

Stage 1 Evaluation of the Australian Nurse Family
Partnership Program

Final Report

Department of Health and Ageing

30 June 2012

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Department of Health and Ageing

30 June 2012

Stage 1 Evaluation of the Australian Nurse Family Partnership Program - final report amendments following stakeholder feedback.

Dear Dr Dullow

Attached please find the Final Report of the Stage 1 Evaluation of the ANFPP, incorporating stakeholder feedback requested and received in April and May 2012. The evaluation considered the establishment and early implementation processes for the program in line with the ANFPP Evaluation Framework and this version of the final report includes responses to stakeholder feedback to the evaluation report findings.

I would like to take this opportunity to acknowledge the contributions made by your officers, the staff and families at the ANFPP sites and the ANFPP Support Service in providing information to assist the evaluation. I particularly appreciate the opportunity to take the findings back to the ANFPP sites and seek their feedback.

Should you have any questions regarding this report, please contact me on 03 8650 7509.

Yours sincerely

A handwritten signature in black ink, appearing to read 'B. Fielding', written over a light blue circular stamp.

Ben Fielding
Engagement Partner

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Abbreviations

The following abbreviations are used in this document.

ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute for Health and Welfare
ANFPP	Australian Nurse Family Partnership Program
ANFPPSS	Australian Nurse Family Partnership Program Support Service
CEO	Chief Executive Officer
EQHS	Establishing Quality Health Standards
FNP	Family Nurse Partnership (UK)
FPW	Family Partnership Worker
FTE	Full Time Equivalent
GST	Goods and Services Tax
NCAST	Nursing Child Assessment Satellite Training
NFP	Nurse Family Partnership (USA)
NHS	National Health Service (UK)
NHV	Nurse Home Visitor
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PDSA	Plan - Do - Study - Act (Quality cycle)
PIPE	Partners in Parenting Education
RCT	Randomised Control Trial
TAFE	Technical and Further Education (College of)

Our report may be relied upon by the Commonwealth Department of Health and Ageing for the purpose of informing the evaluation of the Australian Nurse Family Partnership Program only pursuant to the terms of our engagement letter dated 16th August 2010. We disclaim all responsibility to any other party for any loss or liability that the other party may suffer or incur arising from or relating to or in any way connected with the contents of our report, the provision of our report to the other party or the reliance on our report by the other party. Liability limited by a scheme approved under Professional Standards Legislation.

1. Executive Summary

This is the report of the Stage 1 Formative Evaluation of the Australian Nurse Family Partnership Program (ANFPP). The evaluation team would like to acknowledge the contributions of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) officers and senior staff, the ANFPP Support Service (ANFPPSS), and the Executive and ANFPP teams at the implementing sites in providing quantitative and qualitative information for the evaluation. The team would also like to thank the mothers and their families, who so generously shared their stories and their babies during site visits.

1.1 Background to report

The ANFPP is an authorised adaptation, under licence, of the Nurse Family Partnership (NFP) program. The NFP is one of the few home visiting programs with an evidence base that includes gold standard research studies (RCTs) and proven long term benefits in the populations studied. Following investigation of available evidence-based options, OATSIH implemented the ANFPP in selected Indigenous communities across Australia. The program was established in 4 sites and was planned for establishment (but not implemented) in a fifth. The implementation sites are listed below.

- ▶ Central Australian Aboriginal Congress (Alice Springs, NT)
- ▶ Wuchopperen Health Service (Cairns, Qld)
- ▶ Victorian Aboriginal Health Service (Melbourne, Victoria)
- ▶ Wellington Aboriginal Corporation Health Service (Wellington, NSW)

The Aboriginal and Torres Strait Islander Community Health Service Brisbane withdrew from the program prior to commencing client visits.

The implementation of the program in Australian Indigenous communities was the first licensed application of the NFP in this context and as such has generated a high level of interest. It was also a new approach to program funding by OATSIH in that it required a highly directive approach in order to achieve the required process and content consistency required by the program licence.

OATSIH commissioned Ernst & Young to:

- ▶ develop a comprehensive program evaluation framework that could be used to evaluate the ANFPP;
- ▶ use that evaluation framework to conduct a formative evaluation of the first stage of the implementation of the ANFPP; and if required; and
- ▶ report and provide feedback to sites about the results of the formative evaluation.

The objectives of conducting the formative evaluation of the ANFPP were to determine:

- ▶ the extent to which the ANFPP is an appropriate and effective program that supports the long term health outcomes of Aboriginal and Torres Strait Islander mothers and their babies; and
- ▶ if the ANFPP is suitable for broader implementation in Australia.

The Evaluation Framework has been completed and is contained in a separate document. This report contains the results of the Stage 1 Formative Evaluation.

1.2 Stage 1 Formative Evaluation approach

The methodology for the Stage 1 Formative Evaluation was based on the ANFPP Evaluation Framework and sought to answer those evaluation questions from the framework that could be addressed at this point in the life of the program. In the main these were questions related to process rather than outcomes, although some early indications of outcomes were identified from qualitative and limited quantitative data. In order to inform the findings and recommendations in this report, the evaluation team undertook the following activities:

- ▶ semi-structured interviews with key stakeholders including OATSIH staff, members of the Program Reference Group, ANFPPSS and Leadership Group, ACCHOs, mothers/families and other local stakeholders;
- ▶ review of Fidelity Reports and aggregated data; and
- ▶ consideration of recent literature relevant to, or regarding, the NFP in the US and UK.

These activities were undertaken over the period May 2011 - September 2011.

1.3 Summary of key findings and recommendations

The ANFPP is an evidence based program that came to Australia with a reasonable expectation of achieving desired outcomes if program fidelity was maintained. This expectation was based on the results of multiple research studies. The number of sites in which ANFPP was implemented was less than originally predicted and this drove up the cost of the program on a per client basis. Issues of organisational capacity and capability would need to be addressed if the program were to be rolled out more widely. Achieving economies of scale may require a revision of the eligible population and/or changes to the service delivery model to enable implementation in smaller Indigenous communities.

As with any new program and particularly one that is highly prescribed, there has been a long lead in time and significant effort to reach the point where in the first wave sites, the first babies are reaching 24 months and graduating. Nevertheless 3 of the 4 sites taking part in the evaluation believed they were seeing significant benefits from the program.

Data collected by the sites that would assist in measuring outcomes was not yet available for evaluation purposes and the issue of access to data for the purposes of measuring and monitoring program performance will need to be addressed in the future as a matter of priority. The long establishment period and consequent deficit in reliable data describing the entire span of program delivery, suggests more time is required to fully assess the program's appropriateness and effectiveness. It is important not to lose sight of the original intent of the program, which was to use a tested, evidence-based model to address the long term health outcomes for Indigenous babies and their mothers. The table on the following pages summarises the key findings and associated recommendations. More information can be found in the Findings and Discussion chapters of this report.

It must be noted that this was a formative evaluation, using mainly qualitative data and limited quantitative data, which considered the establishment and early implementation of the ANFPP. Fidelity to all elements of the program was not completely achieved at the time of the evaluation. Observations made regarding the early outcomes of the program should be read in this context and in the context of higher nurse home visitor to mother ratios than in the NFP model as it has been implemented in other environments.

Table 1: Summary Key Findings and Recommendations

Key Findings	Recommendations
<p>Finding 1: The decision to trial the NFP for adaptation in the Australian Indigenous context was taken following consideration of sound evidence and expert advice. The program has not been in place long enough for a determination to be made as to its effectiveness. There were indications (based on qualitative information and observation) that the ANFPP was suitable and acceptable to the communities in which it was implemented and was achieving some early objectives in sites.</p>	<p>Recommendation 1: The program should continue in the sites where it has been implemented, with consideration given to any changes associated with Recommendations 2 & 3. Data monitoring should continue to track outcomes and impact in line with program objectives.</p>
<p>Finding 2: Due to the cessation prior to commencement in one metropolitan site, and the recent wind down of the program in the other, the ANFPP had not been adequately tested in a metropolitan setting.</p>	<p>Recommendation 2: Consideration should be given to testing implementation of ANFPP again in a metropolitan site, with careful consideration given to delivery model and location in relation to the target population;</p>
<p>Finding 3: Two significant limiting factors for selection of sites for the ANFPP pilot were the number of Indigenous babies born within a region (100 or more) and organisational capacity and capability to implement the program. These factors would also limit the number of future sites that could be considered for ANFPP unless they were ameliorated in some fashion. Wider implementation of the program may require revision of site selection criteria, inclusion of a wider population base for eligible mothers, an expansion or change in the delivery model, and/or the addition of intensive capability and capacity building in otherwise suitable sites.</p>	<p>Recommendation 3: Consideration should be given to increasing critical mass using accessible and equitable solutions, such as testing alternative models of delivery that might allow access to ANFPP in smaller communities, e.g. increased outreach or hub and spoke models and/or expanding ANFPP scope to include mothers of non-Indigenous babies in communities with high levels of socioeconomic disadvantage and a critical mass of eligible births per annum. This would require consideration of the following matters:</p> <ul style="list-style-type: none"> ▶ maintaining fidelity to the critical elements of the model ▶ ensuring Indigenous services and communities continue to participate and are not disadvantaged by a broader rollout; ▶ flexibility in selecting the most appropriate organisation/s to manage ANFPP within each community; ▶ the Family Partnership Worker role in communities where both Indigenous and non-Indigenous babies and their mothers are receiving the service ▶ considering funding sources and roles and responsibilities of Commonwealth, State and Territory Governments in an expanded program; and ▶ understanding the licencing costs and requirements of an expanded program.
<p>Finding 4: Under the delivery model at the time and number of sites implementing, there was significant spare capacity within existing resources. The required staffing structure and fidelity requirements incur an irreducible base cost, so a more effective way of increasing efficiency, if future rollouts were</p>	<p>Recommendation 4: Consideration should be given to expanding the program to achieve improved use of existing capacity (refer Recommendations 1, 2 & 3)</p>

Key Findings	Recommendations
to occur, would be to increase the number of clients receiving the program.	
<p>Finding 5: The Support Service holds the expert knowledge about the ANFPP in Australia. The support function provided by the Support Service was critical in assisting sites to establish and implement the ANFPP and would continue to be critical in any future rollout, however unless the program is established in additional sites or support and maintenance activities are significantly curtailed, the ongoing cost if allocated on a per site basis is high.</p>	<p>Recommendation 5: The program support function should be maintained as it is essential to establishing and maintaining program integrity and fidelity. However action should be taken to reduce the per site cost of support. This could involve a combination of determining essential and non-essential support elements, increasing the number of sites being supported and/or reviewing the means by which support is provided.</p>
<p>Finding 6: The adaptation and development of curriculum and other materials by the Support Service was an essential foundation for the program and required an upfront investment which should be increasingly realised as ANFPP is rolled out.</p>	<p>Recommendation 6: Consideration of further implementation of the ANFPP should take into account the up-front investment to develop and adapt program materials, and the potential for an incremental realisation of this investment if the program is expanded to more sites.</p>
<p>Finding 7: It is doubtful the ANFPP would have been acceptable to ACCHOs and their constituents without the Australian adaptations. These required additional effort by all stakeholders, much of which occurred after ANFPP commenced, and this increased the complexity of the roll out and time needed to establish the program.</p>	<p>Recommendation 7: Considerations of the future of the program should take into account the extended period required to establish and implement ANFPP, particularly with its uniquely Australian adaptations.</p>
<p>Finding 8: The Family Partnership Worker role enhanced access to the program for mothers and families. The role did not appear to negatively impact on the development of a strong relationship with the Nurse Home Visitor, which is an essential component of the program. However, a lack of early clarity and structured planning for the Family Partnership Worker role within the program led to varying interpretations of the role which required subsequent corrections to maintain fidelity. This then contributed, in at least one site, to a sense that the Family Partnership Workers were not viewed as partners with complementary roles who shared the delivery of the program. This view then impacted on how the program was interpreted and implemented.”</p>	<p>Recommendation 8: Work on defining and validating the role of the Family Partnership Worker should continue to ensure the role is built into the program in an integrated and clearly defined way that still allows for some local flexibility based on client needs and preferences. Program material should contain a clearly articulated recognition that Family Partnership Workers and Nurse Home Visitors share delivery of the program and their roles are different but equally valued. Action should be taken to address specific issues with the Family Partnership Worker role where these are impacting on the effectiveness of the program.</p>
<p>Finding 9: There were valid reasons for retaining the inclusion of multiparous mothers in the eligible population for the ANFPP.</p>	<p>Recommendation 9: The inclusion of multiparous mothers in the ANFPP eligible target group should be maintained as an adaptation and reviewed regularly.</p>
<p>Finding 10: There were situations where it was not possible or appropriate to provide visits in the home and, in response, ANFPP teams met with mothers in alternate venues. This variation was considered essential to continue visiting these mothers.</p>	<p>Recommendation 10: Ideally visits should occur in the home; however the use of alternate venues for home visitations should be allowed to continue, where it is justifiably based on the individual housing situation of mothers and babies.</p>

Key Findings	Recommendations
<p>Finding 11: Sites produced some excellent cultural resources, but there was no formalised process for sharing resources developed in one site with other sites. There was potential for duplication of effort in developing specific resources.</p>	<p>Recommendation 11: In order to maximise effectiveness and reduce duplication of effort, a formalised process for sharing resources across sites, which addresses issues such as intellectual property rights, should be established.</p>
<p>Finding 12: Where there was strong governance from Board level down to service delivery level and where the ANFPP was deliberately embedded into the existing site service system, program issues were identified and managed faster and more effectively. In some sites, understanding of the program at senior level and organisational governance structures established for the ANFPP were not sufficient to manage the additional demands of the program.</p>	<p>Recommendation 12: Future site selection should include an assessment, conducted with the site Executive, as to whether it has the required philosophy and governance capability to implement the program as prescribed. Discussion should include:</p> <ul style="list-style-type: none"> ▶ the core mandatory elements of the program; ▶ the importance of senior staff in governing and sponsoring the program; ▶ the expected roles of staff in the program; ▶ expectations for data collection, reporting and client consent; and ▶ expectations for training, reflective practice and external supervision of staff. <p>Program fit in sites and within the broader service system should be explicitly explored by the Board and senior staff as part of the planning process.</p> <p>Focused organisational development and support should be provided where sites understand and are committed to the program but need to develop additional governance capability.</p>
<p>Finding 13: Selecting the right staff was critical for effective program implementation and operation, with poor staff selection putting program implementation at significant risk. In addition to professional qualifications, staff also required personal qualities and experience suitable to the role. There was a significant flow on effect where staff, especially Nurse Supervisors, did not have the necessary professional, experiences or personal qualities to undertake their roles in the program. Where sites did not fully understand the ANFPP and the staff requirements there was a risk they might miss critical requirements in selecting for a position.</p>	<p>Recommendation 13: Selection panels for ANFPP positions should include a panel member who has a full understanding of the ANFPP and the requirements of the position being recruited. In the early stages, this may require the involvement of a panel member external to the ACCHO.</p>
<p>Finding 14: There was a view held by some nurses and staff in some sites that ANFPP work was not nursing work because it did not require nurses to exercise traditional nursing or midwifery “clinical” skills. In some cases this led to a perception that the role could be undertaken by other workers and that the nurses were being underutilised by not delivering “clinical” care.</p>	<p>Recommendation 14: The role of the Nurse Home Visitor should be validated and badged as nursing care, acknowledging that there are specific skills taught to nurses in their training and reinforced in their practice that are considered essential in this model (as supported by evidence) and cannot be replicated by a non-nurse.</p>

Key Findings	Recommendations
<p>Finding 15: Staff had access to the training required to deliver ANFPP; however specific issues were consistently raised in consultation with sites, including a perceived need for more physical face to face networking, increased practical skills development and supervised opportunities to practice new skills in:</p> <ul style="list-style-type: none"> ▶ for Nurse Home Visitors and Family Partnership Workers, first home visit ▶ for Nurse Home Visitors, using NCAST and undertaking parent education using PIPE ▶ for Family Partnership Workers, those unique aspects of their role as described in the FPW Guide <p>Nurse Supervisors had key role in ensuring skills development was locally reinforced and that local learning continued, including skills development and supervised practice.</p>	<p>Recommendation 15: Further attention should be paid to ensuring ongoing practical training and practical supervision of skills development in those specific skills that could be considered “new” to Nurse Home Visitors, particularly those required for NCAST and PIPE and in those skills specific to Family Partnership Workers.</p>
<p>Finding 16: Sites identified deficits in the existing data collection, with some areas such as time for supervision by the Nurse Supervisor of Family Partnership Workers; and number of self-referrals into the program not being recorded. Self-referrals in particular are one indicator of community acceptance. Data that might inform program outcomes has not yet been made available for evaluation purposes</p>	<p>Recommendation 16: Attention should be given to including in the data collection those activities which, while not in the original suite of reporting requirements for the program, have been identified as measures of significance to sites. Barriers to using the current data collection for ongoing reporting and evaluation should be identified and addressed as soon as possible.</p>

2. The ANFPP

2.1 Why provide pregnancy and early childhood support?

Historically, Indigenous mothers and babies have had markedly different outcomes to non-Indigenous mothers and babies, particularly in the first years of life. The infant mortality rate for Indigenous children is almost 3 times that of non-Indigenous babies¹ with 83% of Indigenous deaths under the age of 5 occurring in the first year and almost half in the first month of the baby's life. The report "Australia's Mother and Babies, 2008" (released 2010 by the AIHW²) highlights the differences in outcomes for babies of Aboriginal and Torres Strait Islander mothers to those born to non-Indigenous mothers.

More Aboriginal and Torres Strait Islander babies are born preterm, with the associated risks to mortality and morbidity. The proportion of low birth weight in babies of Aboriginal and Torres Strait Islander mothers in 2008 was 12.3%, while the proportion for babies of non-Indigenous mothers was 5.9%. One of the key contributing factors to low birth weight babies is maternal smoking. Over half (50.9%) of Aboriginal and Torres Strait Islander mothers reported smoking during pregnancy. Aboriginal and Torres Strait Islander mothers also attended fewer antenatal visits than non-Indigenous mothers.

These statistics paint a picture of pregnancy and infancy outcomes for Aboriginal and Torres Strait Islander Australians that directly contribute to the life expectancy differences for Indigenous and non-Indigenous Australians. They create a driving need to establish and implement programs that can be reasonably expected achieve real and positive change.

2.2 NFP Evidence Base

There is a growing body of evidence that demonstrates the links between early experiences and the development of chronic disease, psychosocial problems and reduced educational outcomes. It is now well understood that early brain development affects the lifelong health and wellbeing of an individual and that early environmental experiences significantly shape the developing brain, with many environmental factors, including smoking, alcohol, maternal nutrition and illness and traumatic stress, even affecting the development of the unborn child³.

The NFP is an evidence based program that has been informed by neuroscience and grounded in three major theories of attachment, human ecology and self-efficacy⁴.

Bronfenbrenner's theory of human ecology emphasises the importance of parent's care behaviours in influencing their children's development and the role that families and communities play in influencing and supporting parental care. This guides the work of home visiting nurses in attempting to involve other family members and link mothers to community services.

¹ Australian Government, Closing the Gap on Indigenous Disadvantage: The Challenge for Australia. February 2009, Canberra. Accessed online at http://www.fahcsia.gov.au/sa/indigenous/pubs/general/Documents/closing_the_gap/default/htm,17/03/10

² Laws PJ, Li Z & Sullivan EA 2010. *Australia's mothers and babies 2008. Perinatal statistics series no. 24.* Cat. no. PER 50. Canberra: AIHW

³ Silburn SR, Nutton G, Arney F, Moss B, 2011. *The First 5 Years: Starting Early.* Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin: Northern Territory Government.

⁴ Olds, D., *The Nurse-Family Partnership: an evidence based preventive intervention*, Infant Mental Health Journal, 2006, Vol. 27(1), 5-25 published online in Wiley InterScience (www.interscience.wiley.com).DOI: 10.1002/imhj.20077

Bandura's theory of self-efficacy is based on the premise that individuals choose behaviours they believe will result in a given outcome and that they also believe they have the ability to carry out. This theory underpins the work of home visiting nurses in helping mothers to understand the influence of particular behaviours on their own health and that of their babies. It also underpins the strengths-based approach, where nurses help parents to establish achievable and believable goals and build successes, increasing their sense of self-efficacy.

Bowlby's theory of attachment is based on the hypothesis that the level of attachment babies form to a caring and responsive adult influences their trust in the world, and their ability to form healthy relationships and eventually care for their own children. A key component of the NFP, therefore, is the promotion of engaged and responsive parenting in the child's early years and the continual modelling of an empathic and trusting relationship between the home visitor and the mother and family. Modelling this relationship is intended to help mothers to develop trust in others and increase empathy with their own children.

2.3 NFP and ANFPP Goals

The ANFPP shares the same overarching long term goals as the NFP, which are to:

- ▶ improve pregnancy outcomes by helping women engage in good preventative health practices;
- ▶ improve child health and development by supporting parents; and
- ▶ improve parents' life course by helping parents to develop a vision for their own futures, including continuing education and finding work.

2.4 ANFPP Program outcomes

The ANFPP focuses on achieving outcomes in seven main areas, linked to the long term goals of the program. These are listed below.

- ▶ Maternal Health - mothers are aware of and demonstrate positive behaviours related to their health prenatally onwards
- ▶ Maternal Role - increased knowledge of childcare and improved ability to provide competent and sensitive childcare
- ▶ Life course development - increased knowledge of future options & confidence & ability to identify and achieve goals
- ▶ Supports - increased knowledge of services and supportive individuals and increased confidence in ability to access them
- ▶ Environmental Health - Increased awareness of the environment in which the child is being raised and increased confidence in the mothers ability to improve her environment & avoid dangerous situations
- ▶ Newborns - are born at 37 weeks gestation or more, weigh 2500g or more, are raised in a safe environment
- ▶ Infants & Toddlers - are healthy, display age appropriate development and behaviour, are raised in a safe environment

2.5 Defining features

The ANFPP is an evidence-based home visiting program for mothers and babies from pregnancy to 24 months after birth. The ANFPP team consists of:

- ▶ Nurse Supervisor, who manages the day to day operations of the service and provides supervision and support to up to 8 Nurse Home Visitors and Family Partnership Workers;
- ▶ Nurse Home Visitors, who undertake home visits with a case load of up to 25 mothers;
- ▶ Family Partnership Workers who provide the interface between the Indigenous community/families and the program and assist in recruitment, program promotion and ensuring cultural safety; and
- ▶ Administration Officer, who provides administrative support to the program.

The program aims to increase the competence and confidence of mothers in looking after themselves and their babies, including improving their own life course development. The program differs from many other home visiting programs in the:

- ▶ strength of its theoretical and evidence base;
- ▶ focus on prevention through individual capacity building;
- ▶ degree of emphasis on maternal life course as a component of the program;
- ▶ prescribed dosage and content of visits;
- ▶ length of time mothers and babies are in the program;
- ▶ prescribed staff qualifications and roles; and
- ▶ high level of control over program fidelity (through licencing and reporting).

A number of these defining features of the program have been tested through research studies and found to be critical to achieving the program outcomes^{5, 6, 7}.

2.6 Program activities

ANFPP is a relationships-based program, where the Nurse Home Visitor models a trustworthy, caring and attentive relationship with the mother, which the mother can then mirror with her baby. The Nurse Home Visitor provides the mother (and in some cases the father) with parenting information, demonstrates parenting activities and supports her to safely develop and practice her own mothering skills.

⁵ Paulsell, D., Avellar, S., Sama Martin, E., & Del Grosso, P. (2010). *Home Visiting Evidence of Effectiveness Review: Executive Summary*. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. accessed online at <http://homvee.acf.hhs.gov/>

⁶ Olds, D., *The Nurse-Family Partnership: an evidence based preventive intervention*, Infant Mental Health Journal, 2006, Vol. 27(1), 5-25 published online in Wiley InterScience (www.interscience.wiley.com)

⁷ Eckenrode, J., Campa, M., Luckey, D., Henderson, C., Cole, R., Kitzman, H., Anson, E., Sidoar-Arcoleo, K., Powers, J. Olds, D., *Long-term Effects of Prenatal and Infancy Nurse Home Visitation on the Life Course of Youths: 19-year Follow-up of a Randomized Trial*, Archives Paediatrics and Adolescent Medicine, 2010, Vol. 164 (1), 9-15

Of particular note in the program is the emphasis on life course development and the focus on helping mothers to take steps to realise their “heart’s desire”. This may involve looking at options for further education, seeking paid employment, finding stable housing or making decisions about the timing of future pregnancies.

Regular home visits are undertaken with mothers from enrolment into the program until graduation. The interval between visits varies from weekly to monthly, depending on the dosage required at particular points in the pregnancy and parenting journey.

There is a curriculum of set topics, based on the areas above, which are addressed by Nurse Home Visitors throughout the program, with flexibility built in to cater for differences in readiness for particular topics and adapt to client’s particular circumstances. Topics are designed to improve the knowledge and skills of mothers as mothers but also to build their own sense of mastery and increase their sense of themselves as confident and competent.

To this end the program does not offer clinical or midwifery care in the generally accepted sense. Nurses do not replace the antenatal or postnatal clinical care provided to mothers and babies by existing services. Instead mothers are assisted to develop the parenting knowledge and skills and confidence to link themselves and their babies into the broader health and psychosocial support system. They are empowered to take action to address their own particular health, social and environmental needs.

2.7 Program implementation

The ANFPP is funded by the Australian Government and administered through OATSIH. The program is licenced for Australian use (with specific adaptations) by the University of Colorado. National program planning was supported by a Program Reference Group, which included acknowledged experts in the field. Wave 1 sites began seeing mothers in 2009, following a period of structured planning and preparation. The Wave 2 site began seeing mothers in 2010.

OATSIH contracted a consortium under the umbrella of JTA International to provide support services to the sites implementing the program. These support services include:

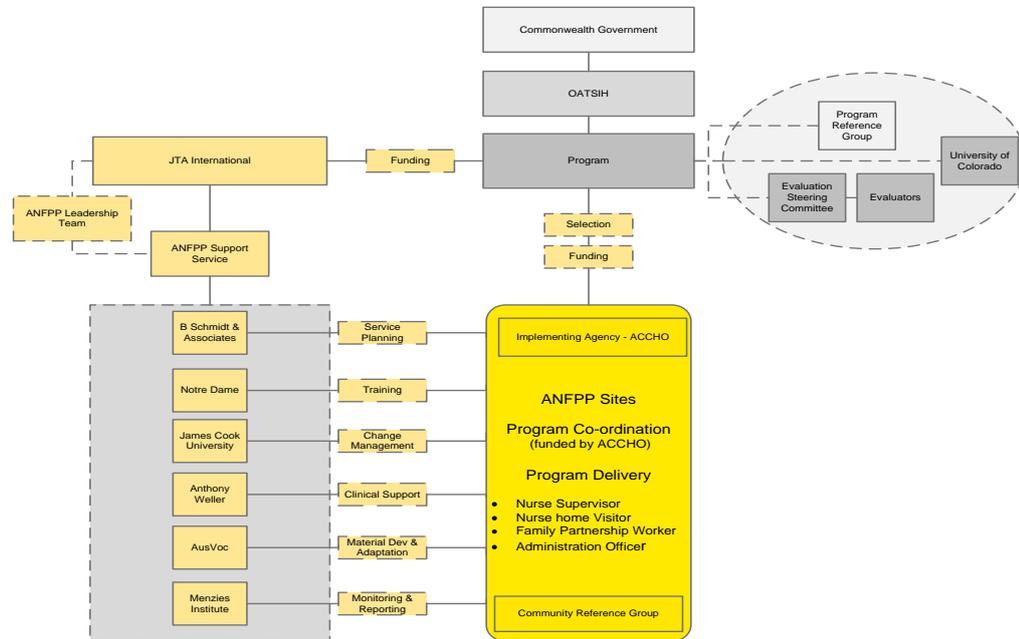
- ▶ technical leadership;
- ▶ core curriculum and training;
- ▶ data and monitoring;
- ▶ materials adaptation;
- ▶ service planning; and
- ▶ empowerment and change training.

Because of the complexities inherent in implementing this particular program, OATSIH maintained a high degree of interest at the operational level. As the program becomes more established, OATSIH should be able to increasingly delegate this attention and focus on contract management and review of outcomes/performance.

The program is currently delivered through local ACCHOs, under existing program areas and is expected to be supported by a Community Reference Group, drawn from the local community. Program Managers or Co-ordinators in the participating ACCHOs manage the ANPP within their existing program portfolios. These Program Managers are part of the existing infrastructure of the organisations and are not funded by the program.

A Nurse Supervisor in each site manages the day to day activities of the ANFPP and the performance of Nurse Home Visitors, Family Partnership Workers and administration staff. The diagram below describes the design and governance of the ANFPP.

Figure 1: ANFPP design and governance



2.7.1 Australian Adaptations

The differences between the US context and the Australian Indigenous context were considered significant enough to warrant inclusion and testing of specific adaptations to the program, outside the fidelity elements. Therefore, the ANFPP includes three endorsed adaptations⁸ to the original model. These are:

- ▶ the inclusion of an Indigenous worker (Family Partnership Worker) in the home visiting team, who introduces the program to the client, family and community and reinforces cultural safety;
- ▶ the inclusion of multiparous mothers in the client group where sites consider this to be suitable; and
- ▶ the adaptation of promotional, teaching and client materials and the creation of new documentation to suit the Australian Indigenous culture and context.

⁸ These adaptations were endorsed by Professor Olds.

3. Evaluation approach

This section describes the methodology applied to the Stage 1 Evaluation, which was based on the overarching ANFPP evaluation framework. The Stage 1 Evaluation was conducted from May 2011 - October 2011.

3.1 Evaluation Framework

An evaluation framework⁹ was developed, which guides a proposed series of evaluation activities for the program over a suggested 5 year period. It considers each of the following evaluation domains:

- ▶ program planning;
- ▶ budgeting and funding;
- ▶ purchasing and provision of services;
- ▶ client use of services; and
- ▶ program outcomes;

and applies these at the different stages in the life of the program - from commencement and early implementation through to full establishment and maintenance.

Initial visits were made to all participating sites in late 2010 to inform the development of this evaluation framework and at the same time gather early information to guide the methodology and content of the Stage1 Evaluation.

3.2 Data collection

The evaluation framework identified a series of key evaluation questions to be addressed in each of the evaluation stages. For the Stage 1 Evaluation, these questions were addressed using the data collection methods outlined in the table contained in Appendix A.

The table below summarises the applicability of each of the data collection methods to each of the key domains identified in the evaluation framework.

Table 2: Summary of methodologies for information collection for Stage 1 Evaluation

Methodology	Planning	Budgeting and funding	Purchasing of services	Provision of services	Client use of services	Initial outcomes	Monitoring and reporting
Review of program/policy documents	✓		✓	✓			
Review of reports on program establishment			✓	✓			
Review of fidelity reports & data collection				✓	✓	✓	✓
Completion of spreadsheet by agencies		✓		✓			
Qualitative interviews and focus groups	✓	✓	✓	✓	✓	✓	✓

⁹ Ernst & Young, The Australian Nurse Family Partnership Program Evaluation Framework (unpublished) 2011

3.3 Information collection methods

The information collection methods used in the Stage 1 Evaluation are described in more detail below.

3.3.1 Document Review

The evaluators reviewed and analysed a range of documents provided by OATSIH and the ANFPP Support Service.

3.3.2 Request for additional information

A spreadsheet was developed to gather additional financial information about the overall cost of the program and how that related to the delivery of services to clients. The spreadsheet was sent to ACCHOs following an introduction to it during site visits and to the Support Service as part of the overall information gathering process. Not all participating ACCHOs completed the spreadsheet.

3.3.3 Interview and focus group

Interviews were held by phone or in person depending on the stakeholder group and location. Each of the ANFPP services was visited over a 2 - 4 day period. This was the second visit to all sites and built on the initial visit, which informed the development of the Evaluation Framework.

During this second round of site visits interviews and focus groups were held with the ACCHO Board, CEO and Program Manager and with ANFPP staff. Focus groups or individual meetings were held with mothers, depending on their preference. Referring agencies were generally followed up by phone. Phone or face to face interviews were also held with OATSIH Officers, members of the Program Reference Group, the Support Service and members of the Leadership Team.

Specific interview questions were consistently asked of each stakeholder group. These questions were shaped according to the audience and ordered to encourage an easy flow of conversation. In some cases, the information gained from interviews and focus groups was used to test or to add depth to quantitative data.

To assist the evaluators to engage respectfully with Aboriginal mothers and families in each of the communities, the method of engagement was designed and implemented in negotiation with the ANFPP staff in each site. The gathering of information from mothers of babies enrolled in the program was led by a female Indigenous consultant in almost all cases. Where logistics meant that this was not possible, mothers were asked by staff if they would accept being interviewed with a non-Indigenous female consultant. The selection of interviewees was made by ANFPP staff at each of the sites. Personal and identifying information was not collected.

Observations of mother infant interaction were made by an interviewer who is trained in infant-parent attachment, holds an attachment based Master's degree in Infant Mental Health, and had completed 12 months of (weekly) supervised infant observation.

3.3.4 Research

Information on the NFP in the US and the UK, as well as relevant information in the Australian context was researched, using a combination of journal articles and reports from government websites.

3.3.5 Feedback on Findings

A report was provided to OATSIH which contained the evaluation findings and suggested recommendations. Following receipt of this report OATSH sought feedback from the Evaluation Steering Committee, Professor Olds and the ANFPP sites. Site feedback was gathered from Board members and/or senior staff and/or ANFPP team members in feedback sessions, led by an Indigenous consultant and attended by representatives from OATSIH, which were held at each site. Feedback has been incorporated into this final version of the Stage 1 Formative Evaluation Report.

4. Findings and recommendations

4.1 Selection of the program

Finding 1: The decision to trial the NFP for adaptation in the Australian Indigenous context was taken following consideration of sound evidence and expert advice. The program has not been in place long enough for a determination to be made as to its effectiveness. There were indications (based on qualitative information and observation) that the ANFPP was suitable and acceptable to the communities in which it was implemented and was achieving some early objectives in sites.

4.1.1 Expert advice and sound evidence

There are other home visiting programs offered in Australia. Some have been locally developed and some have been developed in other countries and applied or adapted in Australia. There are relatively few programs that have been tested through RCTs or similar level studies. OATSIH undertook a literature review of available evidence for health improvement programs for mothers and babies to inform its thinking regarding the most suitable program for its needs¹⁰. The decision to purchase the licence and adapt the NFP to the Australian context was made following this literature review and following discussion with Australian experts in this field.

There are some unique aspects of the adapted ANFPP that are not necessarily replicated in other available programs. These contributed to an expectation that Australian Indigenous outcomes would be similar to those that are currently attributed to the program, if implemented with the ANFPP adaptations and included:

- ▶ a strong theoretical and evidence base;
- ▶ a focus on prevention through individual capacity building;
- ▶ a high degree of emphasis on maternal life course as a component of the program;
- ▶ prescribed dosage and content of visits;
- ▶ the length of time mothers and babies are in the program;
- ▶ prescribed staff qualifications and roles; and
- ▶ a high level of control over program fidelity (through licencing and reporting).

Initial ANFPP planning and governance was well supported and led by the First Assistant Secretary, OATSIH, supported by the Early Childhood Section. Professor David Olds was involved at various points in the early planning stages and has remained involved and interested throughout the implementation.

National program planning was supported by a Program Reference Group, a specially established advisory group consisting of experts in Aboriginal and Torres Strait Islander maternal and child health and wellbeing and/or home-visiting. Initial decisions regarding program selection and governance were made in consultation with this group, whose stated purpose was to provide advice to OATSIH on the development and implementation of the

¹⁰ Herceg, A, (2005), Improving health in Aboriginal and Torres Strait Islander mothers, babies and young children: a literature review, Commonwealth of Australia, Canberra

program¹¹. The Program Reference Group provided OATSIH with a source of advice and critical appraisal of decisions made during the planning and early implementation stages of the program.

The NFP model has already generated a significant body of research in the US. A US review of 11 home visiting program models considered 16 of the NFP studies in detail and found 64 favourable impacts and 6 unfavourable or ambiguous impacts across these studies¹². In Elmira, Memphis and Denver studies, there was evidence of improved antenatal health behaviours (such as reduced smoking) and improved birth outcomes (such as reduced pregnancy related hypertension and fewer preterm births). There was also evidence of more competent and safer parenting on a number of measures in the first two years¹³. The impact of the program has continued to be measured in these three groups, with some long term positive results reportedly continuing into adolescence for some children from the program and/or their mothers¹⁴.

There have been 3 evaluation reports produced from the UK implementation, with the most recent evaluation report considering the implementation in toddlerhood for Wave 1 services and pregnancy and infancy for Wave 2 services^{15, 16 & 17}. The UK is now able to make some comparisons between Wave 1 and Wave 2a sites for pregnancy and infancy stages. The progress and some early outcomes of the implementation of both Waves of the NFP in the UK have been tracked through the three evaluations.

4.1.2 Program life

In Australia Wave 1 sites in the ANFPP have only recently begun graduating their first 2 year old babies. The Wave 2 site has not yet reached that point in the program implementation. The program, in a sense, is still in the establishment phase as Nurse Home Visitors in Wave 1 sites have only recently worked through the entire set of curriculum materials and completed the entire roster of home visits.

Due to the time taken to establish the systems required to collect and record program data and the time taken to achieve reliability of data (a normal process with a new dataset), reliable data to measure achievement of program objectives and client outcomes is relatively recent. While the early outcomes (based on qualitative information and limited quantitative data from recent Fidelity Reports) appear promising, it will take more time for the impact and outcomes of the program to be properly assessed.

¹¹ Home-Visiting Program Reference Group (PRG), Terms of Reference (2007)

¹² Paulsell, D., Avellar, S., Sama Martin, E., & Del Grosso, P. (2010). *Home Visiting Evidence of Effectiveness Review: Executive Summary*. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. accessed online at <http://homvee.acf.hhs.gov/>

¹³ Olds, D., *The Nurse-Family Partnership: an evidence based preventive intervention*, Infant Mental Health Journal, 2006, Vol. 27(1), 5-25 published online in Wiley InterScience (www.interscience.wiley.com)

¹⁴ Eckenrode, J., Campa, M., Luckey, D., Henderson, C., Cole, R., Kitzman, H., Anson, E., Sidoar-Arcoleo, K., Powers, J. Olds, D., *Long-term Effects of Prenatal and Infancy Nurse Home Visitation on the Life Course of Youths: 19-year Follow-up of a Randomized Trial*, Archives Paediatrics and Adolescent Medicine, 2010, Vol. 164 (1), 9-15

¹⁵ Barnes, J., et al, (2008), *Nurse-Family Partnership Programme: First Year Pilot Sites Implementation in England, Pregnancy and the Post-partum Period*, Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London

¹⁶ Barnes, J., et al, (2009), *Nurse-Family Partnership Programme Second Year Pilot Sites Implementation in England: The Infancy Period*, Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London

¹⁷ Barnes J et al (2010) *The Family-Nurse Partnership Programme in England: Wave 1 Implementation in toddlerhood and a comparison between Waves 1 and 2a implementation in pregnancy and infancy*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123238

4.1.3 Program acceptability and suitability

The program was introduced in a range of service delivery environments, ranging from remote Central Australia to rural, regional and metropolitan sites. Each of these environments has unique characteristics that might influence how the program was perceived, planned and implemented.

Boards of ACCHOs, staff, members of Community Reference Groups, representatives from other agencies and mothers using the service were consistent in their view that the ANFPP was acceptable to Indigenous communities. There was a commonly held view that Indigenous Family Partnership Workers were essential to engendering and maintaining community interest and trust in the program.

Some sites noted an increase in the number of self-referrals and family referrals. They were confident the program was being talked up in the community and within families. Some sites were noticing a significant increase in sisters and cousins self-referring having seen the effect of the program on their relative. In one case a mother self-referred following observation of the impact of the program on her daughter.

4.1.4 Achieving client objectives

Although limited by the number of sites and the maturity of the program implementation, there is qualitative evidence suggesting that when the adapted program is delivered within the required dosage and using the prescribed methodology, the predicted result is likely to be achieved. Consultations at sites yielded many stories that illustrated successes for mothers on the program. Some of these were told by staff and others by mothers on the program. These stories can be considered indicative only but there were common themes around increased confidence and competence of mothers which were also observable in interviews.

Generally speaking mothers spoke of strong relationships with Nurse Home Visitors - an essential precursor to achieving the goals of the program. In addition competence and confidence of mothers, signs of attachment to babies, appropriate mother/child interactions and the mother's favourable views of the program and its relevance to their lives were observable in interviews. ANFPP teams at the sites are questioning the relevance of the spaced pregnancies in the context of Indigenous culture. The following early observations are grouped under key outcome areas for the program.

Maternal Health - There were examples provided by staff of mothers increasing healthy practices. Reducing tobacco use is particularly important in achieving improved birth weights. There were examples given of mothers reducing the number of cigarettes they smoked even if they did not give up completely. In one site, there were examples given of mothers directing fellow householders to smoke outside so as to avoid passive exposure to tobacco smoke.

STORY "One mother stopped smoking during her pregnancy. She took it up again after the baby was born but at least she stopped while she was pregnant!" ANFPP Worker

Maternal Role - Interviews were held with 18 mothers and 2 family members across the 4 sites. Mothers had their babies with them at all interviews. An interviewer trained in parent-infant attachment was present at all interviews other than 3. It was observed that

STORY- One mother said "you need to learn what it is really like to have babies - and not just from your mum"

mothers interviewed appeared well attuned to their babies and communicated and responded appropriately to their babies' needs during the interviews, most of which lasted for an hour. In addition interviews with maternity units in three communities indicated the midwives had observed

mothers who were on the program were more likely to actively try to engage and "bond" with their babies and were more knowledgeable about birth and breastfeeding.

Life course development - ANFPP teams provided examples of mothers enrolling in further education, applying for jobs and successfully returning to school. Interviews with mothers on the program and information from other agencies supported these stories. A number of ANFPP teams noted that there did not seem to have been much impact on increasing the length of time between 1st and 2nd pregnancy and questioned whether this measure is culturally appropriate for Indigenous mothers.

STORY - One mother told about how her confidence has increased and how she is planning to go to TAFE. Another mother applied for a traineeship with a major Australian company.

Supports - At most sites examples of a growth in confidence in the mothers on the program were provided. One Nurse Home Visitor provided an example of a mother who was threatened with homelessness and who, with support, was able to contact a real estate agent, choose a possible house from a list of rentals and apply for the house. Although she

STORY "Her face just lit up and she said "I did it!!!"

was unsuccessful, the staff member described an increase in belief in her own ability to find a home for herself using available resources.

Environmental Health - ANFPP teams and mothers gave examples of where the ANFPP had helped mothers to create safe environments for their babies and themselves. There were examples given of mothers leaving the area to remove themselves from a violent relationship which, although it meant leaving the program, was viewed as positive, determined action to provide a safer environment for themselves and their babies.

STORY One mother told about how the ANFPP helped her get strong for her kids by supporting her to be able to ask her family to leave her home "kick the family out" so that she could live in her own home with her babies.

Newborns - One site, which has been collecting its own data for some time, has noted an increase in birth weights over the last 12 months.

STORY One mother told a story about things she had learnt and said while her niece was staying with her, her niece's baby was unsettled. Her niece didn't know that you settle a baby by talking to them so she told her about talking to her baby.

While this increase cannot be directly attributed to the ANFPP, the site believes there is a temporal relationship between the implementation of the program and this improvement. Another site recorded differences between two of its communities, with one having 1 out of 6 births come to full-term, while in the other all births were full-term.

Infants & Toddlers - Mothers provided examples of ways in which being on the program had helped them to feel confident as mothers. A number of mothers specifically talked about how they would not have known about key child development milestones without the program. This was generally linked with comments made by mothers about the high degree of trust and the positive relationship they had with the Nurse Home Visitor, which increased their confidence in the information being provided.

STORY One mother of an almost 2 year old said the written material helped in the period between visits. "The stuff learnt is really useful, for example how to put the baby down for a day rest" Another mother said the program "makes you feel like a mum, talk like a mum"

4.1.5 Achieving program objectives

4.1.5.1 Nurse to client ratio

Apart from one site where there is currently only one Nurse Home Visitor employed, no sites had reached or maintained the 20 - 25 clients per nurse ratio. According to the ratio of nurse to clients applied in the NFP model, there was spare capacity in these sites. This ratio is yet to be fully tested in the Indigenous Australian context, however most sites

expressed concern about the achievability of this target in the context in which they were working. As sites are only now beginning to graduate toddlers, they had not had the opportunity to become familiar with the full cycle of program curriculum and material, from pregnancy through to 24 months. Understanding unfamiliar materials and selecting new materials to suit the client added to preparation time. Sites where travel was required (outreach or within a metropolitan area) found the number of mothers they could visit in a day was reduced.

4.1.5.2 *Eligible mothers*

Sites were confident they were providing services to the target population but most were concerned that there were mothers who would benefit from the service but were missing out. While the exact nature of these groups of mothers varied according to the local environment, common characteristics included:

- ▶ extreme youth; and/or
- ▶ homelessness; and/or
- ▶ isolation or geographic distance; and/or
- ▶ additional vulnerabilities such as drug/alcohol use or exposure to violence; and/or
- ▶ involvement in the child protection system.

Some of the abovementioned groups do not fit the eligibility criteria for the program and may be more suitable for other programs tailored to their level of need. Nevertheless, in recognition that these types of service were not in place, sites were generally seeking to extend their links with the local service network to include agencies that were more likely to have contact with these girls or women.

In some sites, the relationship between the ANFPP and internal referrers were not strong and in some cases there was active competition for clients within the one organisation. This impacted on the recruitment of eligible mothers to the program. In another site, where the ANFPP was firmly embedded within the internal and external service system, staff were confident they were identifying most eligible mothers and offering the service to a high proportion them.

4.1.5.3 *Fidelity to model content and processes*

As at 31 March 2011, the proportion of time spent on addressing most program domains was within the target range, other than maternal role and life course development, which tended to be below the target range¹⁸. Interviews with Nurse Supervisors indicated that Nurse Home Visitors might have still been having difficulty correctly categorising activities across the different domains, and data needs to be considered in this context.

The ANFPP is flexible as demonstrated over and over again in interviews with mothers and with program staff; however it doesn't tolerate variations on the core elements. Core elements are related to:

- ▶ modelling and building relationships - ANFPP is fundamentally a relationships based program;
- ▶ fostering independence and self-efficacy (not always doing it for the client);

¹⁸ Information taken from Site Quarterly Fidelity Reports provided by OATSIH

- ▶ predictability and patterning (reassuring for the nurse and the client); and
- ▶ mother's heart's desire - leading the client to where the client wants to be.

Generally speaking Nurse Home Visitors and Family Partnership Workers believed they were providing the services in the manner planned, with a few notable exceptions. Almost all staff expressed discomfort with PIPE and NCAST. Not all staff could explain PIPE and NCAST adequately, but those who could were more likely to have found a way of working within the principles and purpose of the tools. Some staff, however, could not see beyond the processes and practices associated with PIPE and their sense of discomfort with these. Examples of this included videotaping of mothers (not a mandatory activity) and the use of dolls in educating parents about communication with their baby. PIPE and NCAST were repeatedly cited as activities where further practical training was desired. These are essential elements of the model, which requires a high degree of understanding and mastery of the processes.

There were also situations where Nurse Supervisors did not fully understand or support program content and did not mandate its use. Consequently some staff had not applied all program content as prescribed.

Despite their discomfort with some program content, a number of staff described "aha" moments when they applied the program content exactly as prescribed and had a result exactly as predicted. For some staff, this was the beginning of a deeper trust in the efficacy of the program content even where they did not yet fully understand how it worked. The experience of these staff can be leveraged to increase the confidence of others in the program content and processes.

Recommendation 1: The program should continue in the sites where it has been implemented, with consideration given to any changes associated with Recommendations 2 & 3. Data monitoring should continue to track outcomes and impact in line with program objectives.

4.2 Metropolitan pilot

Finding 2: Due to the cessation prior to commencement in one metropolitan site, and the recent wind down of the program in the other, the ANFPP had not been adequately tested in a metropolitan setting.

Of the five sites selected in Waves 1 and 2, two sites have since decided to discontinue the program. The Brisbane service (Wave 2) decided to opt out before commencing services, and the Melbourne service (Wave 1) decided to phase the program out, with no new mothers recruited after March 2011. These two sites were the only metropolitan sites in the pilot.

Some of the specific challenges identified by the implementing metropolitan site included the spread and location of clients in relation to the service (increased travel time), relationship management with potential referring agencies and the existence of perceived alternative services for mothers and babies. These last two are linked, as a poor understanding of the program differentiators by referring agencies and other ACCHO programs may very well have resulted in a view that the program was a competitor for existing clients. In addition, there were staffing issues in the implementing metropolitan site, which impacted on its capacity to recruit mothers to the program.

While the factors contributing to the cessation and the wind down of the program were different in the two metropolitan sites originally selected for the ANFPP, this has effectively meant an incomplete testing of the program in metropolitan communities. With only one metropolitan site implementing, it was not possible to determine to what extent the challenges faced by the ANFPP were unique to that site and to what extent they were likely

to be faced by any metropolitan site. Further testing of the program in a metropolitan setting, with careful consideration given to risk factors, might provide better indications of the suitability of the ANFPP in metropolitan settings. For example, the service system structure and patterns of health service use by Indigenous families might require consideration of alternative providers for the program in metropolitan areas, or the development of consortia to provide the program across multiple services.

Recommendation 2: Consideration should be given to testing implementation of ANFPP again in a metropolitan site, with careful consideration given to delivery model and location in relation to the target population.

4.3 Considerations for program expansion

Finding 3: Two significant limiting factors for selection of sites for the ANFPP pilot were the number of Indigenous babies born within a region (100 or more) and organisational capacity and capability to implement the program. These factors would also limit the number of future sites that could be considered for ANFPP unless they were ameliorated in some fashion. Wider implementation of the program may require revision of site selection criteria, inclusion of a wider population base for eligible mothers, an expansion or change in the delivery model, and/or the addition of intensive capability and capacity building in otherwise suitable sites.

4.3.1 Increasing the eligible population

The staffing and set up for the NFP in the USA was based on at least 100 families per region to achieve efficiencies of scale. This model was translated to the Australian context, with one of the deciding factors for inclusion on the pilot being the number of Indigenous babies born in a region (not necessarily within the area covered by a specific service).

One of the concerns expressed in the initial Wave 1 planning for the ANFPP was that there would not be enough eligible births in the areas covered by the implementing sites to achieve the expected ratio of mothers on the program. In fact, the potential pool of eligible mothers and babies at each site was relatively small and at the time of this evaluation no sites with full staffing had reached the expected ratio of one nurse to 25 clients. Most had not reached the site-preferred ratio of one nurse to 20 clients. The recruitment rate for sites was affected by a range of factors including:

- ▶ the time taken to establish the program;
- ▶ the slower than expected uptake of mothers into the program;
- ▶ client retention rates;
- ▶ the availability of perceived alternative programs; and
- ▶ migration patterns of Aboriginal and Torres Strait Islander families in some areas.

Generally speaking sites felt it took longer to recruit numbers of mothers than they had originally expected and made various adjustments to address this. One site changed its method of identifying and recruiting eligible mothers, which resulted in an increase in successful recruitments to the program, even though it meant more ineligible mothers were initially approached. In one site, the observation was made by the ANFPP team that including multiparous mothers in the target population had increased the eligible population.

While sites might not have been reaching their intended targets locally, most were aware of communities outside their initially defined range who they believed would benefit from the

program. In some cases they had commenced outreach to nearby communities, but in other cases the distances were too great for the normal outreach model to work. These communities would, under the present ANFPP delivery model, be too small to warrant the cost of establishing the program but might be candidates for alternatives such as a hub and spoke delivery model supported from an existing site. Another option might be the development of consortia across a number of communities, with shared infrastructure and ANFPP staff.

These options would require careful consideration of all implications. For example, evidenced success factors such as Nurse Supervisor to Nurse Home Visitor ratios and access to reflective practice and supervision for ANFPP staff would need to be maintained in any alternate delivery model.

There was interest expressed in expanding the service to mothers of non-Indigenous babies. This interest came from mothers in the program and from staff in some sites. For some Boards of ACCHOs, however, this idea conflicted with their fundamental purpose in providing the service, which was to improve the health of the Indigenous communities that controlled their operations. There are arguments for expanding the scope of the ANFPP to include mothers of non-Indigenous babies who otherwise meet the eligibility criteria. This is based on the following premises:

- ▶ Expansion of the service to include mothers of non-Indigenous babies would potentially increase the economies of scale for the program, by increasing the number of sites suitable for program implementation.
- ▶ There are perceived inequities in communities where the program is currently being implemented, whereby mothers of non-Indigenous babies with perceived similar levels of disadvantage to mothers of Indigenous babies are denied access to a program which has recognised benefits.

Although the program does provide services to non-Indigenous mothers of Indigenous babies, there were not enough of these mothers to provide indications as to the acceptability or suitability of the Australian program in its adapted form to this group. However, there is evidence from the US and the UK that the program is suitable for non-Indigenous populations, and this is the group for which it was initially designed.

Expanding the program to include mothers of non-Indigenous babies would, again, require careful consideration of the full range of implications, including but not limited to the following questions:

- ▶ Would expanding the program to a wider population group dilute its impact on mothers of Indigenous babies?
- ▶ Would this contribute to maintaining levels of disadvantage and the current gap in health outcomes and life expectancy for Indigenous Australians?
- ▶ How acceptable and/or appropriate would ACCHOs find the concept of providing services to non-Indigenous mothers of non-Indigenous babies?
- ▶ How would organisations be selected to provide the program to an expanded population group without effectively excluding ACCHOs and the individuals they service?
- ▶ Which Commonwealth Department would be most appropriate to manage the program if its scope extended beyond that of OATSIH?

- ▶ What would be the cost of expanding the program to include mothers of non-Indigenous babies and therefore how would this be funded?
- ▶ What adaptations, if any, would be required to adjust to the needs of mothers of non-Indigenous babies, including other specific cultural groups receiving the program?
- ▶ How would the role of the Family Partnership Worker be treated?

4.3.2 Improving organisational capability

The ANFPP is a new program to Australia and is also a new way of implementing a program for OATSIH and for the ACCHOs involved. These factors have placed significant additional pressure on existing organisational capacity and capability. There were significant internal shifts required to effectively embed the program into the existing operations of the organisations and a particular need for strong and responsive governance systems.

Senior executives and Board members in sites talked about the extent to which the program challenged their existing governance systems and capability. It is likely that, for more sites to be considered capable of implementing the program, additional capacity and capability-building support would be required.

There is already national activity to improve capability and capacity in ACCHOs. Through the "A Better Future for Indigenous Australians - Establishing Quality Health Standards" (EQHS) program, OATSIH has been supporting ACCHOs to review and revise their organisational systems and processes in order to meet recognised accreditation standards. This program is one way in which governance capability is being strengthened in the sector.

The Support Service has enhanced capability in implementing sites through planning support and through specific support to Nurse Supervisors. If a hub and spoke or auspice type model of delivery were introduced, organisations with stronger governance capability might be able to support organisations which were still developing the level of ability required.

Recommendation 3: Consideration should be given to increasing critical mass using accessible and equitable solutions, such as testing alternative models of delivery that might allow access to ANFPP in smaller communities, e.g. increased outreach or hub and spoke models and/or expanding ANFPP scope to include mothers of non-Indigenous babies in communities with high levels of socioeconomic disadvantage and a critical mass of eligible births per annum.

This would require consideration of the following matters:

- ▶ maintaining fidelity to the critical elements of the model
- ▶ ensuring Indigenous services and communities continue to participate and are not disadvantaged by a broader rollout;
- ▶ flexibility in selecting the most appropriate organisation/s to manage ANFPP within each community;
- ▶ the Family Partnership Worker role in communities where both Indigenous and non-Indigenous babies and their mothers are receiving the service
- ▶ considering funding sources and roles and responsibilities of Commonwealth, State and Territory Governments in an expanded program; and
- ▶ understanding the licencing costs and requirements of an expanded program.

4.4 Program funding

Finding 4: Under the delivery model at the time and number of sites implementing, there was significant spare capacity within existing resources. The required staffing structure and fidelity requirements incur an irreducible base cost, so a more effective way of increasing efficiency, if future rollouts were to occur, would be to increase the number of clients receiving the program.

4.4.1 Costs

OATSIH was allocated ANFPP funding in accordance with a New Policy Proposal that was approved in 2007. Within that document, the expected delivery and expansion of the program was outlined and the funding was allocated accordingly.

Budget allocations for the program¹⁹ (excluding Puggy Hunter Scholarships and OATSIH administration funds) were:

- ▶ FY 2007/08 \$2.464M (start-up funds)
- ▶ FY 2008/09 \$7.072M
- ▶ FYU 2009/10 \$9.424M
- ▶ FY 2010/11 \$11.606M

OATSIH advised that the proposed budget for the program for FY 2011/12 is \$10.903M

Up to 30th June 2011, JTAI had received \$10.4M in funds and had estimated a further \$2.3M for 2011/12 FY²⁰.

OATSIH advised that funding was allocated to sites based on their approved annual budget. Organisations developed budgets based on the following parameters.

- ▶ All sites were initially funded for one Nurse Supervisor, 2 Nurses Home Visitors, 2 Family Partnership Workers, one 6 month Project Officer and one Administration Officer. Additional funds for staffing were released as the program expanded.
- ▶ Sites determined the salaries for staff and all on-costs were set. Salaries were required to be either equal to or greater than 50% of the total budget, to ensure that funding was directed to the services needed to deliver the program.
- ▶ ANFPP training was delivered by the Support Service at no direct cost to sites, however sites were expected to cover travel and accommodation costs, from funds specifically allocated for the purpose, using a predetermined formula based on the Department's staff (non SES) travel allowances.
- ▶ Other training funded for the program included IT training (\$1500 p/new staff member) and Cultural Awareness Training (\$1500 per person annually). Consumables were funded based on an amount of \$3750 per annum for each Nurse Home Visitor.
- ▶ Office costs such as stationery, utilities, printing, equipment, security, phone were generally determined by the organisations requirements.
- ▶ Lease/rent of premises was based on the lease signed by the sites - copies of leases were provided to OATSIH by the sites.

¹⁹ Based on unaudited advice received from OATSIH

²⁰ Based on unaudited advice received from JTAI

- ▶ Vehicle numbers were based on one per Nurse Home Visitor plus one for the Nurse Supervisor. The amount allocated was based on the leasing or purchasing arrangements. If the orgs were paid depreciation on vehicles, they were expected to fund replacement vehicles.
- ▶ Vehicle running costs were generally determined by the sites but in some cases OATSIH capped these line items.
- ▶ An administration fee was included in budget calculations.

Generally speaking and allowing for variation across sites, on average sites received around \$1M per annum to implement the program²¹. As program staffing was the major driver for the funding formula, sites were confident their staffing costs would be met. Negotiations to increase funding to cover expanded services (for example to outlying communities) were successful.

At this stage in the implementation of the program, the costs are high for a relatively small population. It must be recognised that closing the gap and achieving real improvements in health outcomes for the Aboriginal and Torres Strait Islander population can be expected to require significant investment. However the resources allocated to the program are not being used to capacity at the moment. For example:

- ▶ Nurse Home Visitors at 30th June in the 3 sites who provided Fidelity Reports had per FTE caseloads ranging from 11.5 to 14 to 17.2²². The suggested ratio is 1FTE to 25 clients and the site-preferred ratio is 1FTE to 20 clients.
- ▶ Nurse Supervisors were supporting Nurse Home Visitor FTEs of 2.1, 3.1 and 6. The suggested ratio is one Nurse Supervisor to 8 Nurse Home Visitors. This does not take into account the support provided to Family Partnership Workers, which is not recorded but does require Nurse Supervisor time and effort.
- ▶ The Support Service will be providing maintenance support to 3 sites only and has the capacity to support 7 and possibly up to 10 sites²³ with very little infrastructure increase.

ANFPP team members in one site observed that they were becoming more efficient at delivering the program as they became more familiar with it. In another site, ANFPP team members noted that Nurse Home Visitor to mother ratios needed to take into account the complexity of the case load and distances travelled as well as the number.

4.4.2 Contracting

Contracts with sites outlined the expectations held of them by OATSIH, including reporting requirements using Quarterly Fidelity Reports. The recording, reporting and monitoring of program activities (fidelity elements) provided a means by which the funding body (OATSIH) could determine whether the sites were delivering on their required outcomes.

The use of the Fidelity Report by sites to monitor their own performance and to identify areas requiring quality improvement action improved as data reliability and validity issues

²¹ Unaudited information from sites who provided financial data and confirmed by OATSIH

²² Based on information from sites contained in Quarterly Fidelity Reports, reports provided to evaluators by OATSIH

²³ Based on information provided verbally by JTAI

were addressed. The Fidelity Reports, therefore, became a means by which the performance of the sites could be measured.

JTAI was funded on the basis of a contract awarded through a competitive procurement process. Since the original contract was signed, budgets have been negotiated with JTAI on the basis of service activity and required outcomes.

Recommendation 4: Consideration should be given to expanding the program to achieve improved use of existing capacity (refer Recommendations 1, 2 & 3).

4.5 Support Service

Finding 5: The Support Service holds the expert knowledge about the ANFPP in Australia. The support function provided by the Support Service was critical in assisting sites to establish and implement the ANFPP, although not all sites agreed with the approach taken by the Support Service to the role of the Family Partnership Worker and some believed there should be more Indigenous intellectual input into Support Service operations. A centralised support function would continue to be critical in any future rollout, however unless the program is established in additional sites or support and maintenance activities are significantly curtailed, the ongoing cost if allocated on a per site basis is potentially high.

Early discussions regarding the governance of the program included consideration of the establishment of a third party organisation to assist in adherence to fidelity through provision of such functions as recruitment and management of staff, training and support, monitoring, evaluation and research²⁴.

Consequently OATSIH contracted a consortium under the umbrella of JTA International (the Support Service) by tender to provide support services to the sites implementing the program. A Leadership Group made up of 2 Indigenous and 1 non-Indigenous specialist advisers was created as part of the Support Service.

Australia, the US and the UK all recognise the need for and utilise a central function, to maintain fidelity, monitor and support the program. In the US, implementing agencies, which may be funded by a combination of public and private funding, contract with the Nurse Family Partnership National Service Office, which then provides support to maintain fidelity, including planning support, data collection and quality improvement, and training. In the UK the Family Nurse Partnership (FNP) National Unit supports the national implementation of the FNP through the NHS.

In Australia the ANFPP Support Service developed a deep and complete understanding of the program, based on its intensive review and adaptation of materials, development of program guidelines and other related materials, planning, training and ongoing professional support for implementing sites. This knowledge was built on through the learnings from Wave 1 and Wave 2 implementations and would be difficult to replicate if the Support Service was to cease operations.

The initial budget and structuring of the Support Service was based on the consortium supporting an estimated 7 sites. In consultations the Support Service estimated it might potentially provide support for up to 10 sites with little additional infrastructure. However at the time of the evaluation there were 4 (soon to be 3 sites) that could be considered fully operational. Although a percentage of the \$10M costs for the first 3 years of the program

²⁴ *Health@Home Plus Program Reference Group, 29 October 2007 Meeting, Draft outcomes*

could be considered upfront establishment costs, the estimated budget for the Support Service for 2011/12 FY in the maintenance phase was \$2.3M. On a straight division of costs by site (assuming 3 sites moving forward) this equalled a support cost of \$239,000 per site for 10 sites, \$341,000 per site for 7 sites and \$795,000 per site for 3 sites.

The functions the Support Service provided were critically important to establishing and sustaining the program in Australia. Once materials adaptation and development is complete, this function should be reduced to routine review only. Essential support components that could be expected to be required on an ongoing basis include site planning support, training, professional support for Nurse Supervisors, and data collection and monitoring for fidelity and quality purposes.

4.5.1 ANFPSS role in planning support

The planning support provided to sites for the ANFP was greater than for other funded programs and reflected the complexity of the program. The Support Service provided assistance to ANFP sites in their early and ongoing planning for implementation, through one of the consortium partners - Barbara Schmidt and Associates. A quality improvement approach was taken to the planning and implementation of the ANFP, based on the Plan-Do-Study-Act cycle (PDSA). Sites received a series of 4 supportive visits, based on a service planning framework, which was initially devised and then adapted, modelling the PDSA cycle, following the results of the initial rounds of planning visits.

The initial round of planning visits to Wave 1 sites provided a number of learnings for the Wave 2 sites. A final report on Wave 1 service planning was completed in March 2010²⁵ and describes in detail the service planning process and adaptations made. New sites were assisted by the Support Service to:

- ▶ define the program that they would deliver;
- ▶ plan the implementation of the ANFP in their service;
- ▶ identify critical relationships required to deliver the program;
- ▶ identify policies and procedures required to deliver the program; and
- ▶ embed the ANFP into a quality improvement process.

It became apparent through the early planning processes that to receive full value from the planning support offered, sites needed to ensure their senior executive were actively involved in all the planning visits and that recruitments of key personnel, such as the Nurse Supervisor, were completed before planning visits commenced.

4.5.2 ANFPSS role in training

The Support Service role in supporting training included:

- ▶ Developing plans for in-service sessions and supporting their delivery as required
- ▶ Delivering training
- ▶ Identifying topics and speakers and coordinating the seminar series
- ▶ Monitoring and assessing Unit 4 completions

²⁵ ANFPSS, Report On Service Planning, Wave 1 implementation sites, March 2010

- ▶ Providing access to the virtual classroom
- ▶ Further skills development [such as facilitating shadow visits at other sites]

Training provided through the program contributed to CNE points for nurses to maintain their registration. Wave 1 staff recruited in the first phase also received training in Empowerment and Change.

In addition to those staff who were receiving training at the time of the evaluation, the Support Service had delivered the following training since the program commenced:

- ▶ Four Nurse Supervisors had successfully completed 150 hours of pre-service instruction each;
- ▶ 19 Nurse Home Visitors had successfully completed 120 hours of pre-service instruction each; and
- ▶ 12 Family Partnership Workers had successfully completed 100 hours of pre-service instruction each.

In addition the Support Service had delivered 40 Professional Development sessions to site personnel, for example PIPE Booster training.

4.5.3 ANFPSS role in professional support

Professional support provided through the ANFPSS included advice on specific clinical or other issues raised in supervision sessions and other contacts, and provision of Reflective Practice.

Supervision and support has been recognised as a critical element in maintaining program fidelity and improving staff satisfaction and retention in home visiting programs.²⁶ Examples were provided of cases where, through the supervision and support process, the Support Service was able to provide specific clinical guidance to nurses working with mothers with special needs, such as developmental delay and mental illness. Nurses were supported to adapt existing material or access specifically designed material for work with these mothers.

An essential element of the program was the role that Nurse Supervisors played in supporting their team and providing Reflective Practice for the Nurse Home Visitors (and in Australia the Family Partnership Workers). In order to undertake this role effectively, Nurse Supervisors themselves required Reflective Practice and support as provided by the Support Service. Reflective Practice provided supervision and support to nurse Supervisors and also modelled for process for them so they could apply it more effectively within the ANFP team. Nurse Supervisors had a regular schedule of Reflective Supervision sessions, however not all Nurse Supervisors utilised Reflective Practice at the frequency available.

In addition to provision of Reflective Practice the Support Service also developed a reflective practice framework for all staff in ANFP through application of the core curriculum. Units 1, 2 and 3 all have Reflective Practice content to help people to understand framework for Reflective Practice.

²⁶ Coffee-Borden, B & Paulsell, D., *Supporting Home Visitors in Evidence-Based Programs: Experiences of EBHV Grantees*, Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment, December 2010, Brief 4, Mathematica Policy Research and Chapin Hall, University of Chicago

4.5.4 ANFPSS role in materials development and adaptation

The Support Service reviewed the US curriculum materials and other documents and developed these into a set of ANFPP guidelines and related program documentation.

The Support Service adapted the NFP Pregnancy, Infancy and Toddler Guidelines to ensure they were appropriate and safe for use by Nurse Home Visitors in Australia. Because of the differences between the Australian and US contexts two new documents were developed: a Family Partnership Worker Guide and a Practitioners Guide. The Family Partnership Worker guide was developed to guide the Family Partnership Workers in developing a new role in the program. The intention was to update this document as the Family Partnership Worker role continued to develop.

As well as guidelines, the Support Service also adapted other core materials including:

- ▶ Data Collection System manual
- ▶ Nurse Home Visitors Unit 1, Unit 2 and Unit 3 training manuals
- ▶ Nurse Supervisor Unit 1, Unit 2 and Unit 3 training manuals
- ▶ Pre-reading PIPE
- ▶ Competencies for Nurse Home Visitors and Nurse Supervisors

Some of these documents appeared to still be in draft and awaiting approval for finalisation. Sites were still receiving draft documents for feedback.

Materials adaptation was a significant piece of work, which was still underway. While the iterative process of materials development was identified as time-consuming by some sites, it appears there was a high degree of acceptance of the final products. The one exception to this was possibly the Family Partnership Worker Guide. Not all sites appeared to be aware of this guide and in one site, the approach to defining the role in the guide was considered to have contributed to Family Partnership Workers feeling their roles had been minimised. To an extent the adaptation and development of materials was an upfront investment which should be increasingly realised as the program is rolled out in the future.

4.5.5 ANFPSS role in data and monitoring

In phases 1 and 2 of the program, the Support Service worked with staff to collect data on the critical fidelity elements for the program and established a manual way of analysing and reporting on that data. A data collection working group was convened to consider changes to the existing data collection system. The support service worked with each site to:

- ▶ establish data collection, cleaning and transmission procedures;
- ▶ train staff in collection methodologies and data definitions;
- ▶ develop specifications for changes to existing record systems so that data entry and reporting can be seamless with other programs in the organisation; and
- ▶ assess suggestions for changes and identify implications of suggestions.

The Menzies Institute, as part of the JTAI consortium, used the site Fidelity Reports as an educative device to assist sites to develop their understanding of the program and their capacity to collect and record the required program data correctly. Hence, the look and content of the Fidelity Reports changed over the implementation period, with early reports designed to highlight data deficits and their impact on accurate reporting. More recent

Fidelity Reports reported against the fidelity elements, reflecting the increased reliability and validity of source data. The Support Service worked with the Nurse Supervisors to develop reports to assist them to manage their programs. These reports were being built into the patient information record systems at the sites so that Nurse Supervisors could run their own reports. The Support Service also provided ad-hoc reports to sites.

Recommendation 5: The program support function should be maintained as it is essential to establishing and maintaining program integrity and fidelity. However action should be taken to reduce the per site cost of support. This could include a review of the current provider, consideration of essential and non-essential support elements, increasing the number of sites being supported and/or reviewing the means by which support is provided.

4.6 Adaptation of curriculum materials

Finding 6: The adaptation and development of curriculum materials was an upfront investment which should be increasingly realised as ANFPP is rolled out.

Materials development and adaptation was designed to address the differences between the US environment and Australian Indigenous culture, language, health systems and environment. Some adaptations were specifically to address Aboriginal and Torres Strait Islander culture while others addressed the broader Australian environment.

The Support Service initially received multiple documents from the US to convert into manuals and guidelines for the program. These included various versions of the same manuals, sections that needed to be collated into other documents, and some materials that existed as screen dumps from a power-point presentation. These materials were converted into 2500 pages of materials in 3 core guidelines (pregnancy, infancy and toddlerhood); a statement of competencies; a data collection manual; six training manuals and supplementary materials that include guidelines on how to implement the program in Australia. These print materials were made available on line and training materials were developed to support them, including an on-line learning environment and original DVDs.

Significant investment went into this development and adaptation of materials (\$1.67M up to the end of 2009/10 FY); however this work should have a finite end. The cost of materials adaptation and development can be considered an investment which should be incrementally realised over time and as more sites implement the program.

Recommendation 6: Consideration of the future of the ANFPP should take into account the up-front investment in time, cost and effort to adapt the NFP and implement it in the Australian Indigenous context, and the potential for an incremental realisation of this investment if the program is expanded to more sites.

4.7 Effect of adaptations on implementation

Finding 7: It is doubtful that ANFPP would have been acceptable to ACCHOs and their constituents without the Australian adaptations. The adaptations required additional effort by OATSIH, the Support Service and sites, beyond that required to implement NFP in its original form. Much of the additional effort occurred after ANFPP commenced, and this increased the complexity of the roll out and time required to establish the program.

Three adaptations were made to the ANFPP prior to its initial rollout. These were:

- ▶ Inclusion of Family Partnership Workers;
- ▶ Inclusion of multiparous mothers; and

► Adaptation of program materials.

The decision to include these adaptations followed a series of planning discussions with key stakeholders, initial deliberations in the Program Reference Group²⁷ and consultation with potential ANFPP sites. The inclusion of the 3 adaptations to the ANFPP was in response to identified differences between the US context and the Australian Indigenous context and recognised actual cultural issues.

The NFP has a well-documented implementation and theory of change program logic that informs the inputs, outputs and outcomes for the program. This model does not include the adaptations to the Australian Indigenous context or the assumptions underpinning the implementation of the program in Australia, including those informing the adaptations. Program logic for the ANFPP was developed in 2011 to inform the evaluation framework but this was not available for the early implementation of the program.

It is not possible to determine whether the early development of an ANFPP logic model would have helped sites understand the logic of the program and therefore understand the purpose of the adaptations. There is a possibility that the development of a specifically Australian logic model as part of the program planning might have helped sites understand the intent of the program and the importance of adhering to program elements to achieve desired outcomes. It may also have helped clarify the rationale for the inclusion of the Family Partnership Worker, which might then have assisted in an earlier definition of the role and domains of these positions.

There were time and resource costs associated with the inclusion of the adaptations. Implementation occurred at the same time as OATSIH, the Support Service and the sites were learning about the program and coming to understand how it worked and how it could work within the Australian Indigenous context. This complicated the establishment of the program and extended the period before sites could be considered to be fully implementing. For example, the content and mode of delivery of training modules was changed as guidelines were reviewed and adapted.

The Wave 2 site benefited from much of the learnings from the Wave 1 implementation and appeared to have had a smoother and more efficient establishment period.

Recommendation 7: Considerations of the future of the program should take into account the extended period required to establish and implement ANFPP, particularly with its uniquely Australian adaptations.

4.8 Family Partnership Worker role

Finding 8: The Family Partnership Worker role enhanced access to the program for mothers and families. The role did not appear to negatively impact on the development of a strong relationship with the Nurse Home Visitor, which is an essential component of the program. However, a lack of early clarity and structured planning for the Family Partnership Worker role within the program led to varying interpretations of the role which required subsequent corrections to maintain fidelity. This then contributed, in at least one site, to a sense that the Family Partnership Workers were not viewed as partners with complementary roles who shared the delivery of the program. This view then impacted on how the program was interpreted and implemented.”

²⁷ Source: *Health@Home Plus Program Reference Group, 29 October 2007 Meeting, Draft outcomes*

Advice from interviews with CEOs of early implementation sites was that the decision to include an Indigenous health worker in the ANFPP team (the Family Partnership Worker) was the result of direct representations by them to OATSIH. They were concerned that the absence of an Indigenous worker from the program would both inhibit some mothers from agreeing to a home visitation program and also contravene their organisational position on employment of Indigenous workers. Advice received through consultation was that the program would not have been accepted in some sites if an Indigenous worker was not included in the team.

In fact, this view was borne out in site consultations, with all sites (mothers and staff) strongly validating the role. Family Partnership Workers were viewed as essential partners in the home visiting team and valued for the part they played in:

- ▶ Promoting the program in the community
- ▶ Explaining the program to eligible mothers and gaining consent
- ▶ Easing the entry of the Nurse Home Visitor into the family
- ▶ Understanding and interpreting local cultural matters and keeping Nurse Home Visitors culturally safe
- ▶ Interpreting in community language
- ▶ Developing locally appropriate resources

The achievement of outcomes for the NFP is dependent on a successful Nurse Home Visitor/Mother dyad and the addition of the Family Partnership Worker could be considered a risk in maintaining that relationship as intended. In reality, there was no evidence of this occurring, with mothers interviewed describing a strong primary relationship with the Nurse Home Visitors and a positive but different relationship with the Family Partnership Workers. These relationships were described in one site as “complementary” but not substitutable.

Because the Family Partnership Worker role was a new role, included in response to site representations, it was not able to be clearly defined at the commencement of the program. There did not appear to be a structured planning process at the national level prior to implementation to inform how the position would be incorporated into the program.

There was an overarching view at commencement of the pilot that the Family Partnership Worker role would primarily be a cultural brokerage role, enhancing access for Nurse Home Visitors into the family, providing advice on cultural issues and helping to promote the program in the local community. This role was not initially supported by role-specific training and other infrastructure. Although this is understandable, considering the extent and timing of activities required to support sites to the point of program implementation, this early lack of structure allowed differing interpretations of the role across sites. This was particularly the case where the role was a new concept for sites and/or where there were challenges in understanding the role of the Nurse Home Visitor. In at least one site, the national process of reviewing and defining the role of Family Partnership Worker has resulted in local Family Partnership Workers feeling their role is minimised and undervalued. This appears to have influenced their interpretation of the Family Partnership Worker Guidelines and has, in effect, limited access for mothers to this valuable component of the program.

The Family Partnership Worker Guidelines were developed in consultation with sites and went some way to clarifying and validating the role nationally, however some work is now required to assist those sites where interpretation of the role has extended beyond that

considered suitable for the program and its outcomes. As the Family Partnership Worker role is still developing, it will require review and reconsideration in future evaluations.

Recommendation 8: Work on defining and validating the role of the Family Partnership Worker should continue to ensure the role is built into the program in an integrated and clearly defined way that still allows for some local flexibility based on client needs and preferences. Program material should contain a clearly articulated recognition that Family Partnership Workers and Nurse Home Visitors share delivery of the program and their roles are different but equally valued. Action should be taken to address specific issues with the Family Partnership Worker role where these are impacting on the effectiveness of the program.

4.9 Multiparous mothers

Finding 9: There were valid reasons for retaining the inclusion of multiparous mothers in the eligible population for the ANFPP.

Generally speaking, there was a movement away from the inclusion of multiparous mothers in the eligible target group for the program. The evidence from the US does not support the inclusion of multiparous mothers. The Wave 2 site did not include multiparous mothers in the target group. Some sites, including referring agencies at those sites, indicated that older and multiparous mothers were more likely to either refuse the service when offered or to drop out of the program.

Notwithstanding this, there are home visiting programs in Australia that do successfully target multiparous mothers²⁸ and some sites in this evaluation considered that multiparous mothers (under specific circumstances) were able to benefit from the program and that the option to offer the service to these mothers should be retained. These circumstances tended to be related to mothers either not having had the opportunity to parent earlier children (deaths or removal of children) or where they had voluntarily identified a need for the program and self-referred. In a sense, the readiness to learn and willingness to change were critical factors and where these were in place, it appeared multiparous mothers were benefiting from the program.

This adaptation, while not applied in all sites, appears to have enabled access to the ANFPP for suitably motivated multiparous mothers who then benefited from the program.

Recommendation 9: The inclusion of multiparous mothers in the ANFPP eligible target group should be maintained as an adaptation and reviewed regularly.

4.10 Program variation - visits outside the home

Finding 10: There were situations where it was not possible or appropriate to provide visits in the home and, in response, ANFPP teams met with mothers in alternate venues. This variation was considered essential to continue visiting these mothers.

The program model requires that visits are held in the home of the mother. Home visits enable the Nurse Home Visitor to understand and adapt materials to the environment in which the client and her baby live, and increase the applicability of taught skills and behaviours because they are learned and practiced in the real life context of the home.

²⁸ Kemp L, Harris E, McMahon C, et al., *Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial*, Arch Dis Child (2011) Downloaded from adc.bmj.com on April 7, 2011

Most sites found that there were times when it was not possible or appropriate to provide visits in the home. There was a relatively high rate of homelessness in the mothers in the program, masked by the fact that they were accommodated in the homes of relatives. However, staying with a relative often meant the mother had no rights in the household and it was inappropriate for her to invite visitors into the home. In some cases, the home environment was chaotic and crowded and it was difficult for mothers to concentrate or to speak about private matters. There were also situations where home environments were volatile and unsafe for home visiting.

In response to these situations, some sites established home-like visiting spaces in their offices or found safe alternative venues to meet with mothers. This variation was considered essential to be able to continue seeing mothers with accommodation problems. While this is an appropriate response to the unique situations of some mothers, this variation requires close attention to ensure that alternate venues do not become the preferred site for visits for reasons of convenience or relative attractiveness. One site undertook a quality improvement activity to be sure that visits outside the home were necessary and found this was the case.

Recommendation 10: Ideally visits should occur in the home; however the use of alternate venues for home visitations should be allowed to continue, where it is justifiably based on the individual housing situation of mothers and babies.

4.11 Resource development

Finding 11: Sites produced some excellent culturally suitable resources, but there did not appear to be a formalised process for sharing resources developed in one site with other sites. This meant there was potential for duplication of effort in developing specific resources.

ANFPP staff developed specific resources to assist in home visiting that met the variable nature of the client group. Some mothers had high literacy levels and some had low literacy levels. For some mothers, English was their second language. For some mothers and their families, concepts in the curriculum material may have been culturally irrelevant.

Adaptation of resources, for example the replacement of words with pictures, was required for use with mothers with low literacy levels. In other cases, there were specific local cultural adaptations. There were also cases where resources were developed to specifically address a curriculum component that was considered sensitive and difficult, for example to assist in talking about domestic violence.

Sites generally encouraged their teams, in particular Family Partnership Workers to develop these locally suitable resources. Most sites noted that the time to do this work was being reduced as the program gathers momentum and their client numbers increase. However this local material adaptation appeared to play an important role in maintaining relevance for mothers who would otherwise struggle with existing materials.

Sites were aware of some of the resource development in other sites but there did not appear to be a formalised process for sharing resources developed in one site with other sites, which addressed issues such as intellectual property rights. As long as sharing of applicable resources is not systematised, there is a risk of duplication of effort. There are copyright and intellectual property issues to be considered, particularly where sites may be using locally developed resources that are not specifically linked to or developed solely for the ANFPP.

Recommendation 11: In order to maximise effectiveness and reduce duplication of effort, a formalised process for sharing resources across sites, which addresses issues such as intellectual property rights, should be established.

4.12 Program governance in sites

Finding 12: Where there was strong governance from Board level down to service delivery level and the ANFPP was deliberately embedded into the existing site service system, program issues were identified and managed faster and more effectively. In some sites, understanding of the program at senior level and organisational governance structures established for the ANFPP were not sufficient to manage the additional demands of the program.

4.12.1 Board and CEO

It is normal to experience multiple teething problems where a program is untested in the environment in which it is being implemented. The pressures experienced in implementing a new program can include dealing with fear of change, and reluctance to change the status quo, the stresses associated with implementation of new methods and processes, and uncertainty as to whether the right decision was made to take on the program²⁹.

The ANFPP was a new program, based on principles and practises that were not familiar to the implementing sites. The structured nature of the program, its focus on early intervention and prevention rather than treatment, and the requirement for fidelity to the program elements was challenging for senior managers and staff. At the point of choosing to apply for the ANFPP, some sites did not necessarily understand the extent to which the program differed from and would impact on their usual ways of working, although all Boards welcomed it as an opportunity to enhance services to their communities.

There was a process, which included members of the Leadership Group, whereby the program was described and explained prior to sites choosing to apply, however this did not completely address or prevent issues related to not fully understanding the intent and processes of the program. The process did not appear to be enough to help sites develop a proper understanding of ANFPP prior to acceptance into the program - particularly the differences between it and other child health/home visiting programs already in place.

Even in those sites where there was a clear understanding of the preventative and empowering nature of the program, the extent to which this guides program activities was not fully understood at the time of implementation and required ongoing attention and adjustments. In some sites, the governance structures were not adequate to manage poor performance and staff conflict or to address misalignments between organisational philosophy and the structure of the ANFPP.

ACCHOs work within a philosophy of self-determination evidenced by Aboriginal and Torres Strait Islander community control through community Boards. Some sites considered that there was a misalignment between their organisational philosophy and the implementation of a program that is nurse-led and therefore, in the main, led by non-Indigenous staff. This issue of Aboriginal-led versus non-Aboriginal-led programs was not an issue in all sites and the position of the Family Partnership Worker relative to the rest of the team was dealt with

²⁹ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231). Accessed online at <http://centerforchildwelfare.fmhi.usf.edu/kb/Implementation/Implementation%20Research%20-%20A%20Synthesis%20of%20Literature%20-%202005.pdf> 10/10/11

differently in different sites, reflecting the different positions taken within the overarching philosophy of self-determination.

The ANFPP is a relationships-based program and this supportive relationship needed to be modelled within organisations as well as between ANFPP staff and their clients. In one site the observation was made at Board level that “we support the staff, the staff support the mother and the mother supports her baby”. It was evident that ANFPP staff, particularly the Nurse Supervisor, benefited from organisational support in order to effectively implement a program that was new to themselves as well as new to their organisations.

Where this executive support was not in place, there appeared to be a greater likelihood that issues would not be picked up early and would escalate to the point of staff leaving the program. Staff turnover has had a direct impact on the success of the program, with sites that experienced periods of staff turnover also experiencing related dips in client retention rates. Two sites experienced poorly managed staff conflicts, which resulted in staff leaving the program and contributed to an extended period of instability and organisational reconsideration of the program.

4.12.2 Organisational structure

Each of the implementing sites positioned the ANFPP within an existing program structure, specifically within a program area or division that addressed women’s and maternal/children’s health. Existing Program Managers or Co-coordinators within each implementing site were delegated overarching accountability for the program. Where organisations did not readjust their existing programs, this effectively added another direct report and accountability for an additional program to the work load of the Program Manager/Co-ordinator and created a potential overlap with existing services.

Positioning the ANFPP within an existing program, in some cases, required organisational adjustments in order to allow the program to operate in the way it was intended. For example, the roles of Nurse Home Visitors and their relationship with Family Partnership Workers were new to most of the sites, and existing procedural guidelines were not necessarily applicable to all the activities of the ANFPP.

The approach to incorporation of the ANFPP into existing services differed from site to site. In one site an existing service was reshaped in order to deliver ANFPP as a replacement for an existing home visiting service. This required intensive preparatory work and community consultation but resulted in the ANFPP being well-integrated into the organisation’s suite of services and retained experienced nurses and Indigenous health workers.

Another site, having experienced some issues related to the separation of the ANFPP from its partner services, recognised the underlying governance issues with its current structure and is now restructuring in order to embed the ANFPP fully into existing services.

In most cases the ANFPP was housed separately from other related ACCHO services and in some cases the physical separation contributed to the program being poorly understood and led to an organisational sense of the program as separate and different. This was exacerbated by different (generally higher) pay rates for ANFPP staff compared to other staff within the ACCHO and the relative wealth of the program compared to other programs.

4.12.3 Community Reference Group

The program was expected to be supported by a Community Reference Group. Not all sites specifically convened a Community Reference Group, with some using existing reference groups. The role of the Community Reference Group includes advising on how the program could be improved locally; and providing advice on recruitment of clients. Where these groups were not established, sites may have missed opportunities to strengthen community input and involvement in the program.

Recommendation 12 Future site selection should include an assessment, conducted with the site Executive, as to whether it has the required philosophy and governance capability to implement the program as prescribed. Discussion should include:

- ▶ the core mandatory elements of the program;
- ▶ the importance of senior staff in governing and sponsoring the program;
- ▶ the expected roles of staff in the program;
- ▶ expectations for data collection, reporting and client consent; and
- ▶ expectations for training, reflective practice and external supervision of staff.

Program fit in sites and within the broader service system should be explicitly explored by the Board and senior staff at application for selection and again as part of the initial planning process. Focused organisational development and support should be provided where sites understand and are committed to the program but need to develop additional governance capability.

4.13 Recruitment and retention of staff

Finding 13: Selecting the right staff was critical for effective program implementation and operation, with poor staff selection putting program implementation at significant risk. In addition to professional qualifications, staff also required personal qualities and experience suitable to the role. There was a significant flow on effect where staff, especially Nurse Supervisors, did not have the necessary professional, experiences or personal qualities to undertake their roles in the program. Where sites did not fully understand the ANFPP and the staff requirements there was a risk they might miss critical requirements in selecting for a position.

4.13.1 Selecting the right staff

Recruitment and retention of appropriate staff was an issue for most sites. One of the issues confronted by ACCHOs was the size of the suitably qualified and experienced recruitment pool for Nurse Supervisor, Nurse Home Visitor and for Family Partnership Worker positions. Because there were no experienced staff in Australia to take up ANFPP roles, recruiting the right person in the first place and then building that person's skills and capacity in the program appeared to be a major success factor.

Experience showed that it was worth waiting and re-advertising if necessary for the right person for the position rather than recruiting from available, but not necessarily suitable, applicants for expediency. From their experience, sites and the Support Service found that there were key skills, experiences and personal characteristics required for success in the program. For nurses these included:

- ▶ nursing qualifications and relevant experience;
- ▶ cultural competence and experience working successfully with Indigenous communities, preferably in a community controlled organisation;
- ▶ experience in a similar program or in home visiting services; and
- ▶ the capacity to reflect on their own practice and adapt to a new way of working.

It was evident that Nurse Supervisors also required additional skills in leadership and management, including performance management and conflict resolution. The role of the

Nurse Supervisor in establishing and supporting fidelity, maintaining the team and leading by example was identified by all sites as critical in retaining a well-functioning team.

4.13.2 Understanding the requirements of the role

During the initial establishment phases of the program, some sites recruited staff without necessarily fully understanding what would be required of them in the program. In some cases there was a mismatch between the requirements of the program and the skills and capacity of the staff selected. Examples were provided of cases where Nurse Supervisors did not understand or did not adhere to the core elements of the ANFPP and provided ambiguous or contrary direction to the team. This increased difficulties for staff already trying to work within a new and different paradigm.

Other examples were given where Nurse Supervisors did not appear to have the necessary skills to manage internal staff conflict. This is a significant issue and requires ongoing attention as the flow on effects from poorly managed staff issues included high staff turnover, team disruption, loss of program knowledge and delays or breaks in client recruitment and service delivery.

There are now enough experienced personnel within the Support Service and across the sites, for any selection panel to include at least one person who can be considered knowledgeable about the program and understands the requirements of the position being recruited. The use of the support service on selection panels was optional in relation to the recruitment process but is now mandated in new contracts. There may also be benefits in including a panel member at the appropriate level (either from the site in question or another site), who has direct experience in delivering the program.

Recommendation 13: Selection panels for ANFPP positions should include a panel member who has a full understanding of the ANFPP and the requirements of the position being recruited. In the early stages, this may require the involvement of a panel member external to the ACCHO.

4.14 Nurse Home Visitor role

Finding 14: There was a view held by some nurses and staff in some sites that ANFPP work was not nursing work because it did not require nurses to exercise traditional nursing or midwifery “clinical” skills. In some cases this led to a perception that the role could be undertaken by other workers and that the nurses were being underutilised by not delivering “clinical” care.

Nurses were more likely to consider the work in ANFPP as underutilising their clinical skills if they had previously worked in a strongly clinical treatment role, in an inpatient role or were now working in a site where there were challenges in understanding the role and function of the Nurse Home Visitor in the ANFPP model.

Staff in some sites were more likely to consider that that the role of home visitor could be undertaken by any appropriately trained and experienced worker where sites had not historically employed nurses or where sites had previously focused on treatment rather than preventive models. This view was exacerbated by a perceived difference in the value of hands on physical treatment work compared to preventive, psychosocial work. Where the nurse role was poorly understood or not supported, this had the effect of sites potentially undervaluing the importance of having a nurse undertake the home visiting role and a blurring of the boundaries between the Nurse Home Visitor role and the Family Partnership Worker role.

The efficacy of using paraprofessionals instead of nurses in the NFP was tested in a three armed randomised trail conducted in Denver in 1994/95³⁰. The results of this study demonstrated that, in the main, paraprofessionals did not achieve statistically significant improvements in measured outcomes (other than mother/child interaction where mothers had low psychological resources) and that for most outcomes where nurses achieved a positive effect, the effect of paraprofessionals was about half of that.

This study has not been replicated in Australia however these results do support the nurse role in home visiting. In Australia there are specific skills that are taught to nurses and reinforced in their practice that provide them with a practice framework for understanding and delivering program content and maintenance of professional boundaries. As in the US, nurses are highly respected as a professional group, which can validate the information they provide in the program.

There is a high degree of dependency on the Nurse Supervisor to validate and promote the role of the nurse as the primary home visitor in the ANFPP. This needs to be supported within the organisation by Program Co-ordinators and site executives.

Recommendation 14: The role of the Nurse Home Visitor should be validated and badged as nursing care, acknowledging that there are specific skills taught to nurses in their training and reinforced in their practice that are considered essential in this model (as supported by evidence) and cannot be replicated by a non-nurse.

4.15 Training

Finding 15: Staff had access to the training required to deliver ANFPP; however specific issues were consistently raised in consultation with sites, including a perceived need for more physical face to face networking, increased practical skills development and supervised opportunities to practice new skills in:

- ▶ for Nurse Home Visitors and Family Partnership Workers, undertaking a home visit;
- ▶ for Nurse Home Visitors, NCAST and parent education using PIPE;
- ▶ for Family Partnership Workers, those unique aspects of their role as described in the FPW Guide;

Nurse Supervisors had a key role in ensuring skills development was locally reinforced and that local learning continued, including practical skills development and supervised practice.

4.15.1 Delivery of ANFPP training

Mandatory ANFPP specific training was required prior to home visits commencing and was provided to the sites by the Support Service. Nurse Supervisors, Family Partnership Workers and Nurse Home Visitors undertook periodic training for the first 6 months of their employment. There was a clear recognition amongst ANFPP staff that the mandatory training was essential for them to be able to successfully undertake their work. It is worth noting that the program requires a minimum of 2 years of practical application from start up to work through all the home visit material, and probably longer than that to achieve a sense of mastery over the entire program.

³⁰ Olds, D., Robinson, J., O'Brien, R., Luckey, D., Pettitt, L., Henderson, C., Ng, R., Sheff, K., Korfmacher, J., Hiatt, S., Talim, A. *Home Visiting by Paraprofessionals and by Nurses: A Randomised Controlled Trial*, Pediatrics, 2002, 110, pp486 - 496, Downloaded from www.pediatrics.org on March 4, 2010

Initially training was provided en masse in central venues to which staff were flown, supported by visits to sites. Because the program was new, the Support Service trainers were learning the program as they were training the first wave of ANFPP teams. This may have made it more difficult for teams to grasp the underpinning concepts of the program and how they were to be applied in their home settings. Learnings from the first round of training were incorporated into the next round and adaptations made accordingly.

The method of delivery of training changed after the initial mass recruitment, in order to improve cost effectiveness. Most training after this was provided remotely, on-line and through the virtual classroom - Elluminate. The Support Service developed on-line training to supplement the hard-copy program materials. The on-line training was accessible by all staff members and included assessments so that the Education Team could determine who had completed the training satisfactorily.

Limited face to face training was still available, with each staff member attending face to face training at least once in the first six months. This was designed to help staff to practice skills, share experiences and learn from staff in other sites. Feedback from some staff was that they missed having more opportunities to network with each other by being physically in the same space and informally talking through issues. This may partially have been related to the fact that the ANFPP was new to all stakeholders and there was no locally available pool of long term experienced workers to provide feedback and informal support to the teams.

There were some technical communication issues associated with the use of Elluminate that complicated staff reactions to using this as an alternative to physical face to face contact. These included poor access to the internet and local organisational policies that limited how well staff could access Elluminate. One team went for several months with teleconference access only. Situations such as this undoubtedly contributed to an expressed belief that the on-line training was in some sense less effective than the initial face to face training provided to the first teams in the first wave. Nevertheless the cost of providing centrally located training once the initial cohort was recruited and initial training completed would likely have been prohibitive.

Areas where staff expressed most concern regarding the acquisition of ANFPP skills included:

- ▶ the need for Nurse Home Visitors and Family Partnership Workers to have more opportunities to practice skills prior to undertaking their first home visit;
- ▶ the need for practical skills development on how to do a home visit as well what content to deliver at a home visit;
- ▶ a perceived need for additional training in PIPE and NCAST as these were new skills that were outside the previous experience of many of the Nurse Home Visitors and Nurse Supervisors;
- ▶ a perception that on-line training did not deliver the same degree of confidence as face to face training;
- ▶ a requirement for specific training for Family Partnership Workers to equip them for the unique aspects of their role, for example community development;
- ▶ continued inclusion of Family Partnership Workers in existing ANFPP training modules where these related to their role; and
- ▶ the importance of the Nurse Supervisor in ensuring that local learning continued, including opportunities for practical skills development.

While on-line training appeared to be suitable for content acquisition, some staff indicated that they missed having more opportunities to practice their skills, interact with other ANFPP staff and learn from each other. To balance this, other staff expressed relief that they did not have to spend extended periods away from home for training.

Recommendation 15: Further attention should be paid to ensuring ongoing practical training and practical supervision of skills development in those specific skills that could be considered “new” to Nurse Home Visitors, particularly those required for NCAST and PIPE and in those skills specific to Family Partnership Workers.

4.16 Monitoring and reporting

Finding 16: Sites identified deficits in the existing data collection, with some areas such as time for supervision by the Nurse Supervisor of Family Partnership Workers; and number of self-referrals into the program not being recorded. Self-referrals in particular are one indicator of community acceptance. Data that might inform program outcomes has not yet been made available for evaluation purposes

The overarching objective for monitoring and data collection is to provide reports to monitor fidelity of the ANFPP to the Nurse-Family Partnership (NFP) model in order to support implementing sites to monitor their own progress and improve performance wherever possible. Achieving this state was a work in progress, with gradual improvements in data quality leading to higher degrees of relevance in fidelity reports developed for the sites. Sites provided these quarterly fidelity reports to OATSIH as part of their reporting requirements and could also use them to identify areas where they were not meeting fidelity targets so they could work to address these.

In most sites, it took time to reach the point where reliable and valid Fidelity Reports were being generated based on the program data collection system. This was due to a range of factors, including:

- ▶ incorrect completion of data collection forms;
- ▶ inaccurate transfer of written data to the electronic version, exacerbated by differences between the hard copy form and the electronic form; and
- ▶ incorrect data interpretation in developing the reports; and
- ▶ ambiguity in the purpose and use of the data collection.

In most implementing countries, the data collection, as prescribed by the NFP, is used to inform research on the program, most particular the required RCTs. In Australia, the program was not viewed as a research project but as a program within a wider suite of funded programs. Thus the purpose of the data collection was ambiguous and this impacted on the view taken of its benefit and potential for use. There are still issues associated with the publication of data available from the program, and these need to be addressed.

The programmatic approach, however, does open the door to additional data collection designed to measure items of importance for the program in the Australian Indigenous context.

For example, some sites expressed concern that the work of Family Partnership Workers was not adequately reflected in data collection and reporting and that the Fidelity Reports were not a complete record of ANFPP activities. As these were the most regularly referenced and most visible reports on the program, they felt this rendered the work of the Family

Partnership Workers invisible. It also did not allow Nurse Supervisors to fully record the time they spent in reflective practice or other forms of supervision with Family Partnership Workers.

Some sites were concerned that there was no category for self-referrals when recording the source of referrals to the service. This was considered an issue because self-referrals were increasing and were one indicator of the level of acceptability of the program in the community.

Sites and the Support Service both noted that the number of cigarettes smoked should also be measures, along with whether a client is smoking or not. This was because they were aware of reductions in the numbers of cigarettes smoked by mothers as a result of the program. Another measure of success suggested by one site was the increase in instances where mothers were the primary carer for their baby rather than this role being undertaken by the maternal grandmother (described as a common practice locally). This was considered indicative of increased maternal self-confidence.

In recognition of the lack of access for some mothers to any form of income, there was a request for the inclusion of a "Zero Income" or Limited Access to Own Finances" category in the income questions.

There were several suggestions for improvement of the reporting process. These included:

- ▶ incorporating missing data items as identified above into the data set;
- ▶ removing differences between the written and electronic data forms;
- ▶ including a story telling component, using a standardised tool if available, and
- ▶ ensuring staff understood how the fidelity reports can assist in service improvement.

Recommendation 16: Attention should be given to including in the data collection those activities which, while not in the original suite of reporting requirements for the program, have been identified as measures of significance to sites. Barriers to using the current data collection for ongoing reporting and evaluation should be identified and addressed as soon as possible.

5. Conclusion

Two questions are being asked of the overall evaluation of the ANFPP. They are:

- ▶ To what extent is the ANFPP an appropriate and effective program that supports the long term health outcomes of Aboriginal and Torres Strait Islander mothers and their babies?
- ▶ Is the ANFPP suitable for broader implementation in Australia?

This Stage 1 Formative Evaluation begins to answer those questions, through an evaluation of the processes and activities involved in planning, funding, purchasing and providing ANFPP services across the four Wave 1 and Wave 2 implementing sites. There is limited reliable quantitative data available on the program activities and objectives, and this was referenced for the evaluation, however much of the early information used for this evaluation was qualitative.

The ANFPP is an evidence based program that required fidelity to its key elements in order to achieve expected outcomes. Historically ACCHOs are grass roots organisations, directed and led by their communities through Community Boards. In most cases, historic local practice has been to either develop locally driven programs based on local capacity and resources or to select and adapt programs, again based on local capacity and resources. The ANFPP was a radically different approach to this in that the program was imported into the implementing sites as a complete package, with very little ability to make major adaptations other than those already agreed with Professor Olds.

This in itself was a major challenge for organisations, which tested their governance and their organisational capability. Nevertheless, in all but one site the services were overwhelmingly positive about the program, felt it had made real differences to their communities and believed they had addressed or were addressing the organisational challenges it had provided them.

Observations and qualitative information from mothers and families supported this view, with mothers interviewed expressing increased confidence in their own abilities as mothers and demonstrating connected and responsible mothering.

There were significant costs associated with the program's establishment and as long as the number of sites remains small and the number of clients below the desired ratio, it will continue to be a costly program. It is too early to make any judgement about the return on investment for the program as it is still establishing itself, but this would need to be considered in future evaluations when there is an acceptable amount of reliable data. However, with only 3 sites intending to continue with the program, there is a risk that the program will not be able to be adequately tested in the Australian context. In addition, the cost of the program, when apportioned out to a per client basis will be very high and sunk investments to this point will not be fully realised.

Increasing the client base to the point where economies of scale can be realised would also provide a more robust base for evaluation of the program's effectiveness. However this may require reconsideration of either the target population or the service delivery model or both.

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7. Appendix A - Formative Evaluation Questions

Key Evaluation Questions	Key Sources of Information	Data collection method
Planning of the ANFPP		
What are the objectives of the ANFPP (i.e. what problems is it intended to address)?	Government policy statements and program documentation prepared by OATSIH.	<ul style="list-style-type: none"> ▶ Review of policy statements and program documentation ▶ Interview with OATSIH officers
How does the ANFPP seek to address those problems?	NFP and ANFPP program logic models.	<ul style="list-style-type: none"> ▶ Review of NFP and ANFPP program logic models ▶ Interview with OATSIH officers
What process was used to develop the governance arrangements for the ANFPP?	Discussions with OATSIH and ACCHOs as well as program documentation on proposed governance arrangements.	<ul style="list-style-type: none"> ▶ Review of program documentation ▶ Interview with OATSIH officers ▶ Interview with ACCHO Executive
What processes were used to plan the organisational capacity required to implement and operate the ANFPP at both the Commonwealth Government and individual site levels?	Information on the skills and experience of those involved in the management of the ANFPP will be obtained from each of the sites as well as information from OATSIH, ANFPSS, ACCHOs and other key stakeholders	<ul style="list-style-type: none"> ▶ Review of program documentation ▶ Interview with OATSIH program officers ▶ Interviews with ACCHOs ▶ Interviews with Support Service personnel
What process was used to identify the pilot sites to trial the ANFPP?	Site Selection Guidelines for the ANFPP.	<ul style="list-style-type: none"> ▶ Review of site selection guidelines ▶ Interview with relevant OATSIH officers ▶ Interview with Reference Group?
What process was used to forecast the demand for services at each of those trial sites?	Information from OATSIH and ACCHOs on actual and forecast demand for ANFPP services.	<ul style="list-style-type: none"> ▶ Review of site selection recommendations ▶ Interview with OATSIH officers ▶ Interview with Reference Group?
Budgeting and Funding of the ANFPP		
<ul style="list-style-type: none"> ▶ What approach was used to develop budgets and determine appropriate levels of funding for each of the sites? ▶ To what extent is the actual cost of service provision tracking against forecast costs and what are key reasons for any observed differences? ▶ What are the forecast and actual unit costs of service delivery at the program level and for each of the sites? 	Information from OATSIH and ACCHOs on: <ul style="list-style-type: none"> ▶ the development of the overall ANFPP budget and the budgets for each site; ▶ the extent to which actual expenditure at the overall program level and at each of the sites is following forecast trends; ▶ the forecast unit costs of service provision and the extent to which actual unit costs deviate from forecast; ▶ the extent to which actual unit costs of service provision 	<ul style="list-style-type: none"> ▶ Completion of financial information spreadsheet provided by EY to OATSIH, Support Service and ACCHOs ▶ Interviews with OATSIH program officers ▶ Interviews with ACCHO Executive

Key Evaluation Questions	Key Sources of Information	Data collection method
	fall with increases in the number of clients serviced (i.e. the extent of "economies of scale").	
Purchasing of ANFPP services		
<ul style="list-style-type: none"> ▶ What processes have been used to develop the purchase agreement between OATSIH and each of the ACCHOs responsible for the provision of ANFPP services? ▶ To what extent is that purchase agreement consistent with best practice approaches to performance based contracting? 	<ul style="list-style-type: none"> ▶ Copies of the documents that together outline the nature of the purchase agreement between OATSIH and the ACCHOs involved in the provision of ANFPP services. ▶ Information on the experience of OATSIH and the ACCHOs with the application of that purchase agreement. 	<ul style="list-style-type: none"> ▶ Review of funding and performance agreements/ contracts and related documentation ▶ Interview with OATSIH officers and ACCHO Executive
Implementation and initial provision of ANFPP services		
<p>To what extent do ACCHOs have access to sufficient levels of funding and resources to supply the planned quantities and types of ANFPP services?</p> <p>i.e. How are the levels of funding and resources used by ACCHOs to deliver ANFPP services?</p>	<p>Information on:</p> <ul style="list-style-type: none"> ▶ the actual costs of providing ANFPP services and the availability of capital and labour with suitable skills and experience and the feasibility of the planned time allocations of staff across alternative activities (e.g. service provision as opposed to training, travel, and time wasted through broken appointments with clients); ▶ the results of process evaluations and reviews of training programs; ▶ the ANFPP Support Service, including but not limited to AusVoc, Notre Dame and James Cook University; ▶ how appropriate current training courses and materials are in meeting training needs from the view of ACCHOs, Nurse Supervisors, Nurse Home Visitors and Family Partnership Workers; ▶ ANFPP staff from the ANFPP Staff Member data set. 	<ul style="list-style-type: none"> ▶ Completion of financial information spreadsheet provided by EY to OATSIH, Support Service and ACCHOs ▶ Review of position descriptions for NS, NHV and FPW for each site and data collected for fidelity purposes ▶ Interview with NS and/or ACCHO Program Co-ordinators ▶ Information on NHV activity either through review of documents or use of a time diary by selected NHV and FPWs for 2 weeks. ▶ Review of training documentation and process evaluations, issues logs etc for training. ▶ Interview with relevant Support Service personnel ▶ Interviews with ANFPP staff and ACCHO executive
<p>Is the actual organisational capacity and culture sufficient to deliver the program as planned?</p>	<p>Information on the skills and experience of ACCHO management as well as the views of OATSIH, ANFPSS, ACCHOs and other key stakeholders on these issues.</p>	<ul style="list-style-type: none"> ▶ Completion of financial information spreadsheet provided by EY to OATSIH, Support Service and ACCHOs ▶ Interviews with OATSIH program officers, ACCHO executive, ANFPP staff, Support Service personnel
<p>To what extent is the ANFPP providing services to the target population? (e.g. to what extent is the target population being referred to the program?).</p>	<p>Program Referral and Outcome data set, containing:</p> <ul style="list-style-type: none"> ▶ Information on the extent and source of referrals: ▶ Information on the outcome of each of those referrals ▶ Number of referrals of individuals who do not meet the program criteria. 	<ul style="list-style-type: none"> ▶ Review of fidelity reports ▶ Interview with ANFPP staff ▶ Interview with mothers and families

Key Evaluation Questions	Key Sources of Information	Data collection method
<p>To what extent has the ANFPP been implemented in the manner planned? In particular:</p> <ul style="list-style-type: none"> ▶ What is the nature and extent of any difficulties that have been experienced by ACCHOs when seeking to implement the ANFPP as planned? ▶ What is the nature and extent of any changes that have had to be made to planned implementation arrangements to deal with those problems? ▶ To what extent have sites had to vary the planned approach to implementing the ANFPP to address those problems? ▶ To what extent have sites sought and received approval from OATSIH for those changes to the planned approach to implementing the ANFPP? 	<p>The primary source of information on the implementation of the ANFPP will be our interviews with OATSIH, ACCHOs and with the ANFPP Support Service, including but not limited to B Schmidt and Associates. .</p>	<ul style="list-style-type: none"> ▶ Review of fidelity reports ▶ Interviews with OATSIH program officers ▶ Interviews with ACCHO and ANFPP staff ▶ Interviews with Support Service personnel
<p>To what extent are the planned types and quantities of ANFPP services being provided?</p>	<p>Home Visit Encounter/Telephone encounter data set</p>	<ul style="list-style-type: none"> ▶ Review of fidelity reports ▶ Interview with Support service personnel ▶ Interview with ANFPP staff ▶ Interviews with mothers and families
<p>To what extent are ANFPP services being provided in the manner planned?</p>	<ul style="list-style-type: none"> ▶ Visit Implementation Scale data set ▶ Nurse Home Visitors information provided by the Supervision Progress Report 	<ul style="list-style-type: none"> ▶ Review of fidelity reports ▶ Interview with Support Service personnel ▶ Interview with ANFPP staff ▶ Interviews with mothers and families
<p>How efficiently are ANFPP services being provided? This will involve determining the extent to which:</p> <ul style="list-style-type: none"> ▶ the quantity of services provided is maximised for a given quantity of inputs (technical efficiency); ▶ the value of services provided is maximised for a given quantity of inputs (allocative efficiency); and ▶ the provision of ANFPP services is sufficiently flexible to maintain and improve its efficiency over time in the face of changes in the cost of and approach to service provision (dynamic efficiency). 	<ul style="list-style-type: none"> ▶ Calculations for elements of efficiency, including technical efficiency, informed by service activity data and financial data including: <ul style="list-style-type: none"> ▶ the unit costs of providing ANFPP services for each of the pilot sites; ▶ how those unit costs compare against “benchmark” unit costs (e.g. costs incurred by the least cost, most cost effective, provider of those services); and ▶ the extent to which differences in the cost of service provision across each of the pilot sites are due to factors largely within the control of ACCHOs and outside the control of ACCHOs. 	<ul style="list-style-type: none"> ▶ Analysis of financial information provided in spreadsheet against activity data and comparison of results across services

Key Evaluation Questions	Key Sources of Information	Data collection method
	<ul style="list-style-type: none"> ▶ Information on the extent to which the ANFPP is able to maintain and improve its efficiency in response to changes in costs and technologies ▶ Quantitative information combined with qualitative information from ACCHOs and ANFPPSS. 	
Initial client use of ANFPP services		
To what extent is the target population using the ANFPP services provided?	<p>Note: The evaluators may not have access to reliable information on the number of target mothers v's referred/enrolled clients and may have to use proxy measures such as:</p> <ul style="list-style-type: none"> ▶ Quarterly site fidelity reports. ▶ A range of other data sets including: Program Outcome and Referral, the Demographics (pregnancy intake) and specific items from Maternal Health Assessment (MHA03, MHA04). ▶ Qualitative information gathered from ANFPP staff at ACCHOs and from clients 	<ul style="list-style-type: none"> ▶ Review of fidelity reports and data collected for ANFPP ▶ Interviews with ANFPP staff
What are the key reasons why the target population is not using the ANFPP services provided?	<ul style="list-style-type: none"> ▶ Client Activity Status (CAS) data set and the Home Visit Encounter / Telephone data set items relating to Client Engagement; Partner Engagement; Client's Mother Engagement; and Other Family Engagement. ▶ Qualitative information gathered from ANFPP staff at ACCHOs and from clients including, where possible and appropriate, clients who have left the service or declined participation. 	<ul style="list-style-type: none"> ▶ Review of fidelity reports and data collected for ANFPP ▶ Interviews with ANFPP staff ▶ Interviews with mothers and families ▶ Interviews with referring agencies ▶ Interviews (if possible) with mothers who have declined the program or left the program
To what extent are ANFPP services complementary with other services?	<ul style="list-style-type: none"> ▶ Home Visit Encounter / Telephone Encounter data, which provides information of the referrals that the ANFPP makes to other services (i.e. ANFPP services and the services to which they refer clients are complementary services) ▶ Qualitative information sought from relevant community agencies 	<ul style="list-style-type: none"> ▶ Review of fidelity reports and other data collected for the ANFPP ▶ Interview with ANFPP staff ▶ Interviews with other identified agencies, especially other mother and baby programs, maternity and antenatal services

Key Evaluation Questions	Key Sources of Information	Data collection method
Outcomes arising from initial client use of ANFPP services		
To what extent are the services provided achieving the ANFPP objectives?	<ul style="list-style-type: none"> ▶ ANFPP data sets including: ▶ Health Habits data set ▶ Infant Birth data set ▶ Infant Health Care data set (IHC01 to IHC18). ▶ Data will be enhanced by qualitative information sourced from ANFPP staff, clients, families and community groups (where relevant and possible). 	<ul style="list-style-type: none"> ▶ Review of fidelity reports and data collected for ANFPP ▶ Interviews with ANFPP staff ▶ Interviews with support service personnel
To what extent are the services provided by the ANFPP able to meet differences in the needs of clients and changes in those needs over time?	Qualitative information gathered from ACCHOs, ANFPP staff on the extent to which they are able to tailor the services they provide to best meet the needs of clients. This information can be supported by information from clients and families where appropriate.	<ul style="list-style-type: none"> ▶ Interviews with ANFPP staff ▶ Interviews with mothers and families
Monitoring and review of the ANFPP		
<ul style="list-style-type: none"> ▶ What problems have been experienced to date with the implementation and operation of the reporting process? ▶ What changes have been made to the reporting process to address those problems? ▶ What further changes could be made to the reporting process to improve its effectiveness and efficiency? 	<ul style="list-style-type: none"> ▶ Relevant reports, including Fidelity Reports, Progress reports and minutes of relevant meetings. ▶ Information from OATSIH, ACCHOs and the Menzies Institute on the nature of changes made to date, as well as their views on any further amendments that might be desirable to improve the effectiveness and efficiency of the process. 	<ul style="list-style-type: none"> ▶ Review of fidelity reports and data collection group meetings, issues logs, ▶ Interview with ANFPP staff including NS/Program Co-ordinator, and Support Service personnel, particularly Menzies Institute ▶ Interview with OATSIH program officers

8. Appendix B - Release notice

Ernst & Young was engaged on the instructions of the Commonwealth Department of Health and Ageing Australian Nurse Family Partnership Program ("**Project**"), in accordance with the consultancy agreement dated 16 August 2010.

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