and remote context: a synthesis of barriers and enablers. *Rural and Remote Health (Internet) 2015; 15*: 3069. Retrieved from: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=3069

Stephenson, J., & Weil, S. (1992). *Quality in learning: A capability approach in higher education*. London: Kogan Page.

Stoneman, J. & Taylor, S. J. (2007). Improving access to medicines in urban, regional and rural Aboriginal communities—is expansion of Section 100 the answer? *Rural and Remote Health, 7*:738. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_738.pdf

Streubert, H and Carpenter, D. (2011) *Qualitative research in nursing, advancing the humanistic imperative*, 5th ed., Lippincott Williams & Wilkins: Philadelphia.

Sweet, C., Blythe, H., & Carpenter, R. (2016). Why the Revised Bloom's Taxonomy Is Essential to Creative Teaching. In *The National Teaching & Learning Forum* (Vol. 26, No. 1, pp. 7-9).

Taket, A. (2013). The use of mixed methods in health research. In Liamputtong, Pranee (Eds.), *Research methods in health*, (pp. 323-343). Melbourne: Oxford University Press.

Thomas, D.P., Bainbridge, R., & Tsey, K. (2014). Changing discourses in Aboriginal and Torres Strait Islander health research, 1914–2014. *Medical Journal of Australia, 201*(S1), 15–18. doi:10.5694/mja14.00114

Tilley, D. S., Allen, P., Collins, C., Bridges, R. A., Francis, P., & Green, A. (2007). Promoting clinical competence: using scaffolded instruction for practice-based learning. *Journal of Professional Nursing, 23*(5), 285-289. http://dx.doi.org/10.1016/j.profnurs.2007.01.013

Tourangeau, A., E., Cummings, G., Cranleyl, A., Ferrone,M., & Harvey, S. (2010). Determinants of hospital nurse intention to remain employed: broadening our understanding. *Journal of Advanced Nursing, 66*(1), 22–32. doi: 10.1111/j.1365-2648.2009.05190.x

Tracey, D., Craven, R. G., Yeung, A. S., Tregeagle, S., Burnstein, J., & Stanley, H. (2016). A place to learn: cultivating engaging learning environments for young rural Aboriginal Australians. *International Journal of Inclusive Education, 20*(6), 641-658. Retrieved from http://www.tandfonline.com/doi/full/10.1080/13603116.2015.1102341?src=recsys&

University of Colorado. (2014). *ANFPP Guidelines for Pregnancy Home Visits*.Colorado, United States: University of Colorado.

University of Colorado. (2016). *Nurse-Family Partnership (NFP) International Team Literature Review and Environmental Scan of the NFP Core Model Elements*.Colorado, United States: University of Colorado.

Watson, N. (2007). *Implications of land rights reform for Indigenous health. Medical Journal of Australia, 186*(10), 534-536. Retrieved from https://www.mja.com.au/journal/2007/186/10/implications-land-rights-reform-indigenous-health

West, R. (2012) Indigenous Australian participation in pre-registration tertiary nursing courses: an Indigenous mixed methods study. PhD thesis. James Cook University.

West, R., Foster, K., Stewart, L., Usher, K. (2016). "Creating walking tracks to success: A narrative analysis of Australian Aboriginal and Torres Strait Islander nursing students' stories of success". Collegian, vol. 23, pp. 349–354.

West, R., Wrigley, S., Mills, K., Taylor, K., Rowland, D., Creedy, D. (2017). Development of a First Peoples-led Cultural Capability Tool: A pilot study with midwifery students. *Women & Birth.* (Accepted for Publication, January 2017).

Ware, V. (2013). *Improving the accessibility of health services in urban and regional settings for Indigenous people.* Resource sheet no. 27. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Retrieved from http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs27.pdf

Webster, S., Lopez, V., Allnut, J., Claque, L., Jones, D., & Bennett, P. (2010). *Undergraduate nursing students' experiences in a rural clinical placement. 18*(5). 194-198. doi:10.1111/j.1440-1584.2010.01153.x.

Wilkie, M. (1997). *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Sydney, Australia: Human Rights and Equal Opportunity Commission.

Wilson, K., & Devereux, L. (2014). Scaffolding theory: High challenge, high support in Academic Language and Learning (ALL) contexts, *Journal of Academic Language & Learning, 8*(3), A91-A100. Retrieved from http://journal.aall.org.au/index.php/jall/article/viewArticle/353

Wise, S. (2013). *Improving the early life outcomes of Indigenous children: implementing early childhood development at the local level*. Issues paper no. 6. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

Zambas, S. I., & Wright, J. (2016). Impact of colonialism on Māori and Aboriginal healthcare access: A discussion paper. *Contemporary Nurse, 52*(4), 398-409. doi:10.1080/10376178.2016.1195238

11.0 Appendices

Appendix 1 - ANFPP Structure

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