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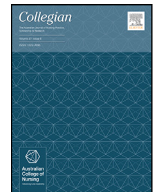

Leadership enhancing culturally safe models of care in a Western Australian Aboriginal community context: A qualitative investigation

Ailsa Munns[a,b,*], Roz Walker[c]

[a] Curtin School of Nursing, Curtin University· GPO Box U1987, Perth 6845, Australia
[b] Child and Adolescent Health Services, Western Australian Department of Health· 15 Hospital Avenue, Nedlands, WA 6009, Australia
[c] Poche Centre for Indigenous Health, School of Indigenous Studies, University of Western Australia, Bilya Marlee, Hackett Ave, Nedlands WA 6009, Australia

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A B S T R A C T

Background: Models of care for community health nursing need to address social determinants of health for families, requiring community health nurse leaders to encourage all nurses to facilitate culturally safe models of care, particularly for vulnerable and underserved populations. Many challenges impact on provision of support for a range of population groups, with increasing attention focusing on how community health nurses lead equitable health activities for Aboriginal Australian families.
Aim: The aims of this study were to investigate the suitability, feasibility and acceptability of parent support, informing a culturally safe model for a peer-led support program for Aboriginal families.
Methods: Participatory action research enabled Aboriginal peer support workers and parents, community agencies and a child health researcher to collaboratively review cultural safety, suitability, and progress of the program. Qualitative data were analysed through thematic analysis.
Findings: The Australian Health Practitioner Regulatory Agency's cultural safety framework guided four themes: Acknowledgement of colonisation, racism, and social determinants of health; recognition of influences of personal racism and power differentials; recognising importance of partnership approaches to care and collaboration with individuals and families to ensure appropriate and acceptable care; and promotion of safe working environments.
Discussion: Community-based initiatives informed by Aboriginal perspectives are needed to support Aboriginal families. Participatory action research enables community health nurse leaders to engage with Aboriginal participants, facilitating co-design of culturally safe models of care.
Conclusion: Reflections on culturally safe strategies enabled development of peer-led support for Aboriginal families, focusing on self-determination, empowerment, and equity. Acceptability of the strategies has contributed to an emerging culturally safe model of care. Indigenous Australian peoples are people who identify as Aboriginal or Torres Strait Islander. Respectfully, throughout this paper, they will be described as Aboriginal.

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Summary of evidence

Problem

Little is known about the role of community health nurse leadership in developing culturally safe models of care for Aboriginal families with young children.

What is already known

The importance of support for Aboriginal parents with children in the early years is well established. Initiatives for Aboriginal families and communities require strengths-based, culturally safe interdisciplinary primary healthcare approaches.

What this paper adds

Through participatory action research, nurse leaders can work in partnership with Aboriginal families, peer support workers and the community to facilitate positive and trusting relationships, enabling development of culturally safe parent support with a focus on self-determination and empowerment to address some of

* Corresponding author.
E-mail address: A.Munns@curtin.edu.au (A. Munns).

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the existing inequities in Aboriginal maternal and child health and wellbeing.

1. Introduction

Community health nursing, underpinned by comprehensive primary healthcare, is embedded within wide ranging psychosocial contexts encompassing social and mental conditions affecting people's health and wellbeing. These contexts include individual and community responses to stressful life events, influencing our relationships with families and groups including community support agencies with whom we interact (Thompson, 2014). It is important to develop nurturing, trusting and supportive relationships that assist people to access their own internal resources as well as external supports (Thompson, 2014).

As such, models of care need to be reflexive, addressing changing social determinants of health, and expectations and diversity of families within communities. Meeting the universal health needs of families and communities, in addition to vulnerable and underserved populations, requires nursing leadership models to be culturally safe within contemporary environments (Clendon & Munns, 2019).

Nurse leaders are able to advocate for all nurses to use evidence-based care in Australian health environments, including community-based primary healthcare settings. This is of particular significance when considering complex factors within community political, economic and psychosocial contexts for client-centred and family-centred models of care (Clendon & Munns, 2019). Community health nurses' understanding of these factors underpins short- and long-term recommendations for policy, management and strategy improvements (Australian College of Nursing [ACN], 2015). It is recognised that all families and babies need the best possible support for their lifelong health outcomes, with Aboriginal support workers recognised as essential to delivery of specifically designed culturally safe care for all Aboriginal populations, including families with young children (Australian Government, 2013).

It is important to acknowledge the differences between cultural awareness, cultural sensitivity, and cultural safety, as these terms are frequently interchanged throughout health services and literature. Cultural awareness and cultural sensitivity are foundational for culturally safe practice. Cultural awareness is described by Ramsden (2002), as being the first step to understanding differences between healthcare relationships, particularly between Aboriginal clients and non-Aboriginal care givers. Cultural awareness establishes understanding of cultural issues, with no formalised practice strategies (Coffin, Drysdale, Hermeston, Sherwood, & Edwards, 2008, p. 143-144). Cultural sensitivity recognises and respects cultural differences, which encourages service providers reflecting on their life experiences and positioning how this may influence others with whom they live and work (Clendon & Munns, 2019; Ramsden, 2002).

Cultural safety is an ecological model requiring healthcare professionals to consider the socio-political reality and historical experiences of the patient/group with which one is dealing (Jiwani, 2000, as cited in Ramsden, 2002, p.171). They need to acknowledge the history of colonisation, as well as issues of racism, oppression, and unequal relations (Ramsden, 2002). Cultural safety entails engagement between health professionals, particularly nurses, and individuals who differ in any way from the professional, with the professional having responsibility to acknowledge their differences (Ramsden, 2002) in order to genuinely establish trust which is negotiated in the actions of giving and receiving nursing care (Ramsden, 2002. p. 179). Culturally safe care is identified as safe by those who receive the service (Best, 2018; Ramsden, 2002).

There are many challenges impacting on the means to support equitable health across a range of population groups, such as program sustainability, clients' access to resources and political influences (Clendon & Munns, 2019). Increasing attention has been focused on how nurse leaders can plan and coordinate health activities for all nurses that are able to effectively respond to health disparities for Aboriginal populations across Australia (Fleming, Parker, & Correa-Velez, 2019), with impacts of cultural safety being considered as important as clinical safety (Reibel & Walker, 2010). Cultural safety relates to professionals acknowledging the role of power and powerlessness. Understanding the politics of marginalisation and recognising and acknowledging difference by gender, sexuality, social or economic status, disability or ethnicity are necessary requisites to recognise and address the power relationships which cultural safety seeks to identify and address (Ramsden, 2002, p.175).

When working with Aboriginal or other marginalised subpopulation groups, it is recognised that nurses from all ethnic populations are influenced by their own cultural life experiences. Consequently, they need to engage in self-reflection within their own values and beliefs which impact their ability to develop culturally safe policies and practices (Best, 2018; Ramsden, 2002). This paper will examine and critique a community-based nursing leadership model that is able to guide nursing practice, which has been developed in partnership with Aboriginal peer support workers supporting their local communities.

2. Background

The importance of support for parents with children in the early years has been well established (Clendon & Munns, 2019; Munns et al., 2016, 2017). Strengths in many Aboriginal family environments are well recognised in relation to family life and raising children. Culturally strong upbringings encouraging a sense of cultural identity, kinship, and community relationships can be a source of lifelong social and emotional wellbeing (Wilkes, 2014; Zubrick et al., 2014). However, a range of social determinants of health impact on families' wellbeing and ability to maintain positive parenting environments which, in turn, impacts child development and ongoing health trajectories (Zubrick et al., 2014). This is of particular concern for families from urban, rural, and remote Aboriginal population groups experiencing vulnerabilities, including immediate and ongoing effects of social exclusion, racism, health system inequity, and intergenerational trauma (Clendon & Munns, 2019; Durey & Thompson, 2012).

It is recognised that initiatives for Aboriginal families and communities require strengths-based, interdisciplinary comprehensive primary healthcare approaches which is culturally safe, accessible healthcare using appropriate technology, and health promoting approaches guided by community involvement (Clendon & Munns, 2019). Embedded within these approaches is the need to acknowledge the profound impacts of colonisation, including intergenerational health inequality, disruptions to cultural strength, trauma, and social exclusion. Notably, since the beginning of colonisation, health and social wellbeing policy decisions have continued to be made by non-Aboriginal people and agencies without consultation or regard for Aboriginal people's circumstances, needs, and aspirations. This enduring colonial practice directly and adversely affects Aboriginal individuals, families and communities, and contributes to decreasing engagement between Aboriginal parents and community support services (Dudgeon, Milroy, & Walker, 2014; Fleming et al., 2019). From about 1900, basic health services for Aboriginal communities were slowly established, however formally recognised health programs and supporting policies were not evident until considerably later into the century. There has been increasing dissatisfaction with lack of co-design of health services for Aboriginal Australians, with little culturally safe practices and strategies apparent (Lovett, 2018). Of prime importance for

community-based nurse leaders is assessment of individual, family and community needs, and working in partnership to negotiate accessible and acceptable ways forward (Clendon & Munns, 2019). Aboriginal Australian people have a diverse strengths-based range of subcultures and worldviews (Clendon & Munns, 2019). However, varying psychosocial influences impact on providers' abilities to maintain health and wellness (Clendon & Munns, 2019). Models of care need to be based on holistic understandings of social and emotional wellbeing, which include connection to country, culture, spirituality, ancestry, family, and community, underpinned by decolonising approaches to social determinants (Gee et al., 2014; Dudgeon & Walker, 2015), in addition to nurses' reflections on their own perceptions of cultures other than their own (Best, 2018; Ramsden, 2002). As agents of change, all nurses, including nurse leaders who are guiding the profession, need to be critically aware of impacts of colonisation and facilitate flexible and contextualised strategies, taking positive steps to ensure optimal opportunities for Aboriginal health and wellbeing through embedding cultural safety within models of care. This acknowledges strengths and resilience of families and communities, with the potential for these important elements to be incorporated into wider health systems (Biles & Biles, 2020).

It is recognised that improved health outcomes are not achieved by cultural awareness alone, with Aboriginal communities' wishes for healthcare needing to be respected and actively incorporated into appropriately designed models of care, enabling culturally safe processes to be applied across all phases of healthcare (Coffin et al., 2008; Westwood, 2005). In healthcare environments, cultural safety is acknowledged as delivering safe nursing care to all people who differ in any way from the nurse, such as through culture, class or sexuality. With the focus being on the nurse's ability to recognise difference and be accountable to develop trusting care, the clients are then able to recognise if the service is safe to use (Ramsden, 2002, pp. 5-6). For Aboriginal people, families and communities who are recipients of care, this mandates health practitioners in acute and community health settings to demonstrate critical reflection of their knowledge, skills, and attitudes towards clients, as well as acknowledging their power and privilege within relationships, thereby enhancing a culturally safe primary healthcare approach (Walker, Schultz, Sonn, & Milroy, 2014). Leadership is needed to develop models of care that can guide all nurses in acknowledging colonisation, systemic racism, and social determinants of health; recognising influences of personal racism and power differentials between Aboriginal clients and non-Aboriginal professionals; recognising the importance of partnership approaches to care; supporting collaboration with individuals and families to ensure appropriate and acceptable care pathways; and promoting safe working environments to support justice for Aboriginal peoples (AHPRA, 2020).

Holistic Aboriginal constructs of social and emotional wellbeing need to be integrated into culturally safe models of care through co-design with Aboriginal communities (Walker et al., 2014). It is important for nurse leaders to be cognisant of historical and contemporary complexities of health and wellbeing from the perspectives of Aboriginal peoples, understanding both strengths-based approaches and challenges in accessing appropriate care (Austin & Arabena, 2020; Walker et al., 2014). Strategies to address health and social disparities are best informed by members of communities with the lived experiences of these inequities (Durey & Thompson, 2012).

Empowerment of families is vital to enable them to voice their preferences for decision making on issues impacting on their lives (Milroy, Dudgeon, & Walker, 2014). Participatory action research (PAR) has been identified as an engaging and decolonising approach to include families and health workers from vulnerable communities to work with researchers to identify impacting issues and realistic outcomes (Dudgeon, Bray, Darlaston-Jones, & Walker, 2020; Garcia et al., 2020). Recent research involving a community health nurse leader, in partnership with an Aboriginal leader and peer support workers, investigated co-design of a community-based parent support program for Aboriginal parents with children in the early years, using PAR. The Community Mothers Program (CMP) provided a framework for this partnership approach, with results demonstrating the development of a culturally safe model of care (Munns, 2017).

2.1. The Community Mothers Program

The CMP has been a critically acclaimed community child health nurse-led parent support program in Western Australia (WA) for Aboriginal and non-Aboriginal families across urban, rural and remote regions since 1995. This is a peer-led parent support strategy where parents are offered support for their child rearing challenges through home visits by experienced volunteer parents. The peer support encourages parent empowerment, thereby helping parents to positively manage the development and wellbeing of their children (Munns, 2017; Miller & Hughes, 1999; Walker, 2010). Community health nurse leaders can work in partnership with Aboriginal community leaders, peer support workers, families, their local communities and practising nurses to develop and implement culturally safe models of practice, thereby exploring culturally safe strategies for complex social and family support issues (Munns & Walker, 2015). Non-professional home visiting is undertaken for an hour each month by peer support workers where the aim is to work collaboratively with parents to develop culturally safe psychosocial support for their parenting role (Munns et al., 2016, 2017).

3. Research aim and objectives

In partnership with a WA community parent support agency, the overall aims of this study were to investigate the suitability, feasibility and acceptability of parent support and inform a model for an ongoing peer-led, home visiting program for Aboriginal families and children. More specifically, a prime objective was to implement and evaluate the Aboriginal peer-led home visiting child health parent support program, identifying and examining elements required to deliver a culturally safe approach, through the use of PAR (Munns, 2017).

4. Methods

4.1. Research design

Prior to development of the research, a leading community parent support agency approached a non-Aboriginal community child health practitioner and researcher to design and lead an evidence-based approach for peer-led parent support for Aboriginal families with young children in an outer metropolitan area of Perth, WA. In partnership with the agency's Aboriginal coordinator, a decision was made to use PAR as a culturally appropriate research design to develop a program acceptable to the needs of the local Aboriginal community and peer support workers (Munns et al., 2016).

PAR is important for advancing development of community-based programs as it facilitates involvement of researchers, client individuals and families, along with their local communities and stakeholder agencies, with a critical focus on enhancing clients' self-identified capacity to improve their own situations (Dudgeon et al., 2020). Those most impacted by the issues become active participants in the research process where collective planning and reflection facilitate acceptable strategies, early intervention and greater community support connections (Crane &

O'Regan, 2010; Dudgeon, Scrine, Cox, & Walker, 2017). This co-design process enabled participants in this community to describe the impacts of sociocultural, economic, and cultural life experiences on their everyday lives, highlighting the need for trauma-informed and decolonising approaches to care for Aboriginal families with young children (Fleming et al., 2019; Munns, 2017; Wyndow, Walker, & Reibel, 2018). Partnership and co-design features within PAR encouraged respect and equality for all participants in the research team (Crane & O'Regan, 2010; Munns et al., 2017), facilitating authentic knowledge acquisition and interpretation, while supporting an Aboriginal concept of social and emotional wellbeing. Of importance, were group decisions on how these understandings could be resourced and implemented for a home visiting peer led parent support service (Dudgeon et al., 2017; Munns, 2017).

Within PAR, Action Learning Sets (ALSs) enabled the Aboriginal peer support workers, coordinator and participants to meet with the community health nurse researcher on a regular four to 6 weekly basis to review program progress and collaboratively decide on ongoing strategies. The participants were also supported by an experienced non-Aboriginal support officer for 10 weeks. ALSs enable participants to work regularly in small groups to explore their real-life issues. These were also scheduled for parents and family support agency workers from the local community every 3 months to discuss the suitability, acceptability, and impact of the program (McKee & Markless, 2017; Munns et al., 2016, 2017). The regular meetings facilitated and advanced co-design and respectful partnerships between all participants. For the peer support workers and coordinator, strengths, and challenges of home visiting in the previous month were reviewed, along with adapted strategies and resources to support the next round of client support. In addition to these reflections on practice, the researcher offered short education sessions on relevant topics identified by peer support workers, such as breastfeeding and safe sleeping strategies (Munns, 2017).

4.2. Participants

Four Aboriginal peer support workers and the Aboriginal coordinator from the community parent support agency, one non-Aboriginal parent support worker (for 10 weeks), five community agency staff and two Aboriginal mothers participated with the nurse researcher for ongoing program feedback. Interviews with a further number of parents was not possible due to family mobility and social issues (Zubrick et al., 2014), however, these parents engaged regularly with peer support workers during home visits who were then able to indirectly contribute parents' feedback during the support workers' own reflective practice ALSs (Munns et al., 2017).

4.3. Instruments

Qualitative data were collected through focus group and individual interviews using unstructured and semistructured interview questions. Questions were designed for reflection on the cultural safety, strengths, challenges, suitability, and progress of the program (Munns et al., 2016).

4.4. Procedures

Ethics approvals were received from the Western Australian Aboriginal Health Ethics Committee (HREC Reference number 462) and Curtin University Human Research Ethics Committee (HR73/2013). Participants were recruited through flyers placed in a range of community agencies and word of mouth from workers in the hosting healthcare agency. Information and informed consent sheets were provided to all participants prior to their signed approval, highlighting privacy and autonomy for participants.

Peer support worker focus group interviews were conducted as part of each of the 10 ALSs, with individual parent and community agency worker interviews undertaken every 3 months. Focus group questions were derived from the PAR cycles of planning, acting, reflecting, experiential learning, and ongoing program plans (Hegney & Francis, 2015: Munns et al., 2016). Using focus groups facilitated peer support worker engagement with each other to explore their understanding of home visiting parent support and their frames of meaning (Green, 2013).

Data were recorded digitally by the researcher, with manual notes taken if participants declined use of the recorder. Confidential data transcriptions were undertaken, with no identifying information linked to participants who were reassured that they could withdraw from the research at any time without prejudice. Ongoing thematic analysis identified themes from each ALS (Braun & Clark, 2006), which were verified by a second research academic, and presented to participants at their following ALS for verification, discussion and action for future home visiting strategies (Munns, 2017). Facilitation by the community health nurse enabled a safe space for participants to discuss issues and ways forward.

5. Results

PAR, guided by the AHPRA cultural security framework and themes (AHPRA, 2020), supported both data collection and analysis. The framework's enabling factors guiding culturally safe and respectful practice were acknowledged in all data collections through ALSs and during data analysis (AHPRA, 2020, p.9). Results highlighted attributes for acceptable models of care for Aboriginal families with young children. Four themes are discussed below.

5.1. Acknowledgement of colonisation, racism, and social determinants of health

This theme promoted the most discussion in each ALS. Participants noted a range of issues that had become normalised into their everyday lives as well as the difficulties they experienced in knowing how these issues could be addressed.

Most of the clients, they're either homeless you know and they're struggling, they're battlers, they don't have work so they don't know where the next feed is coming from. Or like family issues like family, the violence. (Peer support worker 1)

They also were cognisant of colonisation policies and practices affecting the security of families historically (through forced removal of families) and in contemporary times (through child protection), impacting on how support services were viewed by parents. There was initial hesitation by parents to peer support worker roles.

I don't work for welfare. You know I'm working for our people here to help and support them not to take away children. No, far from it. (Peer support worker 1)

Several participants highlighted that non-Aboriginal people and agencies took a deficit approach when considering the situations of Aboriginal families.

But people only see what they want to see, they don't see everything. Like the struggles and all that they just see the bad stuff. They don't see what you're doing you know that you are doing your best. (Peer support worker 2)

Institutional policies developed and implemented through Government and non-government agencies were recognised as not providing holistic, culturally safe approaches for family support which impacted participants' access to support and contributed to their sense of marginalisation. For example, concentrating public

transport systems to higher population density in inner city areas, denies timely, accessible, and affordable transport for families in outer suburban centres. In turn, this impacts on food security with families' abilities to access emergency food supplies being hindered.

The buses, no buses. Twice a day only. (Peer support worker 3)

Only one day [for assistance] for some agencies. For example, you have to be on the doorstep at 7.30 in the morning for bread and eggs. If you're a single mum, five kids, can't get there on time. (Peer support worker 2)

Government welfare policies are causing difficulties for collaborating agencies. (Agency 1)

However, it was recognised that the family support agency engaging with the nurse researcher was working towards addressing a culturally safe service that understood the impact that colonisation, racism, and social determinants of health had on families.

This [parent support] organisation is committed to a culturally appropriate service. (Agency 2)

Colonisation was not specifically addressed by participants. However, evidence links colonisation as a complex social determinant of health with intra- and intergenerational physical and psychosocial effects (Griffiths, Coleman, Lee, & Madden, 2016; Zubrick et al., 2014), which were regularly discussed by participants.

5.2. Recognition of influences of personal racism and power differentials

The adverse effects of unequal power relations and discriminatory behaviours were noted in families' everyday interactions with their community.

One of our clients when we got involved she was having no civilised conversation with the school. She was having with no one, no good communication any way with her kids' school and because the school took action against her regarding the kids yeah it wasn't good. (Peer support worker 2)

They [Peer support workers] understand pressure on clients from the welfare department. (Agency 2)

The peer support workers' understanding of these situations reported in the regular ALS interviews, enabled the nurse and peer support workers to develop strategies to guide parents in addressing these situations, with improved outcomes. As two peer support workers observed in subsequent interviews,

But since she was involved with us, she now started making contact with the school. (Peer support worker 4)

She's got better engagement with the school and better engagement with the child health nurse. The kids are immunised. (Peer support worker 3)

5.3. Recognising importance of partnership approaches to care

During ALS meetings, promotion of partnership approaches to care by the nurse facilitated peer support workers to develop empowering strategies with families. A fundamental aspect of working in partnership is recognising strengths-based approaches to care.

Not doing it for them, but helping them in their decision making. (Peer support worker 1)

We're looking at reinforcing parenting practices, looking at the good stuff. (Peer support worker 3)

Then look at her strengths, what is going well for her, what's OK. Get them talking and seeing opportunities for discussion. Getting their ideas on things. (Peer support worker 2)

5.4. Collaboration with individuals and families to ensure appropriate and acceptable care

The facilitation of partnership approaches by the nurse, led to models of care based on collaboration with families to develop culturally safe support strategies.

To be able to put some strategies in place and help and what I do like about the programs is that parents can choose whether they have an Aboriginal worker or a non-Aboriginal worker. (Non-Aboriginal support worker 1)

And you can actually just sit and listen and watch, observe and then come up with some strategies and ideas to help that person in place which I think is very, very important especially if we're working with Aboriginal parents because they're very diverse, their needs are different. (Peer support worker 4)

It was noted by the families that appropriate and acceptable care needs to feature one-on-one communication with another mother. The lived experience of peer support workers was an essential feature underpinning models of care for parent support.

The visits, like good. They support me. I've got no family here. They make me feel more of a mum. (Mother 1)

Just her coming over. I don't have many friends. (Mother 2)

Having them both here to talk to. I feel comfortable talking to them about certain problems. (Mother 1)

However, throughout the ALSs, to avoid raising then seeming to fail to meet unrealistic expectations, peer support workers highlighted the need for families to understand that support strategies needed time to develop, as there were many complex issues to address.

5.5. Promotion of safe working environments

The nurse and all participants recognised the importance of creating physical, psychosocial, and culturally safe working environments for peer-led support. Safety was an essential feature within ALSs, where all participants could have their ideas credibly recognised within an emotionally safe setting. The nurse employed confidence building strategies within each ALS for the peer support workers, recognising their strengths and giving positive feedback for their work with parents, which contributed to their increased confidence in the value of their roles in improving the lives of families.

We're here for our Aboriginal families. We mean business. (Peer support worker 2)

It's a massive step for [this area] to have Aboriginal Peer Support Workers. Our roles bring whole new impact on Aboriginal families. (Peer support worker 1)

The need for collaboration between team members to establish and maintain a safe working environment within a model of care was highlighted, along with the need to work together to practise self-care to avoid fatigue.

…the burn out rate would be too huge to try and meet everyone's needs. (Agency 3)

Additionally, underpinning all home visits was a safe home visiting policy that was developed collaboratively between the nurse and peer support workers. This strategy included screening of family environments by the parent support agency's Aboriginal coordinator, and peer support worker communication with the coordinator before and after visiting which reduced physical risk and facilitated safe home visiting practices.

6. Discussion

There is a need for community-based initiatives to support Aboriginal families with young children that are informed by Aboriginal people. PAR is an enabling and empowering research method

through which child health nurses can engage with Aboriginal parents, peers, and community agencies to meet regularly in ALS to collectively identify and discuss development of culturally safe and sustainable approaches (Munns, 2017; Munns et al., 2017). Nurse leaders within this strengths-based partnership approach facilitate a continual critical review and refinement of strategies contributing to a place-based model of care that is able to guide culturally safe community health nursing practice.

Use of the CMP can incorporate the principles needed for culturally safe, trauma-informed models of care for Aboriginal parents in the community (AHPRA, 2020). Systemic racism and social determinants of health were discussed within ALSs highlighting prejudicial attitudes and discrimination which peer support workers were keen to empower parents to address. Colonisation was not explicitly raised by participants. However, it is recognised that this history has contributed to intergenerational debilitating social determinants of health whereby a myriad of social, cultural, and political interactions pose potential health challenges, many of which were raised during focus groups and interviews (Clendon & Munns, 2019; Dudgeon et al., 2014; Fleming et al., 2019) and need to be acknowledged as a core guiding principle in strengthening Aboriginal social and emotional wellbeing (Dudgeon et al., 2014). It is acknowledged that nurses, as care providers, need to be cognisant of colonisation and the impacts on Aboriginal clients, with an understanding that the intergenerational impacts of colonisation will influence individuals and families, regardless of whether these are explicitly expressed (Best, 2018). Recognition by nurses of the influences of personal racism and power differentials between Aboriginal and non-Aboriginal health professionals and agencies is another of the guiding principles that was highlighted, thereby underpinning culturally safe practices. In partnership, the nurse was able to guide peer support workers in empowering parents to more confidently engage with Aboriginal and non-Aboriginal stakeholders in their communities and to gain confidence in their parenting roles.

During ALSs, the peer support workers and agency staff expressed difficulties in knowing how to address social determinants of health. However, it was recognised that partnership approaches between peer support workers and families assisted in developing appropriate and acceptable pathways for parents which in turn, centred on acknowledging and where practical, addressing these contemporary and historical factors (Clendon & Munns, 2019). The nurse leader considered facilitation of partnership skills as being fundamental to peer support workers' confidence in family engagement. Throughout the ALS cycles, these collaborations with families demonstrated emerging culturally safe support pathways that encouraged parental confidence. Parent support needs were respected and actively incorporated into the emerging model of care (Austin & Arabena, 2020; Coffin et al., 2008; Westwood, 2005). Maintaining safe physical and psychosocial work contexts for peer support workers was encouraged through both safe home-visiting practices and facilitating respectful collaborative environments during ALS discussions (Crane & O'Regan, 2010; Munns, 2017; Munns et al., 2017).

Nurse leadership throughout PAR encouraged co-design of culturally safe support strategies for Aboriginal parents with young children. Constant challenges to these approaches through ongoing legacies of colonisation impacting social determinants of health which reflect understandings of health and varying family issues, indicate the need for regular ALSs to maintain up to date resourcing and strategies to help address diverse and complex issues. These ongoing ALSs have potential to be managed by a community health nurse or leaders from within the peer support worker group. In addition, meaningful elements of a culturally safe program design have the potential to be transferrable across a range of urban, rural, and remote Aboriginal communities.

7. Limitations

It has been recognised that interviews with more than two parents were impeded by family factors (Zubrick et al., 2014). However, peer support worker feedback during ALSs was able to inform parents' perspectives and contribute to the emerging model of care (Munns et al., 2017).

Although the overall sample size was small, the continuous and in-depth nature of the interviews enabled the researcher to obtain rich data from both workers and mothers that gave credibility to the findings and the need to ensure culturally safe service delivery. The focus groups allowed workers to confirm each other's experiences in a safe environment.

The impact of government policies and practices (i.e., removal of children) and social determinants on health and wellbeing has been recognised. It is important to acknowledge and explore these issues in future studies to provide a more nuanced and deeper understanding of the issues experienced by parents and to enhance practitioner practice.

While initially it may seem that cultural differences between Aboriginal communities may limit the transferability of this study's findings to other population groups, it is the application of the program's principles and processes that take account of the specific needs and aspirations of the groups involved that enable the essential elements of the program to meet specific local/place-based issues in a diverse range of settings. Findings from relevant literature affirm the suitability, feasibility, and acceptability and importance of a culturally safe model for a peer-led support program for Aboriginal families.

8. Conclusion

Aboriginal people are the most vulnerable group in Australia on all indicators of health and wellbeing. Their health inequities begin inutero and continue across the life course. It is imperative that the specific needs and social determinants impacting First Nations wellbeing are addressed. The CMP has provided a range of principles, processes, and strategies to empower families to support their children despite social determinants including the legacies of colonisation, transgenerational trauma, racism, economic disadvantage, and social marginalisation.

PAR is an important, enabling and empowering methodology for development of community-based programs in partnership with researchers, peer support workers, families, and stakeholder agencies. Nursing leadership during the ALS cycles enhanced positive and trusting relationships between all participants in the CMP. Critical reflections on culturally safe strategies enabled development of peer-led parent support for Aboriginal families, with the focus on self-determination, empowerment, and equity.

The acceptability of the strategies has contributed to an emerging culturally safe model of care in a community setting. It is recommended that additional research is undertaken to investigate how community health nurses can further lead these empowering approaches for parent support across a range of geographical and diverse population groups, with health economic analysis that is able to inform ongoing policy and practice development.

Author contribution

AM researched and identified the original manuscript idea. AM wrote the first draft with RW and AM contributing equally to revisions and finalising the document.

Ethical statement

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

1. The Western Australian Aboriginal Health Ethics Committee. Approval number HREC 462. Granted 12th February 2013.

2. Curtin University Human Research Ethics Committee Approval number HR73/2013. Granted 11th June 2013.

Conflict of interest

None.

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