CASE STUDY OF THE NGALA NANGA MAI PARENT GROUP PROGRAM

Strengths, challenges and implications for policy and practice
Case Study of the Ngala Nanga Mai pARenT Group Program: Strengths, challenges and implications for policy and practice

This case study was conducted and this report co-produced as an interactive partnership between the project team at:

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With funding provided by:

Department of Families, Housing, Community Services and Indigenous Affairs
Commonwealth Government
Canberra, Australian Capital Territory

The authors gratefully acknowledge the support of the Aboriginal Health & Medical Research Council of New South Wales
Acknowledgements

This work was done on the land of the Eora people who are and always will remain the Traditional Owners of the Land where the city of Sydney now stands.

This country is the only place in the world where Australia’s First Peoples belong, and there is no place in Australia where this is not true.

This case study aimed at all times to produce a mutually useful product out of a sharing partnership between The Ngala Nanga Mai pARenT Group Program and Muru Marri staff that truly reflects the knowledge and experience of Program developers and deliverers. We share the common goal that the story that has emerged is one that holds value to other Aboriginal and Torres Strait Islander youth programs that utilise empowering initiatives as a mechanism to promote young people’s capacity to enhance and maintain their social and emotional wellbeing, life skills and life trajectory in both positive and negative circumstances.

The University team expresses heartfelt thanks to the pARenT Group Program members, program organisers and service providers, the Sydney Children’s Hospital Department of Community Child Health and the La Perouse Advisory Health-Link Committee for giving their time generously to ensure the research team gained a clear understanding of the strengths and challenges faced by a program that aims to develop healing and empowering relationships with Aboriginal youth. Their trust and openness was tremendous and reflects a willingness to share their knowledge with others who may use it to help other programs become more effective, culturally safe and sustainable. We also wish to acknowledge the Aboriginal Health & Medical Research Council of New South Wales and the UNSW Human Research Ethics Committees for their support and approval of this research.

This case study was made possible by funding from the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). The authors have no conflicting interests to report.
Acronyms

AHEO  Aboriginal Health Education Officer
AHW  Aboriginal Health Worker
AH&MRC  Aboriginal Health & Medical Research Council of New South Wales
AIHW  Australian Institute of Health and Welfare
ASQ:SE  Ages & Stages Questionnaire: Social-Emotional
ECN  Early Childhood Nurse
FaHCSIA  Department of Families, Housing, Community Services and Indigenous Affairs
GEM  Growth and Empowerment Measure
Health Centre  La Perouse Aboriginal Community Health Centre
HREC  Human Research Ethics Committee
IQ  Intelligence quotient
K6  Kessler 6 Psychological Distress Scale
LSES  Low socioeconomic status
MM  Malabar Midwives
NHMRC  National Health and Medical Research Council
pARenT Group, group, Program, program  The Ngala Nanga Mai pARenT Group Program
PIO  Program Implementation Officer
SDQ  Strengths and Difficulties Questionnaire
SCH  Sydney Children’s Hospital
SESIAHS  South Eastern Sydney and Illawarra Area Health Service
SEWB  Social and emotional wellbeing
TAFE  Technical and Further Education
Abstract

Introduction

Programs that operate from a strengths-based, positive promotion approach to strengthen health, wellbeing and social cohesion have been shown to be effective interventions for Aboriginal and Torres Strait Islander communities and populations. However, despite a recent proliferation of such programs aimed at young people, rigorous evaluation that is empowering to participants is not demonstrated in the literature. The *Ngala Nanga Mai* pARenT Group Program, an innovative community health parent program, which utilises group artmaking sessions as a tool for engagement and building confidence, aims to positively influence young parents and their families by providing educational and social networking opportunities, and highly accessible health services. The first formal case study of the pARenT Group Program is currently underway. This report documents the methodological exploration undertaken to develop an appropriate research approach, describes baseline quantitative and qualitative findings and makes key recommendations for ways in which the program can be strengthened.

Methodology and methods

Care was taken to develop a participatory mixed methods approach appropriate and empowering to individual and organisational participants. Quantitative research processes included: analysis of routinely collected program data; collection and analysis of survey data from three formal measures (the Growth and Empowerment Measure, a measure of participant self-esteem and community connectedness; and the Ages and Stages Questionnaire: Social-Emotional; and the Strengths and Difficulties Questionnaire, to measure childhood social and emotional development). Qualitative research processes included: collection and analysis of focus group, semi-structured interview and testimonial data.

Findings and discussion of the implementation process

Initial findings on children’s health status, parental wellbeing and childhood social-emotional development are included in this report, as are categories arising from baseline qualitative data, which explore program establishment steps, transitions and adaptations over time, current processes, program impacts and strengths, program challenges for effectiveness, growth and sustainability, the program’s true potential and what it needs to be able to fulfil this potential. Triangulation, reflexivity and respondent validation employed to increase rigour are also described; and reflections are made on the qualitative data collection process.

Conclusion

The findings demonstrate that this study was appropriately designed and worked successfully within the *Ngala Nanga Mai* pARenT Group Program to provide initial evidence of its strengths and impacts on participants. It also identified important challenges faced by the program and possible ways forward so that it can continue sustainability in its provision of empowering opportunities for young parents.
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Introduction

This report details the methodological design and findings of the case study of the *Ngala Nanga Mai* pARenT Group Program, an innovative community health young parent program located in the Aboriginal community of La Perouse, New South Wales. It utilises group artmaking sessions as a tool for engagement and building confidence, and aims to positively influence young parents and their families by providing educational, social networking opportunities and highly accessible health services. The research informing this case study has met two needs; it was initiated in 2010 as the first evaluation of the program after it had run for 1.5 years, and it is now the crux of this case study, one of six case studies of programs selected to inform the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) on the critical success factors and challenges faced by programs specifically designed to promote social and emotional wellbeing amongst Aboriginal youth.

After an extensive literature review, the process of selecting culturally appropriate methodology and study design in an effort to achieve a research process empowering to community members, stakeholders and the program, is described. Data collection and analysis method are then explained, followed by quantitative findings concerning the health status and socio-emotional development of participants’ children and parental wellbeing, and qualitative findings exploring program establishment steps, transitions and adaptations over time, current processes, program impacts and strengths, program challenges for effectiveness, growth and sustainability, the program’s true potential and what it needs to be able to fulfil this potential. Study rigour and research challenges and successes are then discussed.

1.1 Early childhood

Early childhood is a precious but vulnerable stage of life. Social, emotional and physical development is taking place rapidly, and the structures and experiences that shape a child’s world can greatly affect this development, determining the health, wellbeing and opportunity of adulthood (Sroufe 1995; Herceg 2005; AIHW 2008b). Family strength, parental social support, socioeconomic stability and community connectedness are critical to maternal and childhood health and wellbeing (Eckersley 2001). Evidence-based, holistic and culturally appropriate programs and services that support vulnerable communities and families, intervening at the critical life stages of pregnancy, motherhood and early childhood, are likely to promote better outcomes for young Aboriginal parents and their children (McCain & Mustard 1999; van der Gaag 2002; Silburn, Zubrick *et al.* 2006). In alleviating the experience of social and economic adversity, such programs intervene in the cycle of disadvantage.

1.2 Aboriginal health and the colonial legacy of disadvantage

The Aboriginal peoples of Australia have a long and rich history, having survived and thrived for at least 50,000 years. Aboriginal culture has focused on collectivity and kinship interrelatedness, and a holistic understanding of health and wellbeing as necessarily involving social, emotional, physical, cultural and spiritual wellbeing (Trudgen 2000; Tsey, Wilson *et al.* 2007; AIHW 2009). Aboriginal people have experienced, and continue to experience, significant trauma and stress associated with colonisation, cultural, land and material dispossession, racism, social exclusion, disempowerment and socioeconomic disadvantage. Aboriginal peoples face a disproportionate risk of family separation (Stanley, Tomison *et al.* 2003), early exposure to the criminal justice system (Krieg 2006), poor housing (Bailie & Wayte 2006), racial discrimination (Paradies 2007), extreme social inequities and adverse child experiences (Stanley, Tomison *et al.* 2003). In many cases, these historical and contemporary losses and stressors, which include the “Stolen Generations”\(^1\) of people, have left a burden of disempowerment, ill health and social wellbeing that has not yet been healed (Hunter 1993; Trudgen 2000; AMA 2005; Black 2007; Carson, Dunbar *et al.* 2007; AHMAC 2008b; NSW Health 2008). The following figure illustrates the connection between Aboriginal peoples’ experience of dispossession and disadvantage and their poor health outcomes.

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\(^1\) Children separated from their families as a result of state-sanctioned forcible removal policies.

Source: [http://tinyurl.com/qz2fgf](http://tinyurl.com/qz2fgf)
The gap between Indigenous and non-Indigenous child and maternal outcomes on numerous health and wellbeing indicators is profound (AIHW 2008a; Thomson, MacRae et al. 2010). Aboriginal women are subject to highly disproportionate rates of adverse pregnancy outcomes and Aboriginal children experience higher rates of death and illness in most disease and injury categories than non-Indigenous children (NSWHealth 2003; AMA 2005; Herceg 2005; NSWHealth 2007; AIHW 2008b). The low birth weight and prematurity of Indigenous babies are significant health issues as they increase the risk of perinatal mortality and can contribute to childhood physical and developmental disadvantage as well as poor adulthood health, particularly chronic disease (Singh 2003; AMA 2005: 3-4). The national Aboriginal perinatal mortality rate is 21.4 per 1000 births compared with 9.6 per 1000 births to non-Indigenous mothers (Australian Bureau of Statistics (ABS) & Australian Institute of Health and Welfare (AIHW) 2004). Health data specific to the La Perouse area is incorporated in the South Eastern Sydney and Illawarra Area Health Service (SESIAHS); in this health service area, between 2002 and 2006, 11.5% of Aboriginal babies were born prematurely compared to 7% non-Indigenous, and 11.5% Indigenous babies were of low birth weight compared to 6% non-Indigenous (NSWHealth 2008: 5). These early life risks underlie much of the higher burden of childhood stress, developmental delay, greater adult premature chronic disease, risk-taking behaviour and early death in the Aboriginal population (Trewin & Madden 2003; Zubrick, Lawrence et al. 2004).

### 1.3 Wellbeing and the impact of stressors and maternal depression on perinatal and infant outcomes

Only recently have researchers come to terms with the spiritual and emotional suffering brought on by colonisation and the subsequent disarray (Davis, McGrath et al. 2004). Cultural fragmentation and loss of land, erosion of family structure and kinship traditions largely as a result of the “Stolen Generations”, and the poverty, frequent deaths, suicides and violence experienced in Aboriginal communities have all contributed to a pronounced sense of powerlessness/lack of mastery (the degree to
which an individual feels in control of their life) felt by Aboriginal people, as well as loss of identity, low self-esteem and shame (Hunter 1993; Trudgen 2000; Davis, Knight et al. 2001: 1; NSWHealth 2003: 27). Eades (2004) writes that at the roots of the disempowerment is the ‘wholesale exclusion’ of Indigenous people from Australian society since 1788. The policy of family removal had a tremendous impact, with 44% of Indigenous Australians aged 18 years and over reporting the removal of themselves or a relative from their natural family (AHMAC 2008b: 12). Such paternalistic policies have long governed and assimilated Aboriginal people, and there are ‘clues’ that such disempowering processes are perpetuated to this day (Laliberté, Haswell-Elkins et al. 2009: S64).

Poor psychosocial wellbeing and depression is commonly associated with socioeconomic disadvantage, oppression and marginalisation (Blas & Kurup 2010: 118-119), and is a significant problem for Indigenous Australians; 27% of Aboriginal and Torres Strait Islanders experience high levels of psychological distress compared with 13% of non-Indigenous adults (AHMAC 2008a: 56). A thorough review of direct and indirect evidence by Gallo and Matthews (2003) found that socioeconomic disadvantage exacerbates poor psychosocial wellbeing, and vice versa. Psychosocial stressors have a significant influence on health, contributing to the aetiology of chronic disease through influencing health behaviour (Daniel, Brown et al. 2006) as well impacting upon health measures such as elevated systolic blood pressure (Williams, Neighbors et al. 2003), increased body fat and higher fasting glucose levels (DeVogli, Brunner et al. 2009). Daniel et al. (2006) studied the connection between social disadvantage, nominal control, risk behaviour and morbidity within an Aboriginal community in Arnhem land, and findings supported international studies. Daniel et al. stated that, ‘Chronic low hope for influencing conditions of living is a strong predictor of morbidity and mortality, whereas chronic instability and disorder predict psychological distress and poor health behaviour’ (2006: 2).

Pregnant Indigenous women are at increased risk of poor psychosocial wellbeing and depression, according to national data from the beyondblue postnatal depression program (Buist & Bilstza 2005). Psychosocial stressors found to be significant risks for depression during pregnancy and early parenthood include: childhood abuse (Buist & Janson 2001), personality type, marital disharmony (Kumar & Robson 1984; Dennerstein, Lehart et al. 1989; Goering, Lancee et al. 1992), stressful life events (Dennerstein, Lehart et al. 1989; O’Hara & Swain 1996) and social support (Small, Astbury et al. 1994). In a recent study of urban pregnant Aboriginal women by (Hayes, Campbell et al. 2010), the prevalence of most of the listed psychosocial stressors was high and a significant proportion of the group of women were found to be at risk of depression and its sequelae.

Maternal depression and stress during pregnancy and early parenthood can be detrimental to foetal and infant development. A wide literature base exists on the connection between socioeconomic status and health in populations globally (Marmot 2005; Black 2007), and the negative influence of the associated stress and trauma of poverty and social adversity on reproductive and infant health is well known. Research by Moutquin (2003) suggests that stressful events may be related to an increased likelihood of preterm birth, and other research indicates that accumulation of psychosocial stress over years also may add to adverse pregnancy outcome (Hogue & Bremmer 2005; Rich-Edwards & Grizzard 2005). Social and physical environments of the infant and young child can shape early brain development and have long-term consequences for emotional development, intellectual development, social regulation, mental and physical health (Felitti, Anda et al. 1998; Keating & Hertzman 1999; Stanley 2003; Teicher, Anderson et al. 2003; Anda, Felitti et al. 2006), with adults with a history of childhood adversity being more likely to engage in health damaging behaviour (Felitti, Anda et al. 1998). Three indicators of low socioeconomic status (LSES) (chronic socio-economic disadvantage, mother’s education and family income) are correlated with higher rates of children manifesting development delays (Najman, Bor et al. 1992). Maternal depression has been correlated with infant growth and failure to thrive (Surkan, Kennedy et al. 2011), and has been found to critically impact upon early infant socio-emotional development; infants of depressed mothers show less positive interactive behaviour and limited cognitive development, particularly language and IQ\(^2\) (Martins & Gaffan 2000; Grace & Sansom 2003).

\(^2\) Briefly, IQ or intelligence quotient is a measure of a person's intelligence as indicated by an intelligence test. Source: http://tinyurl.com/qgwr5.
1.4 Adolescent pregnancy

Another significant factor contributing to Aboriginal perinatal mortality, morbidity and poor child health is a high adolescent pregnancy rate (Westenberg, van der Klis et al. 2002; AMA 2005: 6). Research connects adolescent pregnancy with poor outcomes for mother and child (Fraser, Brockett et al. 1995; Borja & Adair 2003; AIHW 2008b:15). In 2008, teenagers made up one in five Aboriginal and Torres Strait Islander mothers (20.5%); by comparison 3.5% non-Indigenous mothers were teenagers (AIHW 2010).

Teenage mothers disproportionately come from socially and economically disadvantaged backgrounds with unstable housing arrangements, poor education and low self-esteem, are commonly of minority status and also often delay having their pregnancy confirmed and/or seeking antenatal care; these factors have all been found to be significant predictors of low birth-weight (Zang & Chan 1991; Borja & Adair 2003: 733; NSWHealth 2003:19; AIHW 2008b: 15). Adolescent pregnancy can compound socioeconomic stresses leading to poorer health, education and economic prospects for mother and child as it is associated with education interruption, high risk of single parenthood, government assistance dependence, employment difficulties and poverty (AIHW 2008b: 15). In line with the risky health behaviours commonly found amongst LSES groups including Aboriginal people facing socio-economic disadvantage (AHMAC 2008b: 18), adolescent mothers often engage in health-damaging behaviours such as smoking, alcohol and drug use, physical inactivity and poor or excess nutrition (Tamashiro & Moran 2010), these being key contributors to poor pregnancy outcomes (Zang & Chan 1991; Borja & Adair 2003: 733-4; NSWHealth 2003:18-19). Smoking, a key determinant of low birth-weight (Brooke, Anderson et al. 1989; Bonellie 2001; Can, Keane et al. 2001), is prominent amongst Aboriginal mothers, with 42% of Aboriginal mothers in the SESIAHS area having smoked during their second half of pregnancy compared with 8.2% of all mothers between 2002 and 2006 (NSWHealth 2007: 100).

1.5 Antenatal care

A key risk factor for poor birth outcomes among Aboriginal women is late presentation for antenatal care (Eades 2004). In the SESIAHS area between 2002 and 2006, 75.9% of pregnant Aboriginal women attended their first antenatal visit before 20 weeks gestation, compared with 90.8% non-Indigenous women (NSWHealth 2007; NSWHealth 2008: 5). Aboriginal women are also more likely to attend less frequently than other women, which is a further cause of poor birth outcomes (AHMAC 2008b: 21). For those Indigenous mothers who do attend antenatal care, their babies are less likely to be of low birth weight (13%) than those who do not attend (39%)(AHMAC 2008a :21). High-quality antenatal care is considered a fundamental right of all women to safeguard their health and that of their infants (WHO 1998); it presents an opportunity for detection and treatment of pre-eclampsia as well as infections during pregnancy that could otherwise harm the health of the foetus (Eades 2004: 6). Furthermore, it is also an important opportunity to support mental health and wellbeing and to screen for maternal depression. As many perinatal outcome determinants are modifiable, supporting effective means to increase and encourage earlier use of antenatal care and parenting services is fundamental to improving birth outcomes for Aboriginal mothers (Borja & Adair 2003: 739).

1.6 The need for comprehensive, family focussed Aboriginal perinatal and parenting services

It can be seen that influence over the general ill-health and poor reproductive and child health outcomes of Aboriginal people is multifactorial, and that intergenerational disempowerment and poor psychosocial wellbeing, as well as material disadvantage, must be integral targets when considering means of improving health outcomes (Plunkett, Lancaster et al. 1996; NSWHealth 2003; Herceg 2005; Marmot 2005; AHMAC 2008b).

Implementation of health promotion, prevention and intervention strategies in the antenatal and postnatal periods have resulted in the reductions in rates of perinatal morbidity and mortality within mainstream population groups, however for Aboriginal people such reductions have generally not taken place (Herceg 2005: 6; AHMAC 2008a). This indicates that strategies need to be altered or entirely re-structured to move away from traditionally focussed public health initiatives towards new health
promotion and service delivery models that culturally and socially suit Aboriginal women (Davis, Knight et al. 2001:1; Herceg 2005; Laliberté, Haswell-Elkins et al. 2009: S65). Family and community are core components of Aboriginal identity, wellbeing and parenting practices (Williamson, Raphael et al. 2010), and so perinatal care services centred upon community and family are recommended as a key step to improving Aboriginal obstetric outcomes (O’Connor & Bush 1996, in; Panaretto, Mitchell et al. 2007). This community orientation would more completely reflect the Aboriginal whole-of-life perception of health, defined as ‘... not just the physical well-being of the individual but ... the social, emotional, spiritual and cultural well-being of the whole community’ (National Aboriginal Health Strategy Working Party 1989).

Research demonstrates that family-strengthening interventions that focus on supporting parents produce lasting change (Moore 2005; Silburn, Zubrick et al. 2006). The strongest influence on early childhood development is quality of care, particularly the care-giver’s active involvement with the child’s early learning and development (McCain & Mustard 1999; van der Gaag 2002). The Aboriginal and Torres Strait Islander Health Performance Framework Report (AHMAC 2008a: 57) indicates that the quality of parenting, family functioning, care arrangements and family stress were important contributors to the rate of Aboriginal children (4-17 years old) found to be at risk of clinically significant emotional or behavioural difficulties (24% compared with 15% of all children). Parenting programs can be preventative interventions, with evidence demonstrating that international and Australian programs reduced both behavioural and emotional problems in children and dysfunctional parenting practices (Black 2007: 2). Strengthening parental social support networks as well as creating opportunities for educational prospects for parents is also important principles of programs that aim to strengthen families and nurture a positive environment for child development. Infant health outcomes are improved when young mothers feel socially supported (Eckersley 2001; Zubrick 2005), and such social support provided by perinatal programs can also boost maternal mental health, with antenatal education and post-partum parenting education shown to improve mental health outcomes (Kowalenko, Barnett et al. 2000). There is also a clear relationship between higher levels of maternal education and improved child health outcomes (Herceg 2005; Gakidou, Cowling et al. 2010). Furthermore, improved education levels in young parents can enhance employment and income opportunities, thereby assisting economic needs and physical health outcomes as well as contributing to the mental health and wellbeing of parents (Gallo & Matthews 2003).

Herceg (2005: 12) identified a list of common principles that contribute to program success after undertaking a review of interventions that have been shown to improve health outcomes or intermediate health measures in Aboriginal and Torres Strait Islander mothers, babies and young children. Such principles include:

- Community based and/or community controlled services
- A specific location intended for women and children
- Providing continuity of care and a broad spectrum of services
- Integration with other services (e.g., hospital liaison, shared care)
- Outreach activities
- Home visiting
- A welcoming and safe environment
- Flexibility in service delivery and appointment times
- A focus on communication, relationship building and development of trust
- Respect for Aboriginal and Torres Strait Islander People and their culture
- Respect for family involvement in health issues and child care
- Having an appropriately trained workforce
- Valuing Aboriginal and Torres Strait Islander staff and female staff
- Provision of transport
- Provision of childcare or playgroups.

Herceg (2005), however, found a shortage of effective programs that focussed on certain areas where burden of disease is high, such as substance abuse in pregnancy, mental health (postnatal depression and anxiety), and social and emotional wellbeing. Herceg recommends implementation of interventions in these areas as well as effective evaluation of these interventions. The AMA (2005)
supports this call for multifactorial interventions that focus more on the above areas; particularly as they are relevant to the specific needs of teenage mothers, and also the inclusion of sexual education with youth development activities.

Attempts have been made to make perinatal care more culturally appropriate in order to improve Aboriginal attendance of services and thus health and wellbeing outcomes. The Commonwealth Government’s policy, *New Directions: An Equal Start in Life for Indigenous Children* and the multifaceted programs, *Healthy for Life, Health at Home Plus*, are reflections of the Government’s commitment to a holistic approach to maternal and child health, the aim being to provide all Indigenous children and their mothers with access to antenatal care, standard information about baby care, practical advice and assistance with parenting, monitoring of developmental milestones by a primary health care service, and health checks for children (AHMAC 2008a: 138-9).

A successful community example of a culturally appropriate, holistic, family inclusive approach to perinatal care is the Townsville *Mums and Babies* Program, delivered from the Townsville Aboriginal and Islanders Health Service (TAIHS) since 2000 (Panaretto, Mitchell et al. 2007; DEECD 2009). The program is based on a primary health care ‘shared antenatal care’ model rather than the traditional antenatal-postnatal care model; maternal and child health are integrated with a young-family focus (Panaretto, Mitchell et al. 2007). The program is open to all pregnant women and families with children under 8 years old, and is run each morning, with accompanied services including antenatal and postnatal care, immunisation and child health monitoring, transportation assistance, childcare/playgroup on site, STD testing, referral, advocacy and social support (DEECD 2009). Evaluation show that the program has improved access to antenatal services for Aboriginal women, has contributed to sustained health gains, improved preterm birth rates and reduced perinatal deaths (Panaretto, Mitchell et al. 2007).

### 1.7 Empowerment

Programs such as *Mums and Babies*, that enable capacity building (Panaretto, Mitchell et al. 2007) and that empower people to take greater control of their health through health promotion approaches that support ‘doing with’ as opposed to ‘doing for’ have a huge role to play in reducing health inequity (Wallerstein 1992; WHO 2005a; Wallerstein 2006; Laliberté, Haswell-Elkins et al. 2009: S65). Empowerment-based approaches in programs ‘explicitly aim to assist people (and communities) to recover from the consequences of disempowerment so that they can become active agents in reducing health disparities and inequities’ (Laliberté, Haswell-Elkins et al. 2009: 1), with strategies that involve increasing people’s capacity to manage their own health, adopt healthier lifestyles and use health services more effectively (Tsey 2010: 170). Wallerstein’s (2006) review reveals that participation, psychological empowerment and sense of community can be best developed by strategies that build on the existing sense of community and cultural networks.

As described in paragraphs above, Indigenous Australians have experienced a long history of powerlessness, and so measures to empower this population are particularly relevant (Tsey 2010: 170), especially for women, with many stating that their main health concerns are stress, low self-esteem, and lack of control (CWPHU 1997; NEHS 1997). Alongside strong cohesive communities and appropriate health care, empowering Aboriginal women (improving self-esteem and confidence) is listed as one of the three essential components needed to improve Aboriginal maternal and perinatal health (NSWHealth 2003: 1). A mother’s capacity to give birth to, nurture and care for a healthy new baby is influenced by her psychosocial wellbeing (NSWHealth 2003: 2; Eades 2004: 6); the evidence is clear that incorporating wellbeing and empowerment as part of perinatal care alongside parenting support will improve outcomes.

### 1.8 How participatory arts in community health programs contributes to health and wellbeing

There is evidence that engagement with arts activities promotes individual wellbeing and health outcomes (Secker, Spandler et al. 2008; White 2009; Stuckey & Nobel 2010). Creative expression for healing through pictures, stories, dances and chants has been explored and utilised by many different cultures for thousands of years (Davis, Knight et al. 2001; Stuckey & Nobel 2010). In the modern world, the
‘arts’ has many dimensions: literature and writing, theatre and drama, music, dance, visual arts which include crafts, new media, architecture, design, moving image, and combined arts (Working Group on Arts and Health 2007). Governments such as the UK as well as some Australian states (Victoria and Western Australia) have appreciated the potential of the arts in contributing to various state priorities, and have incorporating arts initiatives into policies in areas such as education, community cohesiveness and development, social behaviour, crime prevention as well as health and wellbeing (Working Group on Arts and Health 2007; Dyer & Hunter 2009).

The foremost researched effect of arts practice on health is on improving mood and emotions; it helps people to explore and gain a sense of who they are and their place in the world (Eakin 2003; Dyer & Hunter 2009), and it has an inherent ability to promote positive messages and encouragement (Davis, Knight et al. 2001; Macnaughton, White et al. 2005; White 2009; Stuckey & Nobel 2010). It has the potential to ‘heal emotional injuries, increase understanding of oneself and others, develop a capacity for self reflection, reduce symptoms, and alter behaviour’ (Camic 2008: in; Stuckey & Nobel 2010). Through reducing stress and depression (Argyle & Bolton 2005; Stuckey & Nobel 2010), the arts can improve physiological parameters. Chronic diseases such as cardiovascular disease and diabetes, which contribute a large health burden for both developed and developing countries (WHO 2005b), are associated with psychosocial difficulties such as depression (Zhang, Norris et al. 2005) and chronic stress; alleviation of these mental states can contribute to reducing negative cardiovascular outcomes (Stuckey & Nobel 2010).

Table 1 is White’s (2009: 213) appropriation of the World Health Organization’s (WHO) Quality of Life Scale (Power 1999), a compilation of 4 domains and 24 facets of quality of life; White has highlighted in italics the most relevant facets for arts in health intervention, in an effort to emphasise that the means by which the arts impact on health is through a social process of impacting on the holistic factors that contribute to wellbeing.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Facets incorporated within domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Financial resources</td>
</tr>
<tr>
<td></td>
<td>Freedom, physical safety and security</td>
</tr>
<tr>
<td></td>
<td>Health and social care: accessibility and quality</td>
</tr>
<tr>
<td></td>
<td>Home environment</td>
</tr>
<tr>
<td></td>
<td>Opportunities for acquiring new information and skills</td>
</tr>
<tr>
<td></td>
<td>Participation in and opportunities for recreation/leisure activities</td>
</tr>
<tr>
<td></td>
<td>Physical environment (pollution, traffic, noise, climate)</td>
</tr>
<tr>
<td></td>
<td>Transport</td>
</tr>
<tr>
<td>Social relationships</td>
<td>Personal relationships</td>
</tr>
<tr>
<td></td>
<td>Social support</td>
</tr>
<tr>
<td></td>
<td>Sexual activity</td>
</tr>
<tr>
<td>Psychological</td>
<td>Bodily image and appearance</td>
</tr>
<tr>
<td></td>
<td>Negative feelings</td>
</tr>
<tr>
<td></td>
<td>Positive feelings</td>
</tr>
<tr>
<td></td>
<td>Self-esteem</td>
</tr>
<tr>
<td></td>
<td>Spirituality, religion, personal beliefs</td>
</tr>
<tr>
<td></td>
<td>Thinking, learning, memory, concentration</td>
</tr>
<tr>
<td>Physical health</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td></td>
<td>Dependence on medicinal substances and medicinal aids</td>
</tr>
<tr>
<td></td>
<td>Energy fatigue</td>
</tr>
<tr>
<td></td>
<td>Mobility</td>
</tr>
<tr>
<td></td>
<td>Pain and discomfort</td>
</tr>
<tr>
<td></td>
<td>Sleep and rest</td>
</tr>
<tr>
<td></td>
<td>Work capacity</td>
</tr>
</tbody>
</table>
As White states, ‘Arts in Health projects assist in the creation of suitable environmental and social conditions for arts activity that may promote improvement in psychological and physical health’ (2009: 213). The facets White has highlighted are also closely aligned with the main themes and subthemes of successful empowerment programmes, as seen in Figure 2 below, adapted from Tsey et al (2010: 174).

Table 1: WHO Quality of Life Scale facets and domains

<table>
<thead>
<tr>
<th>Relevant to indigenous people</th>
<th>Transformation &amp; change</th>
<th>Social connectedness &amp; support</th>
<th>Environmental constraints &amp; opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous developed</td>
<td>Self reflection &amp; awareness</td>
<td>Parenting</td>
<td>Constraints</td>
</tr>
<tr>
<td>Practical &amp; holistic</td>
<td>Hope &amp; vision</td>
<td>Empathy/ability to help others</td>
<td>Opportunities</td>
</tr>
<tr>
<td>Identity &amp; respect</td>
<td>Dealing with emotions</td>
<td>Collective action</td>
<td></td>
</tr>
<tr>
<td>Sharing stories</td>
<td>Self care &amp; healing</td>
<td>Reconciliation between black &amp; white</td>
<td></td>
</tr>
<tr>
<td>Intellectual curiosity &amp; further studies</td>
<td>Addressing alcohol &amp; violence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


There is a growing evidence base for the effectiveness of Arts in Health programs in empowering participants. A UK nationwide study of 22 arts intervention projects found that participants gained hope, meaning, purpose and value through undertaking the programs (Secker, Spandler et al. 2008, in; White 2009: 222). Through a mixed method evaluation and triangulation of results, evidence of mental health and social inclusion improvement was moderate; however there was very strong evidence for empowerment indicated by increased levels of confidence and self-esteem.

Arts can also be used in community health settings to improve community cohesion and wellbeing as well as individual wellbeing, through improving social capital (Putlant 2008; Dyer & Hunter 2009; White 2009). It is a means to create and share meaning and meaningfulness, an important healing method for those impacted by cultural and family disintegration (Stuckey & Nobel 2010). Social capital, being the integrity of social structures that engender community safety, trust, reciprocity, and inclusion (Lomas 1998), is well needing to be strengthened in Indigenous communities. If many of the above themes and subthemes of empowerment programs are able to be achieved through an arts in community health project, the community will be moving towards growth in social capital (Zubrick, Lawrence et al. 2004: 296), with such growth aiding mothers’ capacity to cope with the vast number of social, emotional, structural, political and economic stressors that they face in their lives (James 1993; NSWHealth 2003: 27).

In the Aboriginal perinatal program setting, arts activities can nurture a sense of identity, self-concept and pride, and help link the women via their shared background through employing cultural images and themes that restore Aboriginal origins (Davis, Knight et al. 2001). Visual arts practice can also be an effective means of expression particularly when experiences are too difficult to put into words (Stuckey & Nobel 2010: 256).
An example of an arts intervention within perinatal care in an Aboriginal community is *Mubali*, a program initiated by non-government organisation *Beyond Empathy* with young Aboriginal women in Moree. *Mubali* uses arts techniques to engage mothers, build parenting skills, self esteem and confidence, health knowledge, life skills and support the transition through the early development stages through facilitating connection with family service providers (Beyond Empathy 2008). Through the integration of conventional and traditional perspectives on wellbeing, birthweight and breastfeeding rates have increased as has sustained health service use (Beyond Empathy 2009: 36).

### 1.9 The Ngala Nanga Mai pARENt Group Program

The *Ngala Nanga Mai pARENt Group* is another current art in community health perinatal program for young Aboriginal parents, initiated in June 2009 in the La Perouse Aboriginal Community Health Centre. Auspiced by the Sydney Children’s Hospital (SCH) Department of Community Child Health, the program reflects an ecologically-based model of child development (Silburn, Zubrick *et al.* 2006; Valentine, Katz *et al.* 2007), operating from a strengths-based strategy to address parental social isolation as well as child wellbeing outcomes. The pARENt program is of a similar comprehensive perinatal care design to the *Mums and Babies* and *Mubali* programs, aiming to empower participants with community connectedness, practical parenting skills, improved engagement with health knowledge and services, the facilitation of early intervention and regular access to primary and community health care. However, the pARENt Group program also incorporates pathways to education and training opportunities (CCDNSW 2010). The confidence drawn from arts practice is intended to build parents’ confidence, encouraging them to pursue educational and vocational aspirations (CCDNSW 2010). The artmaking also considered to contribute to an atmosphere conducive to social network strengthening and the sharing of knowledge about available services.

The program has used an interactive participatory action approach to guide its activities over its first two years of operation; however it has not been formally evaluated. Aware of the program’s benefits, organisers requested the Muru Marri at UNSW to assist them in adding ongoing evaluation as part of their program process, and this research is now being used to inform this case study.
Methodology

2.1 Rationale for the research approach adopted for this project

For research to truly contribute to improving the social and economic status of Aboriginal peoples and other minority groups, it must wholly depart from the positivist paradigm of inquiry and explanation (Liamputtong & Ezzy 2009) and embrace methodology that seeks the inclusion of the research participants and incorporates their values and world-view; as Maclure (1990) states, ‘The insights and aptitudes of local people must be enlisted and brought to bear on the research process itself.’ This is particularly fitting for Aboriginal Australians. Subjected since colonisation to positivist study that has not led to improvements in quality of life or equality, but rather has exploited and exacerbated their vulnerability, Aboriginal peoples have developed a strong suspicion of research (Hunter 1992; Smith 1999:3, 63, 66-67, 69; Hunter 2001; Holmes, Stewart et al. 2002; Prior 2007; Wand & Eades 2008; Toombs & Gorman 2009). The methodological approach needs to be sound from both Aboriginal and academic perspectives, and to be sound for the former it must be congruent with Aboriginal research principles, facilitate self-determination, participation and partnership rather than passivity, and incorporate systematic strategies that force the evaluator to bridge the epistemic gaps between their own rationalities and those of the research participants (Ivanitz 1999; Smith 1999:115-116; Wand & Eades 2008; Toombs & Gorman 2009).

Methodology considered appropriate to frame this study of the pARENt Group Program was that of the phenomenological (interpretivist) paradigm. Within this paradigm it is understood that meaning is not fixed but is constantly (re)negotiated between people, and that values cannot be suspended in order to understand but rather that values mediate and shape what is understood (Maykut & Morehouse 1994:12). This approach, in which qualitative methods are essential, seeks to gain insights into varying world-views rather than to objectify human experience. It acknowledges that there are multiple realities (Ritchie, Zwi et al. 2009) and that individuals must be seen within their social contexts. A key component of the approach is that the research agenda is shaped by both the evaluator and the participants (Guba & Lincoln 1985; Dickson-Swift, James et al. 2008:7). Through decentring the focus from the aims of the evaluator to engaging the people, listening to their voice and understanding their cultural context and history, such an approach engenders a decolonising enquiry (DiGiacomo 1999; Prior 2007).

Also incorporated into the study design was the participatory evaluation model (Lennie 2006; Markiewicz 2008) as its underpinning values reflect those of Aboriginal research, which are explored below. Furthermore, inductive grounded theory methodology was drawn upon during the analysis process, leading to the regular emergence of themes bearing little semblance to prepared interview topics. This was in preference to a deductive approach, which attempts to place ideas into a pre-existing coding frame determined by evaluator preconceptions (Patton 2002:453-4, 487-492; Braun & Clarke 2006; Tsey, Wilson et al. 2007).

Awareness of and adherence to all ethical aspects of Indigenous research is pertinent to a sound methodological approach in this study (Knight, Comino et al. 2009). Aboriginal health ethics, values and objectives include reciprocity, respect, equality, genuine consultation, community control of and community involvement in all stages of the research process, relevance and utility, cultural sensitivity, and the enhancement of Aboriginal skills and knowledge (New South Wales Health 1998; Australian Institute of Aboriginal and Torres Strait Islander Studies 2000; NHMRC 2010). Table 2 details how these values and objectives were incorporated into this project:
| **Table 2: Incorporation of Aboriginal health ethics, values and objectives into the pARenT Group Program research** |
| --- | --- |
| **Community consultation and involvement in study design development** | Aboriginal people from the evaluated community (pARenT Group Program participants, program stakeholders and community members of La Perouse Advisory Health-Link Committee) were involved in the development of the study design and were consulted throughout the study implementation, ensuring alignment with Aboriginal world views and community control principles and priorities (Brown, Hunter et al. 2002). Negotiations regarding methodology were held at the La Perouse Advisory Health-Link Committee monthly meeting in August. A community-friendly information document explaining the research-based evaluation process was provided. As indicated in Aboriginal research guidelines, issues of ownership, method and publication of data were clarified in the discussion and community document. It was also stated that methodology was open for discussion and amendment, progress and findings would be communicated effectively in a community friendly document, all contributors to the project would be appropriately acknowledged in the written report, all data collected would remain the property of the community members of La Perouse, and that community members would have the final say on all matters to do with the evaluation including publication. Members consented to the study and agreed to being involved in the development and ongoing process of the research through receiving a regular review of progress at subsequent meetings, giving suggestions for adjustments and providing a guiding role in the running of the project. |
| **Involvement of an Aboriginal person from the academic community** | An Aboriginal person from the academic community was involved with the research design and implementation. The primary researcher was supervised by an Aboriginal woman, as well as two other experienced Aboriginal Health researchers, all of whom are part of the Muru Marri at the University of New South Wales. |
Utility

It is important that Aboriginal research serves the information needs of the intended users and benefit the community (Joint Committee on Standards 1994). The La Perouse Aboriginal community wants the program to continue as it addresses key community concerns such as child health and the education and economic opportunities and wellbeing of young parents. In a number of informal discussions, the pARenT Group also indicated their interest in program continuation and recognised the need for an evaluation.

The inclusive, participatory nature of the research approach will also increase the likelihood of findings being utilised, as project outcomes are more likely to be relevant to the program and program stakeholders. To ensure inclusivity, the evaluator worked in partnership with pARenT Group Program developers in addition to community members to design the evaluation. The decision to assess both process and outcomes and to use a balance of quantitative and qualitative methods was made in consultation with community members and program developers. Interview topics were developed in consultation with program developers to ensure appropriateness, and observations of the pARenT Group sessions prior to data collection were also useful in achieving this end (Patton, 2002:342).

In a broader sense, this research will also contribute to the research literature base on the broader Indigenous research agenda, which, as Smith (1999:117) outlines, centres on self-determination through four processes: healing, transformation, mobilisation and decolonisation, and four ‘major tides’ that represent the conditions and ‘states of being’ for which Indigenous peoples strive: survival, recovery, development and self-determination. In confluence with this, the improvement of mental health and social and emotional wellbeing are key goals of the National Indigenous Health Equality Targets (Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering Committee for Indigenous Health Equality 2008). Empowerment and control have been found to be integral components of social and emotional wellbeing for Aboriginal people (Tsey, Wilson et al. 2007). However, despite the important role of grass-roots, wellbeing-focused community programs that utilise strength-based approaches in empowering communities and aiding the achievement of these goals (Wallerstein 1992; Tsey & Every 2000; Laverack & Wallerstein 2001; Wallerstein 2006; Tsey, Wilson et al. 2007), limited research into such interventions and methods for their evaluation exists (Legge 1999; Tsey 2010).

2.2 Project aim and study design

This is a quasi-experimental one-group design study with baseline data collected 18 months after program commencement and follow-up data to be collected approximately 18 months later. This paper discusses findings from baseline data. The study aim is to elucidate program processes as well as the impact of the program on the participants involved, in a manner that will further enhance the program and its participants.

It is important to ascertain to what extent the program is reaching the target group, whether there are discrepancies between what is observed and what was planned, projected or needed, as improvements can then be made (Posovac & Carey 1997:26; Robson 2000:52). To assist with the process of defining the program’s objectives and the strategies planned to achieve these objectives, and then determining whether the intended objectives and strategies are in line with the program in operation (the ‘theory in use’ (Patton 2002:163-64)), the researcher drew on the program’s ‘theory of action’/’logic’ model (logic model). A logic model articulates program developers’ reasoning behind program activities, corresponding objectives with actions believed to contribute to their attainment (Weiss 1998: 55; Patton 2002:163). Program logic models are also useful for determining when to measure certain impacts and outcomes, as change in some areas may be expected to take a few weeks but in other areas may take many months (Nutbeam & Bauman 2006:65); this can increase the efficacy of detecting program effects related to the goals and objectives within a realistic timeframe for the intervention. The primary researcher’s interpretation of the pARenT Group’s logic model is included in the ‘Findings’ section of this report (Table 6).
The framework used by this study to assist in planning the evaluation of the pAREnT Group's processes and outcomes are listed below in Table 3 and 4 respectively. Conceptual structure is aided by advice from Nutbeam (2006:54), Posovac (1997:8), Robson (2000:49) and Patton (2002:471-477).

**Table 3: Process evaluation method**

<table>
<thead>
<tr>
<th>PROCESS questions</th>
<th>EVALUATION METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the program logic and intent?</td>
<td>Documentation (summarised in logic model), interviews with key informants</td>
</tr>
<tr>
<td>Is the logic linked to program structure and delivery methods, indicating potential to produce benefits?</td>
<td>Documentation and interviews with key-informants and stakeholders delivering services</td>
</tr>
<tr>
<td>What happens when it is in operation?</td>
<td>Description of program inputs and outputs</td>
</tr>
<tr>
<td>Does it operate as planned and expected?</td>
<td>Focus groups and semi-structured interviews – Reports of positive performance from key stakeholders</td>
</tr>
<tr>
<td></td>
<td>Comparison of actual process with original program</td>
</tr>
<tr>
<td></td>
<td>Logic Model</td>
</tr>
<tr>
<td></td>
<td>Evidence of collaborations and links developed with affiliated and complimentary services</td>
</tr>
<tr>
<td></td>
<td>Evidence of clear targeting</td>
</tr>
<tr>
<td>Is the program attracting a sufficient number of clients? Program attendance</td>
<td>Registration statistics</td>
</tr>
<tr>
<td>Are clients representative of the targeted Group?</td>
<td>Registration statistics</td>
</tr>
<tr>
<td></td>
<td>Evidence of program reach to those most in need</td>
</tr>
<tr>
<td>Does what is provided meet client needs?</td>
<td>Focus groups and semi-structured interviews</td>
</tr>
<tr>
<td>How can it be improved?</td>
<td>Focus groups and semi-structured interviews</td>
</tr>
</tbody>
</table>

**Table 4: Outcomes evaluation method**

<table>
<thead>
<tr>
<th>OUTCOMES questions</th>
<th>EVALUATION METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>What kind of effect or impact is the program having on those taking part?</td>
<td>Evidence of outcomes and impact from quantitative and qualitative data collected, health statistics and course enrolment. Compare between baseline and follow-up data-sets</td>
</tr>
<tr>
<td>Does it attain its goals or objectives?</td>
<td>Comparison of outcomes with goals</td>
</tr>
<tr>
<td>Are there any unexpected outcomes?</td>
<td>Comparison of outcomes with goals</td>
</tr>
<tr>
<td>How much support for the theoretical foundation of the program was found?</td>
<td>Literature review: The existence of an evidence base for the approach, and similar models attempted and evaluated</td>
</tr>
<tr>
<td>What evidence is there that the program can be implemented effectively elsewhere?</td>
<td>Detailed notes on conditions for success</td>
</tr>
</tbody>
</table>

2.2.1 Tools and procedures

This research project employs a rigorous mixed methods approach that is aligned with the methodology chosen.

2.2.1.2 Quantitative research

Baseline quantitative data is to be compared with qualitative findings, as well as results from future surveys in follow-up research. Current health and descriptive data, collected routinely by the paediatric clinic and the coordinator as participants register with the Group, was drawn on to develop a
picture of participants’ use of the educational opportunities, community/Health Centre services, referrals to allied health, community and specialist services, as well as health issues and development progress of participants’ children.

Culturally appropriate surveys of the social and emotional wellbeing of participants and their children were chosen after consideration of factors such as psychometric validation, prior use with Aboriginal people, and area health service preferences. They include the Growth and Empowerment Measure (GEM), the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) and the Strengths and Difficulties Questionnaire (SDQ).

The GEM, a measure of emotional wellbeing and social connectedness that seeks to reflect the complex process of change that people experience as they gain confidence and capacity in their lives, was developed for this purpose with and for Aboriginal and Torres Strait Islander Australians. The instrument has been psychometrically validated with Indigenous Australians (Haswell, Kavanagh et al. 2010) and is also considered to be highly appropriate for this study as it is a strength-focussed tool, reflecting the nature of the program. Please see Appendix 7.1 for more information regarding this tool. For this study, adjustments were made to two of the three GEM scales to increase their relevance to the pARenT Group.

The ASQ:SE is a screening tool for assessing children’s social and emotional development and is currently used by the local area health service. The ASQ:SE can be used to recognise young children at risk for social or emotional difficulties, identify behaviours of concern, and identify any further assessment needs (Squires, Bricker et al. 2002).

The SDQ is a brief screening measure of behavioural and emotional problems in children and adolescents (Youth in Mind 2010) that has been used to survey Aboriginal children as part of the Western Australia Aboriginal Child Health Survey (De Maio, Zubrick et al. 2005; Zubrick 2005). It is a well established tool (AHMAC 2008a: 57); a study of the SDQ with Australian children illustrated evidence of sound psychometric properties (Hawes & Dadds 2004). An abnormal total score can be used to identify likely ‘cases’ with mental health disorders. Approximately 10% of a community sample scores in the abnormal band on any given score, and 10% score in the borderline band (Youth in Mind 2010).

2.2.1.3 Qualitative measures

Qualitative methods such as semi-structured interviews and focus groups have been utilised in this study, being appropriate tools for a participatory and constructivist approach to research as they enable the voices of participants to be heard and to define the research findings (Mayoux 2001:115-127; Stewart & Mackinlay 2003). Focus groups are particularly empowering as they encourage the active formation of group views (‘retrospective introspection’ (Bloore, Frankland et al. 2001) and collaboration can create a sense of group identity, solidarity and safety (Madriz 2000:835-36; Bloore, Frankland et al. 2001:93; Lloyd-Evans 2006:154-55).

Insights gained from these qualitative methods will contextualise, support and extend quantitative findings, and engender greater researcher responsiveness to participants’ interests (Weiss 1998:253). The explorative style of semi-structured qualitative research is ideal for identifying program outcomes, more complex a task than assessing attainment of pre-specified goals (Robson 2000:49). A deep understanding of stakeholders’ sentiments concerning real program impacts on participants lives can be gained, as well as the influence of context and factors which may have instigated evolutionary developments. Such holistic insights cannot be substantiated via reductionist, primarily quantitative, approaches (Stewart & Mackinlay 2003; Rumbold & Cunningham 2008; White 2009), as Kibel (1999:13) explains:

For programs engaged in healing, transformation and prevention, the best source and form of information are client stories. It is through these stories that we discover how program staff interact with clients, with other service providers, and with family and friends of their clients to contribute to outcomes, and how the clients, themselves, grow and change in response to program inputs and other forces and factors in their lives. There is a richness here that numbers alone cannot capture. It is only for a story not worth telling, due to its inherent simplicity, that numbers will suffice.
It is particularly important that this study enables participants to tell their stories of change as a key objective of the pARenT Group Program is self-reflection and growth; furthermore, many Aboriginal people consider this a necessary and important sign of respect in an evaluation of a program designed to meet their needs. The figure below depicts a summary of the study design. Methods are seen as integral components of the broader methodological framework, which emphasises community participation and Aboriginal ethics.

**Figure 3: Study design summary**

<table>
<thead>
<tr>
<th>Research approach rationale</th>
<th>Qualitative approach</th>
<th>Quantitative approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Phenomenological (interpretivist) paradigm</td>
<td>• Emphasis on semi-structured qualitative research to ensure inclusivity, extend understanding of quantitative data and identify non-quantifiable impacts</td>
<td>• Gain a descriptive understanding of the population being studied, their social and emotional wellbeing as well as their health and education service use</td>
</tr>
<tr>
<td>• Mixed methods</td>
<td>• Interviews with program participants, program developers, deliverers and service providers; focus groups with program participants</td>
<td>• Surveys: SDQ/ASQ, GEM</td>
</tr>
<tr>
<td>• Inclusive</td>
<td></td>
<td>• Participant statistics: Health service use, educational courses</td>
</tr>
<tr>
<td>• Aligned with Aboriginal research ethics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Method

3.1 Literature review on methodology and program context, formation of program logic model

A literature review was performed on different methodological approaches to research, including quantitative and qualitative paradigms, evaluation design, participatory action research, participatory evaluation and ethical considerations. The ‘Methodology’ section discusses the research approaches chosen for this study. The Aboriginal history of La Perouse was also explored to contextualise the program and the Health Centre.

The researcher’s interpretation of the program’s logic model (Section 4.1) was formed by extracting information from key program documents (e.g., grant applications). Conceptual structure was aided by Weiss (1998), Patton (2002) and Taylor-Powell (1996).

3.2 Ethics approval process

Ethics submission to the UNSW Human Research Ethics Committee (HREC) and the Aboriginal Health & Medical Research Council took place in September 2010, and approval was granted in October after the following clarifications and adjustments to method were made (Table 5).

Table 5: Ethics Committee deliberations

| Proposed recruitment approach was too direct; Aboriginal people may feel under pressure to participate when asked directly by researchers (McMasters 1996). | Confidentiality concern in relation to the potential revelation of data to notifiable bodies; sensitive context of Aboriginal people having experienced discriminatory privacy breaches for generations (Holmes, Stewart et al. 2002). |
| Research intentions needed to be elucidated further in the Participant Information Statement (PIS) particularly regarding use of participants’ current health data. | Focus groups needed to explore program challenges to a larger extent. |
| The first paragraph of the PIS was found to prejudice the evaluation results and so required rephrasing. | The degree to which the research aligns with “best practice” evaluation strategies used previously for similar programs. |
| Counselling must be provided by experienced professionals in the possible case of distress during or after interviews and focus groups (see below for arrangements to address this requirement) | Explanation of reasoning behind methodology, choice of wellbeing measures and how these measures will contribute to program understanding. |
| Arrangements for participants’ access to counselling (see below) | Arrangements for participants’ access to counselling (see below) |
Counselling access
Due to broader life issues participants may be potentially vulnerable. To ensure the safety of all participants the focus group facilitator (the primary researcher) would be accompanied by a researcher experienced with qualitative research in Indigenous social and emotional health and adept at discerning distress. After each interaction, the student and supervisor would discuss the interaction and determine whether either identified evidence of distress. If this occurred the researchers would immediately contact the Project Director. Participants of interviews and focus groups would also be informed of the existing support mechanisms available should they feel distressed during or after the discussion, such as the Health Centre’s psychological and counselling services.

3.3 Recruitment
Program participants gave the evaluator permission to visit the pARenT Group. The proposed research purpose and process was explained in detail and information statements were handed out and read. Following an opportunity for questions, the evaluator left the room and the participants were given time to decide whether or not they wanted to be involved. All participants present agreed to be part of the evaluation. Signed participant consent forms were then handed to the Program Implementation Officer (PIO).

3.4 Data collection
Data collection took place over two weeks in February, 2011.

3.4.1 Quantitative data

3.4.1.2 Health statistics
Current health and descriptive data, systematically collected by the health centre, was sourced, as well as data concerning participants’ enrolment in education and training with program assistance.

3.4.1.3 Surveys
The ASQ:SE, the SDQ and the GEM were filled out by program participants.
An indicative comparison has been made between pARenT Group Program GEM results and those of the sample (n=184) reported by Haswell (2010).

3.4.2 Qualitative data

3.4.2.1 Documentation
Testimonials produced previously by participants were provided by the program coordinators and were examined. Annual funding reports were also utilised for secondary information on program inputs and processes.

3.4.2.2 Interviews and focus groups
Interview and focus group topics revolved around program establishment steps, successes and challenges, program impacts on participants, views of the program’s future and recommendations for attaining these visions. Topics were tailored slightly differently to each stakeholder, reflecting their specific involvement with the pARenT Group. All interviews were recorded on digital recorders. Brief notes were made when pertinent issues arose. Focus group discussion was facilitated by the evaluator with an experienced research supervisor acting as second moderator to assist in the conduct of each session and to ensure the social and emotional safety of participants (see Table 5). No distress was detected in any of the encounters.
3.5 Data analysis

3.5.1 Quantitative data

Descriptive, health and educational data was entered into a Microsoft Excel 2007 file (Microsoft Corporation 2007) and simple frequencies and averages were determined.

GEM data was entered into a separate Excel file and imported into PASW® Statistics 18 (SPSS 2009). Descriptive statistics, including minimum, maximum, frequencies and average scores for the GEM’s three scales and four subscales (inner peace, capacity, healing and connectedness) were identified.

3.5.2 Qualitative data

Analysis began during data collection (interim analysis). Initial data gathered aided the researcher’s refinement of questions and opened new avenues of enquiry to reflect the emerging concerns (Pope, Ziebland et al. 2000). The final data set consisted of interview and focus group transcripts as well as testimonial text. Content analysis was essentialist, ‘reporting experiences, meanings and the reality of participants’ (Braun & Clarke 2006), and inductive (Patton 2002:453); analytical categories were generated from content using grounded theory methodology.

A combination of thematic analysis frameworks as described by (Braun & Clarke 2006; Green, Willis et al. 2007) were performed: data immersion (audio recordings transcribed by author); preliminary coding (by hand and also using NVivo 8 (QSR International 2008)); clustering of codes into categories and then finally into emerging themes. Preliminary data triangulation was undertaken, with comparisons made between literature, qualitative and quantitative findings.
4. Findings

4.1 Program logic model for The Ngala Nanga Mai pARenT Group Program

<table>
<thead>
<tr>
<th>Social issue</th>
<th>Teenage pregnancy, poor education outcomes, poor health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term aim</td>
<td>To reverse the cycle of disadvantage by ensuring young parents return to vocational or educational training even if they dropped out of school after becoming parents</td>
</tr>
<tr>
<td>Objectives</td>
<td>To empower participants with confidence and education through art workshops and educational support.</td>
</tr>
<tr>
<td></td>
<td>To improve the social connectedness and sense of community amongst young parents through regular social gatherings and Group work</td>
</tr>
<tr>
<td></td>
<td>To improve the health of young Aboriginal parents and their children through improving access to health services, education (health promotion and parenting workshops) and modelling of healthy lifestyles.</td>
</tr>
<tr>
<td>Inputs Resources</td>
<td>Paediatrician and Early Childhood Nurse providing ‘drop in’ sessions, service and care</td>
</tr>
<tr>
<td></td>
<td>Biweekly four-hour sessions in the La Perouse Aboriginal Community Health Centre</td>
</tr>
<tr>
<td></td>
<td>Art practitioner facilitating workshops</td>
</tr>
<tr>
<td></td>
<td>Art materials</td>
</tr>
<tr>
<td></td>
<td>Aboriginal Education Officer providing guidance and support</td>
</tr>
<tr>
<td></td>
<td>TAFE courses, tutor</td>
</tr>
<tr>
<td></td>
<td>Social worker</td>
</tr>
<tr>
<td></td>
<td>Child care</td>
</tr>
<tr>
<td></td>
<td>Transport</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outputs, Process Activities and participation</th>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of transport and childcare, provided to support participation</td>
</tr>
<tr>
<td></td>
<td>Health</td>
</tr>
<tr>
<td></td>
<td>Easy access to health services</td>
</tr>
<tr>
<td></td>
<td>Participant use of ‘drop in’ appointments, information and referrals</td>
</tr>
<tr>
<td></td>
<td>Participation in health promotion and parenting educational sessions</td>
</tr>
<tr>
<td></td>
<td>Provision of healthy food options during workshops</td>
</tr>
<tr>
<td></td>
<td>Confidence and social connectedness</td>
</tr>
<tr>
<td></td>
<td>Creation of social networks through regular group sessions</td>
</tr>
<tr>
<td></td>
<td>Art workshops for expression and confidence</td>
</tr>
<tr>
<td></td>
<td>Cultural outings</td>
</tr>
<tr>
<td></td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Participation in educational courses and utilisation of tutoring support</td>
</tr>
<tr>
<td></td>
<td>Cultural outings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intended Project Outcomes</th>
<th>Short term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Build a sufficient attendance level of target group</td>
</tr>
<tr>
<td></td>
<td>Learning, awareness, knowledge of self, confidence, problem solving (cognitive outcomes)</td>
</tr>
<tr>
<td></td>
<td>Improved sense of social connectedness</td>
</tr>
<tr>
<td></td>
<td>Improved engagement with health and accessing of health services. Attendance of child health service (attitude change outcomes)</td>
</tr>
<tr>
<td></td>
<td>Medium term</td>
</tr>
</tbody>
</table>
### 4.2 Baseline quantitative findings

#### 4.2.1 Descriptive statistics

In February 2011, 31 women and 44 children were engaged with the pARenT Group Program, with approximately 15-20 regularly attending each week. Eleven (31%) women from the program consented to participate in surveys and interviews for the study, with 13 children the subject of surveys filled out by parents. Eight of the 11 participating women identified as Aboriginal and all children engaged with the program are Aboriginal. The average age of the participating parents was 27.1 years, excluding a grandmother and elder of the community, age 65, who also attended the Group. The 11 participating parents had been involved with the program for an average of 15 months, with 4 having attended since its inception in mid 2009 and 2 having joined in the past 6 months. All of the 11 participating women attend each bi-weekly session.

Most participants became aware of the program through the Early Childhood Nurse (ECN), as Table 7 conveys.

**Table 7: Documented method of referral to pARenT Group**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/parent/carer</td>
<td>5</td>
</tr>
<tr>
<td>ECN</td>
<td>7</td>
</tr>
<tr>
<td>General practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Allied health</td>
<td>1</td>
</tr>
<tr>
<td>Not documented</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: pARenT Group registration database, SCH Department of Community Child Health

#### 4.2.2 Health statistics

Data from the paediatric service was used to examine participants’ use of this service as well as referrals and diagnoses made. Of the total number of children engaged with the pARenT Group, 33 (75%) had visited the paediatric clinic. The average number of visits per year for this group was 3.1 per child. Ten (30%) of the children had a chronic disease of some kind, 15 (45%) had a neonatal problem, 7 (21%) had global development delay (DD) and 6 (18%) had delayed speech and language development (Table 8). Some children had multiple diagnoses (co-morbidities) and so are included in more than one category, however the number listed in the ‘chronic disease’ category represents individual children. Many children in this group had been successfully referred for specialist care (Table 9).
Table 8: Number and percentage of children with health conditions

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number (N=33)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic disease (asthma, obstructive sleep apnoea, diabetes, bronchiectasis, severe allergy/anaphylaxis, genetic/chromosomal syndromes, obesity)</td>
<td>10</td>
<td>30%</td>
</tr>
<tr>
<td>Neonatal problems (sacral dimple, birth marks, jaundice, cutaneous vascular malformations, plagioccephaly, microcephaly, hexadactyly, craniosynostois, thrush, hepatitis C)</td>
<td>15</td>
<td>45%</td>
</tr>
<tr>
<td>Global development delay Children with specific speech and language delay</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>Nutritional/diet/weight problems</td>
<td>9</td>
<td>27%</td>
</tr>
<tr>
<td>Chronic otitis media</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>Mood/emotional problem/behavioural concerns</td>
<td>7</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: Paediatric clinic database, SCH Department of Community Child Health

Table 9: Number of children referred by the paediatric clinic to specialists (appointment attended); number diagnosed with a condition by specialist

<table>
<thead>
<tr>
<th>Referrals</th>
<th>Number (N=33)</th>
<th>Number Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical specialists (cardiology, dermatology, respiratory, genetics, endocrinology, gastroenterology, neurology)</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Surgical specialist</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Ear Nose &amp; Throat (ENT) specialist</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Audiology</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Eye clinic</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Child protection/welfare services</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Radiology</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Pathology</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Speech therapist</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Dietician</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>GP/Aboriginal Medical Service</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Early Childhood Nurse</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Behavioural support</td>
<td>5</td>
<td>-</td>
</tr>
</tbody>
</table>

3 Non-clinical referrals indicated with a dash, ie behavioural support, early intervention, parenting support Department of Education and Training, Department of Housing.
4.2.3 Surveys

Of the 11 women who were invited to do the research, 10 participants individually filled out the surveys.

4.2.3.1 Ages & Stages Questionnaire: Social-Emotional

Ten ASQ:SE were filled out by 8 women who had children younger than 4 years of age, with questionnaires intervals being for every 6 months of age. Three children's scores fell above the cut-off score, suggesting that these children may require mental health evaluation. There are, however, many variables that influence a child’s life that should be considered before referrals are made (Squires, Bricker et al. 2002).

4.2.3.2 Strengths and Difficulties Questionnaire

Three SDQ were answered by 3 women with children over the age of 4. One child’s total score fell into the borderline range, indicating need for further assessment. Borderline scores were recorded for the conduct problems, hyperactivity and peer problems scales. A second child’s conduct problems scale score fell into the abnormal range, and the third child’s scores for peer problems and pro-social behaviour scales were in the abnormal range.

4.2.3.3 Growth and Empowerment Measure

Ten women filled out the GEM. There were 4 sections within the GEM.

GEM Section 1: Description of participants who answered the survey

This section gathered important background information covering age, gender, community, partner status, number of children, housing situation, education and occupation, with an additional question concerning time involved with the group.

Surveyed participants’ age ranged from 20-49 years old. Seven of the 11 study participants identified as Aboriginal.

Education level

All women attended school up to Year 10, with two having completed Year 11 and three having completed Year 12. One woman reported university experience, while seven reported having attended TAFE courses. Through the education component of the pAReNt Group, three women are currently completing their Certificate 4 in Community Service Work via TAFE Open Training and Education Network (OTEN).

Housing and family circumstances

All lived in the Sydney area (nine in the suburbs of Botany, La Perouse, Malabar, Maroubra, and Coogee) and 4 indicated that they had also lived in other regions of NSW and Australia (1 participant is from Alice Springs). Nine women reported that their current housing met most of their family’s needs, while 1 reported living in poor housing. Nine women reported that they have a partner.

Employment

Four women indicated that they work part time and 6 reported unemployment. One of the 10 women indicated that they volunteer some of their time to helping others.
GEM Section 2: Emotional Empowerment Scale (EES14)

The ‘Emotional Empowerment Scale’ (EES) is designed to capture the extent to which an individual is able to feel and show specific signs of wellbeing in their everyday life (Haswell, Kavanagh et al. 2010). All 14 questions were answered by the 10 women. Scores ranged from 1 (least desirable option) to 5 (most desirable). On average, the items which the women scored themselves most highly on were, ‘I am hopeful for a better future’ (4.3) and ‘I am skilful and able to do things that are important to me’ (4.0). Those that the women scored themselves lowest on as a group were ‘I feel calm and relaxed even when busy’ (2.8) and ‘I feel safe and secure and I can face whatever is ahead’ (3.1). Remaining EES such as EES 6 fell in the midrange. These were consistent with Haswell (2010), in which the same items had the highest average scores, and the item with the lowest average score (3.79) was also ‘I feel calm and relaxed even when busy’. However, the pARenT Group’s score for this item was considerably lower (2.8), and the average total for all 14 items was also lower (50.7 compared to 58 out of a possible 70).

GEM Section 3: Kessler 6 Psychological Distress Scale (K6)

The standard K6 involves 6 questions which ask participants to indicate how often in the last month they have felt negative emotions such as severe sadness, nervousness, restlessness, worthlessness, a lack of hope and that everything is a struggle. Scores on the K6 can indicate harmful levels of stress that can be associated with a diagnosable mental health condition (Furukawa, Kessler et al. 2002; Kessler, Galea et al. 2008). The use of the K6 with the GEM enhances an understanding of how people are able to experience social and emotional growth and greater wellbeing despite emotionally stressful circumstances within their lives (Haswell, Kavanagh et al. 2010).

For this group of 10 women, scores ranged from 1 (least desirable option) to 5 (most desirable). Five indicated they experience low levels of distressing emotions (score between 6 and 13) while 4 reported mild/moderate distress levels (14 to 18) and 1 reported high distress levels (above 18). The latter score suggests that one of the women may experience clinical depression and/or anxiety and counselling support may be helpful.

The additional questions assessing how often you feel happy in yourself and angry at yourself and others were analysed individually. Among the group, half the women said they were happy some of the time, 2 most of the time, and 3 only a little of the time. Half the group also indicated that they feel angry some of the time, with 1 reporting feeling angry most of the time, while 4 indicated they had angry feelings only a little of the time.

Figure 4: Distribution table for the highest Emotional Empowerment Scale item, showing frequency of the 7 possible choices as selected by the 10 participating women
GEM Section 4: **Empowerment Scenarios (12S)**

The 12S aim to capture the extent to which the respondent has achieved movement between degrees of empowerment in aspects of life, from the lowest state to the highest state, reflecting emotional and relationship strengthening.

Valid scores were obtained from all 10 women on most of the scenario questions, with 8 women responding to S6 and 9 women to S8 and S12. The range in scores was from 1 to 7. Amongst the ten scenarios, the highest average score was observed for scenarios asking participants to indicate their ‘sense of knowing self’ (S7) and ‘ability to create safety for self and family’ (S2) (5.1 and 5.6 respectively). The scenario topics that the women scored themselves lowest on included the extent to which they feel they can ‘speak out and be heard in their community’ (S8) and ‘deal with judgement and criticism’ (S10) (3.6 and 3.7 respectively). These were consistent with those reported by Haswell (2010), where S7 and S2 also had the highest average scores. The pARENt Group however exhibited a considerably lower average score for S8 (ability to speak out and be heard) and the overall average for the pARENt Group is also significantly lower (45.5 compared to 53.5 out of a possible 70).

Scenario 7 is displayed below to demonstrate the structure of the Scenario items. The circles at the bottom of the figure show the number of women who responded to the different choices for this scenario.
Table 10: Comparison of scale and subscale mean scores from pAREnT Group GEM data (see Appendix 7.1, Table 13 & 14)

<table>
<thead>
<tr>
<th>Scale/subscale</th>
<th>N</th>
<th>Total Possible Score</th>
<th>Mean Score (% of possible score)</th>
<th>Min Mean</th>
<th>Max Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total EES14</td>
<td>10</td>
<td>70</td>
<td>50.7 (72.5%)</td>
<td>43.9</td>
<td>55.0</td>
</tr>
<tr>
<td>EES inner-peace</td>
<td>10</td>
<td>40</td>
<td>27.8 (69.5%)</td>
<td>20.0</td>
<td>32.0</td>
</tr>
<tr>
<td>EES self-capacity</td>
<td>10</td>
<td>20</td>
<td>15.1 (75.5%)</td>
<td>11.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Total 12S</td>
<td>10</td>
<td>70</td>
<td>45.5 (65%)</td>
<td>25.0</td>
<td>56.7</td>
</tr>
<tr>
<td>12S healing</td>
<td>10</td>
<td>42</td>
<td>26.8 (65%)</td>
<td>12.0</td>
<td>35.0</td>
</tr>
<tr>
<td>12S connection</td>
<td>10</td>
<td>28</td>
<td>18.4 (65.5%)</td>
<td>13.0</td>
<td>23.0</td>
</tr>
</tbody>
</table>

Table 10 shows that participants’ sense of self-capacity is higher than their sense of inner-peace, healing or connection. Note the large range difference between individual item minimum mean and maximum mean scores for Empowerment Scenarios (12S). This reflects the diversity that the group holds, with some older participants possibly in a more empowered stage of life than others.

4.3 Baseline qualitative findings

4.3.1 Respondents

Seventeen face-to-face interviews took place (please see Figure 7 below). Of the 11 parents who consented to the research, eight were interviewed. Nine interviews took place with program developers, delivers and health centre service providers. Two focus groups with participants were held, one of four women and one of three.
4.3.2 Qualitative categories

4.3.2.1 Program establishment and adaptations over time

The La Perouse Aboriginal Community Health Centre has delivering a growing number of services for child and maternal health since its inception. Such services include paediatric and speech therapy outreach clinics run by The Sydney Children’s Hospital, midwifery clinics (Malabar Midwives), Aboriginal Health Education Officers, a counselling service and a drop-in GP clinic run by the Redfern Aboriginal Medical Service. An Early Childhood Nurse (ECN) undertakes early childhood care home-visits in the Eastern Suburbs area four days a week accompanied by an Aboriginal Health Education Officer/Early Childhood Worker (AHEO) from Prince of Wales Hospital.

Prior to the pAReNT Group, an informal playgroup/mother’s group, assisted by the Malabar Midwives (MM), took place in a meeting room adjacent to the clinic rooms within the Health Centre during the weekly maternal and paediatric clinics. To enhance the potential of the playgroup, an Aboriginal child and family health staff member organised outdoor play equipment to be installed in the yard next to the meeting room and a childcare agency to supervise the children during the playgroup time. The staff member started to sense, however, that more support was needed for the young mothers of the La Perouse community. During home-visits with the community nurse, she had noticed that most mothers infrequently visited the Health Centre, were socially isolated and withdrawn and had not finished school, having left upon entering motherhood. She was concerned about the number of teenage pregnancies in the local area, the little social support these young mothers had and that without educational qualifications they may find it difficult to gain employment in the future. The idea came to her that the Health Centre could host a program for these women. Here she describes the young mothers’ concerns, and her early ideas for the program:

Some of the young mothers that were mothers at 14 or 15 whatever, they thought, ‘Well, I’ve got no skills,
what can I work as?’ One of the mothers said to me, ‘Oh [name], you know if I have to go out and work, I don’t know anything, and I don’t want to be somebody’s cleaner!’ And I said, ‘You have the opportunity to go back to school and TAFE.’ The mother said, ‘Oh yeah, but I’ve got the baby, and how am I going to manage study and the baby and getting there and stuff like that?’ So that’s when I thought, well maybe that’s what we need in the community for the young mothers – we need an education program as well as organising to have baby-sitting, transport – everything so that there are no barriers for these girls to study.

The Centre was an ideal location; it was central to the La Perouse community, and there was already a ‘captive audience’ to begin the program with, the mothers attending the informal playgroup while waiting for their child and maternal health appointments. The staff member also could see that the program may be able to attract more mothers to the Health Centre services.

The staff member began advocating for funding for a parent support program that would support the community’s young parents’ easy and early access to primary healthcare services, help them pursue educational and training opportunities and provide them with a support network through which they could develop friendships, strengthen self-confidence and aspirations and share parenting skills and experiences. The community paediatrician joined in her efforts to develop a program proposal, defining objectives and processes, and after receiving permission from the La Perouse Advisory Health-Link Committee, the pair applied for grants. An Aboriginal staff member describes the community’s support of the program:

The community were on board because they thought that, you know, we were startin’ to get a lot of teenage pregnancies in the community. So they thought it would be a good idea because if it could either get them back into education programs or back to school or, however they study, then that was fine... They thought it’d be good for the youth to know that even if they left school the only option wasn’t to fall pregnant, they could get into other tertiary courses.

In mid-2008, the pair secured a two-year grant from the Greater Eastern, Southern and Illawarra Child Health Network (GESCHN) to cover the salary of a program implementation officer (coordinator) and goods and services. It took one year however to recruit the position; after three rounds of advertising for an Aboriginal person to fill it, a non-Indigenous, community arts educator with a strong background in facilitating community art programs in South Africa was given the role in June, 2009. The original staff member’s role was to introduce the coordinator to the community and provide cultural guidance.

The program’s conceptualisation did not incorporate a pre-defined idea of a tool to engage the target group. As the new coordinator had used art as an engaging mechanism in her prior community work, it was also adopted by the pAReNT Group. This proved to be a huge success in attracting parents to the program as well as facilitating individual growth and group cohesion. It was also an appropriate approach for the community, as local La Perouse Aboriginal people have been industrious producers of shell-art and other crafts for generations. Regarding her choice of art as an engaging mechanism, the coordinator remarked:

I said, ‘Well I’m happy to work within the program aims but I’m going to use art to have a conversation to facilitate these outcomes.’ Basically I don’t know how else you could do it. For me, art is an obvious choice of language. Of course there are other strategies, but there’s a lot of documentation to support the idea that art can be a very powerful tool for working with communities.

The team consisting of the community paediatrician, an early childhood nurse, an Aboriginal Health Education Officer, Malabar Midwives and the new coordinator recruited parents to the program by brainstorming lists of clients they knew would benefit from the program and contacting them, followed by a personal invitation by the coordinator. After the coordinator had contacted these parents as well as approached other parents in the Health Centre, it didn’t take long for a group of regular attendees to form.

The only requirement to be part of the group was that the children must be Aboriginal. A bus was bought with grant money; transport would facilitate the success of the program with most young mothers in the target community not having cars.

There were some changes during the ‘settling in period’. Early on, the program ran only once a week. It quickly became apparent however that that was not enough. Another day was added and the
time-structure became more concrete. It also took some time for the program to fit in with the other existing programs, staff and facilities at the Health Centre, as a slight distrust of new programs in Aboriginal communities exists due to many dissolving after promises made. This challenging period soon abated, however, and the program quickly became a well-accepted part of the Health Centre. The program developed into a mothers’ group instead of a parents’ group, however it is still inclusive of families, with grandparents present if they are the primary carers or fathers if they are more involved with the primary care of the child.

An early activity, which assisted in the formation of a regular group, was a course delivered by TAFE Randwick, as the program director explains:

It was quite structured but fun and it was about identity and Aboriginality and being a mother in that community. And I think people found that quite engaging, and people just started coming ... We had something interesting to offer.

After this course the coordinator turned the program focus to individual artwork projects, with less program structure providing for time more experimentation with materials.

Partnership with TAFE continued, with TAFE OTEN providing tutoring services to parents; as part of the implementation of its key aim of education, the pARENt Group Program offers participants the opportunity to enrol for correspondence courses, which they can complete with the flexibility essential to them as parents.

After the group had been formed for a year, the participants decided together on a unique group name. The name chosen, ‘Ngala Nanga Mai’, means ‘We Dream’. As one team member explains, the naming of the group was a significant moment in the group’s history, that of the evolution of a group identity within the group, which had grown from a state in which disagreement and tension were common, to a level of cohesion and unity that enabled such an important collective decision to be made.

The name – yes it means ‘We Dream’. The process for finding a name was a lengthy and exciting one with many brainstorming and discussions (and arguments) about our sense of who we are and what our purpose is. This was a very important part of the evolution of the group that involved discussion about the role of art in our group, the overall objectives of our group, etcetera. Finally, as if by magic, one day, we sat with a dictionary of Aboriginal words (the Macquarie Dictionary of Aboriginal Words) and came upon the phrase/words ‘we + dream’. It is the Sydney language as defined in the dictionary. Prior discussion did involve whether we use an English and/or Aboriginal name ... in the end, the name chosen was accepted by all of the group at the time.

4.3.2.2 Current processes: How does the program work?

An Aboriginal health education officer, an early childhood nurse and a social worker assist the coordinator in the running of the program. Parents are recruited through the nurse, MM or service providers telling the coordinator about a potential attendee, with the coordinator then personally approaching the parent when they attend the Health Centre. The program is delivered from approximately 10am-2pm each Tuesday and Thursday.

The program has used an interactive participatory action approach to guide its activities over its first two years of operation. Requests from the group are discussed collectively with the coordinator helping the group reach a shared decision that reflects the interests of the majority.

At the insistence of the group, artmaking has become the central activity of the program, with program hours mostly consumed by art and informal conversation, which is generally about shared experiences of parenting, both challenges and accomplishments. Food is also central to the socialisation, the sharing of light snacks taking place throughout the course of the day, children joining their parents to eat. The parents sit around a large table in the centre of the room, working on their projects and chatting, the communal art materials in the centre of the table. Often the women work on collaborative art projects, which are donated for fundraisers or donations. At least once a year the parents are busy preparing for an exhibition; four art exhibitions have been held to date to showcase the parents’ artwork. Most of their exhibited artworks have been sold, providing income for the artists and stimulating aspirations to develop a young women’s commercial art group.
At the beginning of each session the coordinator instigates a short ‘check-in’ in which announcements can be made, parents can share their thoughts and conversations can be initiated regarding current processes and ideas for future cultural outings or collaborative group projects. Service providers believe that this a key feature of the program’s success:

I think the check-in is a really effective feature of the group, because it gives it a bit of structure, and I think it’s just helpful for the women to kind of focus, almost in a mindfulness kind of way, like, why we’re all here and for people to share what’s happening for them, and I think that’s helpful for the others to know what’s happening for them. I don’t know if all women feel entirely comfortable sharing, but I think they’ll get there.

A childcare agency delivers a playgroup in the play-area outside the meeting room. This allows parents to participate in the educational and cultural activities of the program whilst also being available to their children if required. This provides an opportunity of modelling of positive parent-child interactions as parents observe their children being played with and read to in an affirming manner. Parents regularly join in with the activities, interacting positively with the children.

One day a week the TAFE OTEN tutor attends the group to assist students in their studies. In a room adjacent to the meeting room, students can have private assistance on assignments and other queries they may have.

The group regularly visits cultural sites and galleries to learn about different artmaking approaches as well as about aspects of Indigenous heritage. They have visited the Art Gallery of New South Wales to view the Aboriginal Art Collection as well as a special exhibition on the shell work by Aboriginal people of La Perouse. They have also visited the Sydney Opera house to view and meet performers from the music/dance performance Nguurra-Milmarramiriw Wrong Skin.

Health has a constant presence at the group, as was originally intended in early conceptualisation of the program. The program runs at the same time as drop-in maternal, early child health and allied health clinics, allowing the mothers to access health advice and check-ups when required. Health workers are regularly present in the program room to chat, to take part in artmaking and to give advice if needed. This provides an opportunity for the parents to interact informally and become more familiar with the health professionals while painting, allowing for casual discussion of concerns held by the parent to spontaneously take place. The program itself operates within a wellness framework with healthy lifestyle choices modelled by food choices as well as by monthly health promotion sessions run by SCH health workers on topics suggested by group members. The sessions involve a speaker presenting informally while parents continue artmaking. Topics covered include oral health, ‘reading to your child’, ‘fussy eating’, ‘dealing with tantrums’, ‘managing toddler behaviour’, ‘the wonderful world of words’, anxiety and stress management, ‘healthy lifestyle choices for parents’, ‘creative play for children’, ‘new ways at looking at smoking cessation’, ‘mother matters and self care’, ‘surviving a household’, breastfeeding, first aid and resuscitation, injury prevention, ‘water safety’, childhood nutrition, ‘asthma and your child’, ‘lift the lip’, ‘kids matter’, ‘all about ears’ and ‘sun safety’. While the Early Childhood Nurse assists the coordinator in the program implementation, she also is available to undertake well baby and child health checks and review the immunisation status of participants’ children when required. The health education officer is often present to provide support and guidance to the coordinator as well as to parents when needed, and the social worker’s presence is often utilised by parents with questions of housing and other personal issues.

The program was going to have a stronger emphasis on parenting; however the art was enjoyed so much by the parents that other strategies for developing a parenting group were marginalised. Formal weekly parenting information sessions were trialled early on, however parent decided against this traditional didactic approach. The program’s resultant non-direct approach was supported by the director and organisers as it has a large evidence base as is explored in the above literature review; that supporting mothers to enhance their own sense of self and self-efficacy eventually positively affects their parenting and child-rearing capacity, that is, their ability to handle their role as a mother. The director of the program, explains:

We’re not saying, ‘This is what you must do when a child has a tantrum and this is what you need to be aware of.’ We’re working from the basis that the more confident and essentially the less stressed a mother
is, they will naturally talk to and engage with their child, and the more generous they will be, in playing and just being there emotionally for their child because they are stable in themselves. They will be better parents if they’re coming from a better place themselves.

4.3.2.3 Program impacts and strengths: What makes it work?

Health and holistic early intervention

Participants overwhelmingly felt that their personal health has improved since they have been attending the pARenT Group Program. They particularly valued the program’s concurrency with the maternal and child health clinics, commenting on the ease of access this provides to required health advice and assistance. Due to the regular contact they have with health workers and the improved management of their children’s chronic diseases, they feel less anxious now about accessing health services. The casual visits to the program by health professionals were noted as a significant factor in increasing health-service use as the resulting familiarity with the professional staff had the important effect of reducing barriers of intimidation and distrust. One woman perfectly articulated the familiarity that has developed:

The health workers are in touch with you. They know you by your first name, they come out and speak to you and they talk like they’re amongst their own family.

Another parent reflected that she feels the paediatricians and nurses know her children personally because of the frequent interactions and that their conditions are better managed as a result:

Coming here is just, like, it’s an opportunity that I wouldn’t be able to get anywhere else. I wouldn’t be able to get any of the medical services for my son anywhere else but here. And I’ve found that I’ve found a lot out about my son by coming here, like with his medical conditions and stuff, like, I wouldn’t have found that out otherwise, ‘cause no one would fit me in here or there and just coming here, they’re always available. And they’re offering me their services; I don’t have to go and look.

Also valued by the parents were visits by Redfern AMS doctors and the regular attendance of an Aboriginal health education officer, which were generally felt to be judgement free opportunities to talk about their children as well as parenting issues. Self-help has grown remarkably, with parents commenting that they now ask each other for health advice while they are artmaking; ‘We’ll go to each other first.’

Both common and rare childhood illnesses have been discovered within the group, as is mentioned in the above quote, pointing to the probability that intervention is taking place earlier than it would have otherwise, due to increased health service use. Otitis media, a common condition amongst children, is one such diagnosis regularly made in the group that if left undiscovered could cause significant speech and language development delay. The program also assists regular and prompt immunisation delivery, as one staff member explains:

With this program, more of the mothers are learning that, ‘Oh it’s time to immunise the baby, it’s time to have a baby check, kid check.’ So their health is getting better. So one of the, one of the mothers, she’s had four kids, and the last three, weren’t even immunised. Now we’ve got them up-to-date.

Of utmost importance to note in this study is that all service providers and program developers see the program as a provider of a culturally appropriate, holistic forum where the origins of most health issues can be worked on. One respondent articulates: ‘It has a very unique, culturally grounded approach that promotes health at all levels.’ Most social determinants of health are explored by the pARenT Group Program – education, employment, housing, social support, early life, stress and healthy food (Wilkinson & Marmot 2003), with much of this work performed subtly through the program’s focus on empowering the mothers with support networks and self-confidence. As one Aboriginal staff member explains, ‘The group opens up other avenues and breaks down barriers. It’s allowing not just health but all these aspects of their lives to be worked on.’ This is particularly important when many of the children present with development delay, as the speech therapist explains:

In terms of the literature there is an increased risk of presentation of speech and language problems in communities where there’s a higher rate of unemployment, low levels of maternal education, poverty and a mix of other factors. Trying to work out where social/health services fit in when there are issues of domestic violence or homelessness or drug and alcohol use within the family is a bit tricky ... Sometimes it’s a matter
Allied health service providers such as the speech therapist and social worker also reported that use of their services by the parents in the group have increased since program inception. They believe this is mainly due to the familiarity and sense of trust the women now have with them because of the ease with which they can interact with the women, being present during the casual activities and taking part in the art and conversation. Staff commented that over the program’s duration the women are approaching them more often with their concerns, including housing and financial issues and other questions of a personal nature. Another noted that three years ago children were presenting to her at 4.5-5 years, and now they are 3-3.5 years old. In the following paragraph she describes the reduction in stigma, which she believes has had a large part to play in the increase in service use:

I think that as a result of the familiarity it’s been more open. Everyone is just able to talk about delays in terms of their children’s speech and language; it’s not something to be ashamed of. Some that have been in the past a little bit apprehensive, whose children either the PIO or AHEO have told me they’re a bit worried about, now just in the last kind of 6 months or so have been approaching me by themselves and asking questions, like, ‘What age does this certain sound come about?’ By being at the clinic and seeing the families week in, week out has established a level of understanding and trust, so I think that’s really helped.’

The coordinator works with the Aboriginal staff to identify specific children that may be in need of speech assessment, which has been particularly useful for the speech therapist in achieving early intervention. The speech therapist also reported that friends of the pARenT Group members have been using the service more, suggesting that word-of-mouth is increasing access.

The health promotion sessions are also enjoyed by parents, with demonstration and conversation valued over book-reading for gaining information on practical issues such as childhood teething needs and first aid. Most service providers, however, viewed the promotional sessions as ineffective, with a program developer stating:

I’ve never thought presented talks are a major part of health promotion... I think that people take control of their lives when they feel able to and they naturally would like to live a healthier life if they’ve got access to some information.

**Strengthened spirituality and connection with Aboriginality**

The parents feel a sense of belonging from being part of a group consisting of Aboriginal women and children. They report that they share similar experiences, family histories, as well as humour, which gives them much satisfaction. Some parents also use artmaking to explore their Aboriginality, depicting totems and traditional symbols as well as images and painting styles reflecting their present reality as an Aboriginal person in modern Australia:

We don’t have that traditional society here no more, so how can we practice it and sell that when that’s not who we are, that’s not what we’re living? We’ve got to bring contemporary into it, so the colours are changing, no ochre colours that you’ll see everywhere ...This reflects who we are, how young we are, our future, our reality.

Those girls in there are amazing, they are so talented. Aboriginal art obviously, you tell a story through everything that you’re doing, and the more they come down here the better and better they get. For some of them girls, you can see where they come from, ‘cause they are so traditional, so beautiful ... Without even realising it, they are jus’ so natural to it. It’s a very big thing to them. Some of them come from down the coast, Alice Springs, this and that, and it’s who they are, kinda thing. That’s their sense of belonging. That’s how they keep who they are and their tradition alive. Hopefully they’ll be able to grow up and pass it on to their kids. Because the tradition, Aboriginal society today, is, you know, a minority compared to the rest of them. So, the tradition, everything, food, culture, everything, it’s all kind of been forgotten. I know that with my children I’ve got to leave it up to other people to teach my kids. I can teach them what I know but it’s not practiced as much. I was lucky I got to do Aboriginal dancing and stuff when I was younger. I was exposed to it; everywhere and anywhere it was there. But these days it’s not like that. The painting is one way keeping who we are and our traditions alive.
One staff member commented that she has observed an emerging sense of loss as participants find knowledge of their culture. She describes it as, ‘a doubled edged thing, a beautiful thing that happens ... A making in order to celebrate, but also in order to signify loss.’

**Artmaking impacts: contributing to a sense of calm and unity**

Artmaking is integral to the program. Not only is it an avenue to grow one’s identity as an Aboriginal person, as explained above, as well as an effective mechanism to attract parents to the group. It has provided group members with a much-needed sense of calm and expression in the midst of the busyness of motherhood and it has enabled growth in confidence and self-worth. One woman explained that the act of doing art creates, ‘...a space and time for ourselves, to stop our minds from thinking. It is an escape from the family and the children; we all have such full-on, chaotic lives.’ Another participant reflected that artmaking calms her in such a way that she is less frequently stressed with her children when she is with them at home. Much self-expression and reflection takes place in the artmaking process, with one mother describing it as, ‘...a release, a time to think and put your thoughts into your artwork. It’s your inner that comes out. You start painting and the next thing you know, you can’t stop.’

The art has become an important bonding tool. The following comments reflect this:

- I think the group wouldn’t work without that space of the painting. It’s that painting that brings us together.
- I reckon if it weren’t there it’d be harder for people to be so relaxed around each other and relate, as (the art is the) one special common ground.
- I think that the art makes it more enjoyable as well, it’s not such an effort to come because you want to come and do the art, and it’s not like there’s any pressure to talk. We come here and do our art, and it turns into normal talk, conversation.

The women felt that collaborative artmaking in particular brought the group closer, as it encourages conversation and ‘...opening up; putting aside that ego pride thing.’

A focus group also revealed that collaboration teaches teamwork skills such as shared decision-making and conflict resolution:

- It’s teaching us about teamwork, you know ... Some of us have never been in a team or worked together and it’s teaching us, and I think that’s good cause a lot of them are young. It’s teaching them those skills like everything from, you know, working together to being able to sort out a small conflict.

**Education**

Parents and service providers view the program’s focus on education as an enriching element of the program. Only some parents thus far have utilised the opportunity to pursue courses through TAFE OTEN, reflecting that the stage that they are at in their life is not yet conducive to returning to study, however those that have are optimistic about their progress and what the courses will contribute to their potential to gain work in areas they are interested in. Courses currently enrolled in include: Community Services, Information Technology, Year 10 Certificate and Horticulture. The tutor reflected that the education that is taking place ‘seems to be having a flow-on effect’, with expressions of interest in courses coming lately from other group participants. Current students remark that they try to encourage the other parents to use the opportunity while it is before them. The tutoring provided once a week during the program is an essential factor in ensuring that study is successful, students report.

**Impact on participants’ children**

As well as the early intervention that takes place in health conditions and developmental delay as a result of attending the program, parents value the Group’s many other contributions to their children’s wellbeing. First, most see it as a valuable opportunity for social and cognitive stimulation, with some suggesting that they do not have other friends or family members with children with which their children can play. Also, a number of women described that their children have become less ‘clingy’ or attached; prior to the group they would not leave their mother’s side but now they are happy to be separated, playing in the playground with the other children. Furthermore, parents see the program as a unique resource to foster their children’s Aboriginality, with few Koori playgroups existing in southeast Sydney.
Other benefits mentioned include: physical activity; knowing their children are being looked after while they take a small break from parenting; mothers caring for each others' children and the influence of the artmaking on their child’s creativity.

**Impact on parenting**

Parents reflected that the program has helped them want to move forward in their lives into positive activities and better parenting. Seeing other women’s parenting style inspires them to adapt their own:

> It’s the good things that they do, but also the things that they don’t do that makes me see how I want to be... I wanna, you know, be better, do better, get a move on with my life, like, do things for my son that I should be doing.

Confidence in parenting has also grown: ‘Knowing that other people are dealing with the same kind of stuff... If they can get through it I can get through it.’ The two youngest mothers commented that the program has helped them to nurture their ‘motherly instinct’ as it has engendered an alignment with the role of motherhood rather than the teenage world of irresponsibility that their friends still exist in.

> Literally before, I would get up and be like, ‘What am I gonna do today, like, really, like, what am I gonna do?’ I was just going to my mum’s all the time, and she works, so I was just going there and doing nothin’, like drinking with my baby, like, you know what I mean? There’s nothing that’s constructive or positive in that... it’s just like all my friends are young and stuff and I was just eighteen when I had my baby, and all of my friends were just turning eighteen, and when I’d go out, if I wasn’t going to my mum’s, I was going to see my friends and what would they be doing? Like... Yeah like it’s brought out, you know, more of the motherly instinct within me or of me, out of me or whatever... yeah. And it taught me how to sacrifice, like, you know, putting things on hold, like the drinking, putting that on hold until I have the time, like when he’s older and not around.

**Personal and organisational empowerment**

The women feel that they are becoming more enabled on several levels: inner strength, a sense of community support and a desire to give back to community. Wallerstein’s (1992) ‘levels of empowerment’ will be used as an organising tool to explore this experience (Table 11).

**Table 11: A framework for empowerment evaluation**

<table>
<thead>
<tr>
<th>Wallerstein’s “Levels of Empowerment”</th>
<th>Corresponding settings applied in Case Study</th>
<th>Related empowerment attributes/variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal or psychological empowerment</td>
<td>The individual and family</td>
<td>Improved perceptions of self-worth and mutability of social environment as evidenced by: empathy and perceived ability to help others; emotional responses to change; critical thinking abilities of root causes of problems, belief in one’s ability to exert control; and a sense of coherence about one’s place in the world.</td>
</tr>
<tr>
<td>Organisational empowerment</td>
<td>The pARENt Group</td>
<td>Stronger social networks and community/organisation competence to collaborate and solve problems as evidenced by: perceptions of support, satisfaction and community connectedness; and changes in network function and utilisation.</td>
</tr>
<tr>
<td>Community empowerment</td>
<td>The wider community</td>
<td>Actual improvements in environmental or health conditions as evidenced by: changes in public policy; systems level changes; and the community’s ability to bring in resources to create healthier environments.</td>
</tr>
</tbody>
</table>

Source: Adapted from Wallerstein (1992)
Participants reflect that they have felt their confidence and sense of self grow as they have been involved with the group, and this is largely attributed to the socialisation it offers as well as the encouragement it provides to help identify one’s unexplored and neglected interests. One parent mentions:

I’m getting more confident just coming here, ‘cause I didn’t really do stuff, talk with many people, before... So just being here in the group, being social, communicating with people, it really helps.

Another parent describes it as a ‘healing group’, that allows for previously ignored or unexplored dimensions of themselves to shine: ‘Coming here, we laugh, we talk, we share things, you know. The girls and I ... It opens up other roles than being a mother.’ The women now feel that they can move forward into new activities into positive activities:

Now that I have that support and facilities, I feel that I am able to get out, do things, move along with my life... It’s started me thinking about my life and what’s ahead of me, and it’s giving me the encouragement and the willpower to actually get out and do something, giving me hope to move forward... I want to start to do some courses or something to build up my skills.

The growth in sense of self beyond parenting that the women are experiencing has also affected relationships at home. One woman explains, ‘I go home on Tuesdays and Thursdays and my partner even says to me, “Oh you’re in a good mood today”, and I’m like, “Yeah, ‘cause I went out today and talked to other grownups.”’ [My partner and I] now have something to discuss, we actually have a conversation topic rather than being a mother. ‘I want to start to do some courses or something to build up my skills.

Most of the women resoundingly agreed that the group helps them to feel in control of their lives, with their week ‘positive and full’ rather than mundane and ‘unproductive’. This has flow-on effects on their relationships with their loved ones:

We get so excited when we are getting ready for the group because we know we are going somewhere, doing something for the day, we’re not just, you know, sitting inside and stuff ... I don’t feel slack, I feel like I’m on track. So it all makes us happier at the end of the day, and I’ve noticed a change between me and my son, just how much we’re making more of a productive day and we do have a lot more energy because we’re into more of a structured routine.

Before I started coming I wasn’t doing anything, I was just like waiting for every day to end, basically ... I would be sitting in the park yelling at the kids ... doing nothing structured or good ... Now it makes my week more structured. I have things on every day.

The women reflected a sense of feel valued that was previously rare or unknown:

You feel like you’re being heard and other people are listening to you ... You almost have that role in your community again. I didn’t have that for a long time. And coming here I feel like I play a big role in sort of influencing the younger girls and so I feel like I am a role model.

When we have group discussions, and I put my ideas in, a lot of people say, “Yeah! I wouldn’t have thought of that,” and [I’ll think to myself], “I never would have thought that information would be useful ’til now.” So it makes me feel valued and liked.

Artmaking seems to plays a big part in this personal development. A large proportion of the women emphasised the influence of artmaking on their self-esteem:

It makes you feel good ‘cause everyone’s commenting on your painting. It makes you feel proud, proud of your work, that it’s been shown and maybe get recognized for your work ... Proud moment.

The parents feel that they are now part of a community that supports and cares, and this has nurtured much of the above-mentioned descriptions of inner growth and reflection. As such comments indicate the social environment is one that gives a sense of belonging, participation and being valued. A significant flow-on effect of this seems to be an improvement in mental health within the group. A woman reflected that before being involved with the program she felt ‘... lost and alone, without support.’

Another woman commented, ‘The group has helped me with my happiness, ’cause before I was starting to
feel depressed and felt that I wasn’t going to make any new friends at this time in my life …’ One mother offers an explanation of why this happens to young parents:

Young women, we have kids, and regardless of how many you’ve got, the first thing you do is isolate yourself from the world. As a mother you lose confidence in socialising and what’s happening around you in the world, and if all your friends are still doing the same thing and you’ve got a baby. You lose touch with everything, and it can be really, really hard. The postnatal depression comes from when you haven’t got anyone else to talk to and I guess, just feeling that you’re a mum but you’re not really anything else.

An Aboriginal staff member explains the value of the program:

I think a lot of them are quite depressed and or they've got mental health issues and I think that the group really helps them to just interact with other mums, and I think they’re really proud about their painting and their Aboriginality – that’s their way of expressing their Aboriginality and that in term helps their mental health and their anxiety and that sort of thing, makes them have a sense of belonging ... Being in groups like this is great because it gets all the women socialising, gets them thinking and talking, so helps the mental health and the confidence levels of women the post-natal depression ... comes from ... when you haven’t got anyone else to talk to and I guess, just feeling that ... you’re a mum but you’re not really anything else.

Organisational empowerment

Perceptions of support, satisfaction and community connectedness reveal that social networks are strengthening as a result of involvement with the program, and that this is stimulating a growth in resilience and coping skills, the ability to withstand life’s challenges and stresses. The women feel a sense of solidarity in the group as they all share similar life experiences; this supports them in their daily routine, as does the parenting and life knowledge that they share together, educating each other. Service providers and parents stated:

Participants are often dealing with and balancing a raft of life challenges and roles, such as parenting, academic needs and social roles. This group provides the support that is necessary for them to be able to adjust to the pressures of these roles.

(Parent) It makes you realize you’re not such a bad parent. We’re all struggling, we’re all in the same boat, and we all get advice off of each other to cope

(Parent) We’re all going through the same sorts of issues – emotionally, financially, with the kids, so we can either come here and, whether we talk about it or not, we’re being supported ... We’re being shown that we’re allowed to be up and down and have all these emotions. So basically now it’s just like this family.

It is agreed that the program’s lack of judgement is one characteristic that contributes greatly to the perceived safety of the program’s social space: ‘Everyone listens to everyone’s ideas, so you never get shot down,’ ‘It’s like the rules are: express what you’re feeling, don’t judge, listen, and you just support.’ Such a respectful environment is particularly important considering the heightened sensitivity to judgement that young people experience, which was commented upon by a few mothers.

Friendships have grown strong in the group. Parents spend time together outside of the sessions, and the members reflect that they are learning from each other:

I’m trying to teach them to be more open, to look in to the future, to expand their horizons and to keep their mind open, to accept compliments and be proud, and they’re teaching me to be more accepting of other people...They give me inspiration, hope and encouragement.

The group has reached a level of resilience and connectedness where parents are moving beyond themselves to care about and work towards improving societal issues, both within and outside their own communities. They recently finished a collaborative artwork, which was donated to a charity to help raise funds for flood aftermath victims in Queensland. They have other ideas to assist communities in need in the future, such as fundraising through their art sales, volunteering, organising benefit nights and donating money to children’s hospitals. They also would like to organise a mentorship program with younger mothers.

Two parents want to use part of their TAFE Community Services Certificate course time to assist in the running of the group to make it easier for the coordinator as well as to learn organisational and administrative skills. One woman’s dream is that one day she will run a similar course for teenage girls in her locality. Some group members also mentioned that they would like to independently run the group
with little help from other organisations as possible, aspiring to consolidate the group through sourcing funds to achieve program security, organising a website and a code of conduct manual, and managing the collaborative art work income: ‘We all want to sufficiently do our group.’

Community empowerment

As discussed above, through the program parents are being exposed to a holistic health approach that aims to prevent illness as well as promote a strong community. Impressive health gains are being made, with the program being an extension of the Health Centre’s efforts to offer holistic health services that encourage community members to taking more control of their health and develop a trusting relationship with the service. The La Perouse Advisory Health-Link Committee oversees the services and projects implemented by and within the health centre, ensuring cultural appropriateness and empowering benefits. The health centre and the pARENt Group have become integral community gathering places where support can be found, and hope and self-determination developed.

Additional key enablers of success

Skill of the Project Implementation Officer

All respondents have resoundingly agreed that the PIO (coordinator) has been integral to the success of the group so far. Parents reflected that she makes each participant feel understood and valued, she encourages the participation of the parents in decision-making while also ensuring that group interests, not individual interests, are upheld, and she constantly networks to assist women with service access as well as employment opportunities. The most common reflection was that she has a respectful, confidential way of facilitating positive interaction between people in the group, fostering good relationships and trusting, open communication, and that without this the group would have collapsed due to the diversity of personalities and opinions that it holds. Here is a quote which illustrates the affection held for her by parent:

Oh, [Name] is amazing ... [Name’s] just like a different type of person, you know, she’s so open. I don’t know, you can’t explain it. Without realising, she’s changed so many people’s lives. As much as we could all come together with the group, [Name] made it happen. She made it feel like a family because she went to so much effort. She gave so much attention to people; the kids just love her so much. It is like she’s part of our family, you know what I mean. Not only her, the other ladies as well, but she goes the extra mile, you can see things that affect her, she thinks about you when she’s not here, kinda thing. She believes in what she’s doing. She can see the vision and she believes in it. She’s always one step ahead, thinking of bigger and better things.

Food

Parents have emphasised that the fact that food is provided is greatly appreciated, however healthier food is respectfully requested, and they discussed that they do not mind contributing to the preparations or the ingredients. Respondents reflected that food offers many positive qualities, such as enhancing the welcoming environment, a way of relating to each other, and is an opportunity to interact with children through the sharing of snacks. A program developer remarked that she was pleased to hear that the food isn’t thought of as healthy enough, as ‘it shows that they must have moved a long way forward, as when they first arrived [when the program first began] they hadn’t had anything to eat in the morning and were just happy to eat!’

Transport

Transport has been an essential factor in the program’s effectiveness, allowing parents access the program when otherwise lack of mobility would render it unfeasible:

It makes my life a hundred percent easier. I don’t drive, I can’t get around on my own, yet I can just be picked up, brought here, and everything I need is, like ... all fitted into one, for me and my son.

A service provider mentioned:

Transport is the key thing for this population who are socially isolated because they’re a bit geographically isolated in terms of public transport or availability of funds for transport, so I think that’s key.
4.3.2.4 Program challenges for effectiveness, growth and sustainability: What holds this program back from doing its best and growing and threatens its survival?

Space for new members

It is recognised by all respondents that the strong social bond that has formed between Group members may be a potential barrier for new women curious about joining. The group of women who regularly attend the pARenT Group has not changed much over the last year, their personalities are strong and vocal: ‘Within the group there is a sense of group security, hence members appear to interact in a very confident manner amongst themselves.’ There is a concern that an outsider’s first impression may be that there is not enough physical or personality space for new members, and that they do not belong. A service provider remarks:

When everyone is in that room, its busy and hot and claustrophobic … and I think that sometimes that can be a little off-putting to our clients. They won’t go in there because there are so many people. So they will sit outside in the waiting room, which they would never do before. The space … it’s so tight, and if you open up that door and there are all these people and all this happening, you kind of go, ‘Oh, do I belong in here?’ close the door and walk back out.

Newcomers to the program may perceive the established group as a ‘clique’:

I think that one of the things that I worry about is that it is a small group of women who now have become a group, and I feel that new people join the group it might feel to them that there is very much a group and that becomes like an in-group and an out-group. So potentially, as the group gets closer, maybe it gets more closed for newcomers…

I don’t know how it would feel to be not part of that core group coming in … I don’t know how easy that would be for someone to integrate into that group because they’re fairly tight knit.

Parents resoundingly emphasised their hope that once newcomers join they realise quickly that the group is in fact warm and welcoming, however it encourages peer members to ‘… speak their opinion, whether it’s right or wrong’, thus the group is quite loud and animated at times. All members of the group, new and old, stated that they found the group incredibly friendly when they initially joined. Most, however, reflected that they were apprehensive beforehand about joining and were not sure that they would be accepted by the group. Program participants, service providers and program developers all realise that this negative perception of the nature of the group is a real barrier for some women, preventing them from accessing the service.

Age

Although the group was intended for young parents they have been difficult to engage, as the program director explained:

We do know of some very, very young mums, 14-15 years old, who sort of see the people in the group as quite empowered and self-confident already, and it’s quite an intimidating group to come into for them. There’s not many of them, only one or two a year, but for me they are probably the most important. They really are unable to access services well, they tend to get depressed and isolated; you can imagine how incredibly hard it is to have a baby at 14 or 15. So we need to work harder at getting them, we need to provide more house visiting services for them. They might not be ready for the kind of service that [the coordinator] is offering, which requires quite a lot of internal motivation.

Parents also postulated intimidation and shyness as possible reasons for younger mothers not joining the group: ‘The younger kids that you get here have very outgoing personalities, and the ones other than that, you won’t get them coming here,’ ‘… they aren’t confident talking about their feelings and themselves.’ The coordinator suggested that as well as young parents not feeling that they have much in common with the older women that attend the program, they also still want to be teenagers, not mothers, and so an organised program may not appeal to them:

The program was to initially work with the younger group of women up to 24 years old, and what became apparent was the younger group didn’t want to engage. We were getting the older mums, which I think makes a lot of sense. The younger women have a different relationship with their children … It seems like a
A lot of them give their children to their mums and go and hang out at shopping centres and whatever. These people still want to still be young – they are interested in parties and stuff like that, whereas the older ones are sort of more resolved about balancing their role as mothers and as individuals, so they are more receptive to these sorts of programs. So maybe have to catch the younger parents in a different way. They might not be interested in artmaking, they may be more interested in having a coffee in Eastgardens [local shopping mall] and having it there.

One parent emphasised that teenagers have a large sense of ‘shame’, which hinders their independence from peers and may prevent teenage mothers from trying new things such as parent programs:

The young people, you’re not going to get them to come in here... I’ve tried. Everything is ‘shame’ to them... It’s this image thing... a confidence barrier that you’ve got to break through.

It was also reflected that fear of judgement may also affect attendance by younger parents:

(Parent) That’s a big issue when you’re younger, you know, you’re always feeling as though you’re being judged or you’re not good enough, things like that.

(Staff) They probably don’t come because of um, fear of, um, ‘Oh if I start going down there, well they’d say, I’m not a good mother, I’m not doing the best for my baby,’ you know. And most young teenage mothers only do what their mothers told them, you know. ‘Cos they live at home. And some of them really aren’t good parents because mummy feels like she’s gotta take over the role and... um... don’t let them do anything. My sister was like that with my niece, my niece had her first child at seventeen, and you go over now and my sister’d be doing this, doing that, and ‘do that, do that’, and I said to her one day I said, ‘Let her learn on her own! She’s gotta be a mother, so if you’re not around one day or she moves out she’s still gotta be a mother, she’s not gonna be a mother!’ And that’s what I say to [the coordinator].

**Dependency**

There were remarks made by some parents and service providers regarding elements of dependency and disempowerment fostered by a program arrangement where food, childcare and resources are all provided without input or effort from participants. One parent comments that participants need to be more responsible, and that workers could encourage this rather than allowing them to be passive:

Everything is done for us, right down to our kids, to bringing us food, to getting us a drink, like... I’ve said it on many different occasions that sometimes, a worker just needs to turn around and say, ‘you need to get up and do it.’ If we’re reminded to do the things that we should be doing then the days when we’re not here maybe we might.

**Childcare**

Another challenge has been organising and affording appropriate childcare. A lot of the kids have special needs, as the program director explains:

There have been difficulties getting quite high level child care to manage some of the kids. These kids just can’t just happily play outside for a couple of hours. But we haven’t had the budget to pay for that. That’s been difficult. You see what happens when there is no childcare. Hard for [the coordinator].

**Family planning**

A key aim of the program is to promote family planning, however so far this has not been successful, as a service provider explained:

One of our aims was to help people make choices around whether they want contraception and when they want the next baby, but I think they’re having quite a lot of unwanted pregnancies in the last few months. So I’m not sure that we actually are achieving that.

**Supervision for program implementer**

As the program implementer’s role is one in which many diverse and often confronting challenges arise, the need for supervision that allows her an opportunity to ‘debrief’ has arisen, as she explains:

I think one of the things that is lacking from the program is a truly supportive structure for me for supervision, to check myself to see whether there are ways in which I can be delivering things differently.
At some point after about a year of the project I was feeling completely overstretched and overwhelmed. I felt I needed help to debrief – I needed supervision. However, because this program is non-traditional and non-mainstream, there weren’t structures for supervision. Nurses, allied health workers, psychologists have supervision. It’s basically a peer who debriefs with you on what’s going on. And because my work touches on different disciplines, psychology, art therapy, artmaking, education, health, social work as well, it’s huge. I’m not a qualified psychologist. I’m not saying I’m not qualified for the job, but you need structures to support somebody in my position. At that point I went to [the program director] and said I need supervision. We looked for a few possibilities, but it never took off. And whilst people have given it in an ad-hoc way, it’s not actually built into the program itself, and that’s partly financial …

4.3.2.5 What is this program’s true potential and what does it need from policymakers to enable it to fulfil this potential?

Respondents identified some key areas where the pARENt Group could work better. These are explored below. First though, funding must be mentioned. Securing sustained program funding allows a program to reach its full potential. Currently, finances are only available for the salary of the PIO; this is provided by Rio Tinto and will expire in 2013. There is no existing funding source for other essential goods and services such as childcare, insurance and running costs of the program bus and new art supplies. The program urgently requires funding to support these key current functions before it can be extended into new areas and processes, with priority being the recruitment of an Aboriginal community services worker, as well as a supervisor, to support the PIO in her position so that her energy is sustained, not exhausted.

The PIO explores the program growth that was able to take place as a result of the security temporarily gained through receipt of the 2011-2013 Rio Tinto grant:

When you set up a pilot project you have a skeleton sense of how it will be, and when it is successful, you need the flesh. And the flesh is basically staff and funding and I suppose why so many projects fail is because they don’t transition from the pilot phase to the sustained phase. But we are lucky to have got the [three year] funding from Rio Tinto Foundation [allowing us to transition]. When you have a pilot project there is a lot of pressure from funders to be successful quickly, and I think that you tend to … you don’t go deeply as you need to do. I think that when you have a sense of more time, even though three years is not that long, we have an opportunity to go deeper in all ways … in the processes we put in place, in the time and patience that we’ve got for things to unfold, in the structures, and even with things like databases – having all that information, working out what we need in order to be a better program, to be a ‘best-practice’ program.

With funding drawing to its end, new finances, sufficient enough to support the program’s many new developments, needs and aspirations, as well as current processes, is required.

Aboriginal person to assist running of program

The need for someone to work alongside the PIO in the running of the program was an issue frequently raised by respondents. The ECN and AHEO originally assisted the PIO, however, they are increasingly unable to commit time due to ever expanding roles. This has resulted in the PIO feeling, in her own words, ‘overstretched and overwhelmed’, and without additional human or financial resources new ideas for improving the program cannot be implemented. The ECN stated that the dilemma revolves around the program being ‘set up without staff’:

I try to make sure that I’ve got no appointments on Thursday from 10 ‘til 2 so that I can be at the group, but then sometimes someone will want to talk to me to check their baby, so I’m late, or I’m in and out a bit. But [the coordinator] needs someone who’s rock solid and who’s there … I often feel like I’m not there enough for her, but there’s nothing I can do because they’ve set up the group without the … you know … They were assuming that me and [the Aboriginal worker] be there all the time but we can’t always be there, ‘coz, you know, I have to prioritise people in the waiting room that want to see me, and [the Aboriginal worker] wherever she is, the midwives might have to go and do things, and she’s [the coordinator is] there by herself. You know, that group can have twenty, thirty people and heaps of little kids and she often has to run it by herself. I don’t think that’s fair, but that’s typical of [NSW]Health, isn’t it.
The PIO added:

Essentially, [the ECN and AHEO]'s role, which it has taken me a long time to understand, is they have their own jobs, which include and overlap with this project. So if you could draw a pie, they do have designated time with the group, but how much that pie would be is up to them and the managers and everybody else grappling for time. So in terms of how do I cope, I've learned to continually basically just do what I can do and remind myself that there are certain boundaries within which I operate, and I think that in a way if I do too much too quickly then I'm going to burn out and I won't be there in the long haul.

Program organisers have identified that a new funded position for an Aboriginal community worker to fill this role would be of great benefit to the program, as the Aboriginal staff member who helped to develop the program, is not regularly available:

(PIO) I think that [Name's] position is completely unenviable. She is, at the moment, the only Aboriginal Health Worker for Prince of Wales Hospital. There is no one at Sydney Children’s Hospital. If anyone needs anything about Indigenous health, that’s [Name], even though there is an Aboriginal Health Department, but they certainly don’t work in La Perouse.

(ECN) It’s not fair on the Aboriginal people, because they need an Aboriginal person from health to be there at the program, but [Name] can’t make it all the time ‘coz she has to be available to the whole Aboriginal community, she’s gotta drive people all over the place and make sure they get to their appointments and all of that.

Modelling of positive parenting

The data revealed that parents feel a tension between using the program to relax via painting and socialising, and working on other program goals such as education and positive parenting. There is a well-shared perception by parents and stakeholders that there is a need in the program for more opportunities for encouragement of playful, quality engagement with children and modelling of positive parenting. One parent articulated:

We’re just coming here and forgetting about them … I know that one of the reasons why most of us come out here is to get away ‘cause all we do is look after our kids, but it’s just to look after them in the right way I guess. We need to incorporate them into what we’re doing.

Service providers agree:

There are many missed opportunities because they’re [mother and child are] quite separate. It’s great for the mums to be able to have time out and to concentrate on their art, but there could be an alternate day of the week where they are being really engaged with their children as well as with the group, that would also be good. Something interactive and you [program staff] can slot in there and subtly suggest another game or model a language-stimulation strategy to implement. Maybe that might be an easy way for parents to up-skill, and it’s also an opportunity to praise the parents for really good interaction.

The overwhelming opinion from respondents is that positive parenting education needs to take place in a subtle, not didactic, manner, to be received well by parents. Three possible, complementary strategies have arisen from the data: the first, regular incorporation of art activities in which children and parents create work together in the sessions; second, a roster for mothers to spend time in the playground with the children; third, weekly or monthly social excursions to parks or the beach for a picnic and play-day. This would involve parents interacting with their children while making healthy snacks such as sandwiches and doing activities with them, such as sand and water play or reading books. Also, with more funding, the program could run healthy cooking courses in which parents and children learn to cook healthy meals together, educating both parents and children about healthy food preparation and essential dietary needs, and creating a new opportunity for positive interaction.

A staff member from Malabar Midwives emphasised the importance of modelling positive, stimulating parent-child interactions to parents:

There are so many different and positive ways to play with your kids that can have brain stimulation, but if you’ve never seen ... if that wasn’t done with you as a child or you haven’t seen it before, you don’t know.
Parents commonly commented that in their home playful interaction with their children is rare, with ‘routine’ and ‘stress’ dominating, as one parent reflected: ‘You go through the motions and you lose that connection.’

A private room needed for maternal and childhood services clients

An unexpected limitation of the program mentioned by some service providers is that the room in which the pARenT Group takes place was originally intended to be a space in the Health Centre where women could sit, have a bite to eat and chat while waiting for appointments with the midwifery or early childhood health services. Women who do not join the activities of the group now do not have a safe, private place to wait, the common waiting room being ‘too public for comfort’, as a service provider described. The clinics only run on the days of the pARenT Program. This issue reveals that there is a need for a second room for women attending child and maternal health services, as the Malabar Midwives’ staff member explained:

There needs to be a safe space so that they want to come [to the services], otherwise some won’t come.

They also remarked that the new room could be a bridge between informal socialising and gathering and involvement with the pARenT Group, with women perhaps growing familiarity with the program.

Ways to increase access

Respondents all agreed that there are many opportunities for growing the number of parents involved with the pARenT Group Program. Some emphasised that there could be further collaboration between services to feed parents into the program; the Sydney Children’s Hospital, the Royal Hospital for Women and in other early childhood centres and midwifery clinics could promote the program to their clients. Other suggested approaches to overcome perceived or real barriers to the program included: holding an advertised open day where new parents are welcomed into the program; moving the program into a bigger physical space; creating a new group specifically for teenage mothers.

Targeting young parents

With teenage parents not currently accessing the service, it was suggested that this could be remedied by a second group only open to young parents and tailored to their needs and interests. It was emphasised by respondents that such a program should be designed with input from young parents themselves to ensure its relevance and appeal. Some of the younger parents currently involved with the program made suggestions of what could characterise a ‘safe’ program space for young people: a trusting environment with familiar program and health workers; program leniency and a focus on the practicalities of parenthood, with return to education a possible long term goal. As one worker who was 16 years old when she had her first child reflected:

I think it’s great for us to say that they [teenage mums] want to have an education, but at the end of the day ... um, I think what has become the important thing in their life is the child. So I think things about the going back to school, I think that is the end thing that you want to achieve with the program but there are so many little things in between that need to be done first, and that’s things like the women getting their confidence back, and parenting better, and learning how to cook and learning all these little things about themselves.

Program developers have ideas of trialling a 10 week art therapy group for young parents and their babies, and are in the process of applying for funding.

5. Discussion

5.1 General Impressions

Evaluations can play a critical role in demonstrating and enhancing the capacity of a program to assist people to achieve desired outcomes, however this study is limited due to the lack of robustness in such a small sample size, and that it is assessing a single point in time. Ideally for an evaluation, measurements would be taken prior to starting (pre-program baseline) and then at regular intervals after
commencing in order to detect changes in response. In this case, that was not possible since the women had already had significant exposure to the program and therefore it is not possible to identify how they would have scored at the beginning of the program. Nevertheless, based on the qualitative data, it is expected that there is a continuing benefit from attending the program as more profound changes, greater experience and understanding become possible for the participants. The quantitative and qualitative data reported here thus form an initial dataset that will be added to by follow-up data collected in 2012.

5.2 Rigour

5.2.1 Triangulation

Triangulation was an integral component of this research, with data source and methods triangulation employed to provide ‘more illuminating, relevant and sensitive evidence of effects than a single source of information’ (Gifford 1998: 553) and to potentially strengthen the relatively limited study design (Pope & Mays 1995; Mays & Pope 2000; Lennie 2006; Nutbeam & Bauman 2006: 65-67).

Although we were not able to identify changes in quantitative measures that may have been the result of attending the program, triangulation of qualitative data from focus groups and interviews discussing experiences of positive change supports and extends the quantitative data.

In a preliminary assessment for convergence between quantitative and qualitative results, powerful evidence of consistency has been found, providing reassurance that the methods used were appropriate (Barbour 2001). The aspects of the program that participants described as valuable have consonance with what GEM content articulates individuals consider to be important components of change as one grows towards becoming more empowered (Haswell, Kavanagh et al. 2010; Haswell, Tsey et al. submitted). This helps to validate the preliminary qualitative categories developed thus far, and assists in confirming the logic behind the choice of study design and inclusion of the GEM. It also enhances our confidence in the validity of the GEM as an appropriate tool for measuring perspectives of psychosocial well-being and empowerment at the individual, family, organisational and structural levels (Haswell, Kavanagh et al. 2010).

5.2.2 Reflexivity

The author is aware that her stance was an active component in the research process of this study. Despite attention given to maintaining a neutral and passive presence, the data and qualitative thematic findings, did not just ‘emerge’; the evaluator’s values and assumptions were pervasive and influenced the content and the outcome of the collected data, as did the interview process itself (Mays & Pope 2000). This understanding is in line with the phenomenological (interpretative) approach underlying the entire study (Maykut & Morehouse 1994: 12). In the qualitative research process of interacting with subjects during the production of interview statements, the context and the body language and questions asked by the evaluator, portraying her values, shaped what was said by the interviewee (Pratt & Hannan 2010). While the aim of the qualitative research was to gain an insight into perceptions of the program held by stakeholders, many of the thoughts expressed by participants may only have been created as a result of being asked; they were, as Pratt (2010) explains, ‘constructing an account as they went.’

Attempts to contain the evaluator’s influence were made and these included: preparing a defined set of topics rather than a set list of questions for interviews to encourage the interviewee’s personal views to arise rather than be restricted by the imposition of the evaluator’s assumptions and perceptions through extensive questioning (Patton 2002: 353); use of minimal directiveness, with verbal and non-verbal feedback such as pauses, prompts and probes utilised to explore expected and unexpected issues as they emerged, to ensure the interview remained on-topic and that all members of focus groups could participate (Britten 1995; Patton 2002: 372-3). Awareness of the interview purpose aided the evaluator in maintaining a degree of control (Britten 1995).

The evaluator appreciates that she is a non-Indigenous person working in an Indigenous community. Her differing background means that she does not intimately know the cultural and
geographical context and subjects’ patterns of living, creating a divide in perspectives (world-view/paradigmic shift) between herself and the research participants (Mays & Pope 2000). Table 12 outlines how the evaluator attempted to temper this divide.

Table 12: Initiatives employed to reduce the divide between evaluator and participants

| Table 12: Initiatives employed to reduce the divide between evaluator and participants |
| Involvement of two levels of ‘insiders’ in the research |
| Evaluator’s supervisors (one an Aboriginal woman who is also a highly regarded and experienced researcher, and two who have extensive experience with research in Aboriginal communities) pARenT Group program developers, who have worked intimately with the pARenT Group since its inception (they participated in the research design development process [see ‘Methodology’]) |
| Development of rapport with program participants |
| The evaluator volunteered at the pARenT Group in 2009 and attended pARenT Group sessions for 5 weeks prior to the 2011 data collection phase. Through this her understanding of the Group was deepened, as was her rapport with the program participants, through participating in the regular painting, lunch-preparation, child-care and social activities. Rapport building is known to increase study validity as participants’ trust of and familiarity with researchers can lead to openness and honesty, engendering more accurate information (Voyle & Simmons 1999; Holmes, Stewart et al. 2002). Participants are also more likely to share their feelings with a familiar face, especially if the topic is of a sensitive nature (Dickson-Swift, James et al. 2008: 4-5). This latter action renders the evaluator to be an ‘insider’ according to the definition of Louis and Bartunek (1992) as she did not begin to relate to the issue under study only at the time of investigation commencement. On introducing the proposed research to participants, many responded that they were glad that someone they knew was doing it. |
| Familiar with Aboriginal culture |
| The evaluator is not unfamiliar with Aboriginal culture; yearly she spends a few weeks immersed in clinical practice and daily life in remote Northern Territory communities, and she attended public schools with many Aboriginal children in South West Rocks and Kempsey, NSW. |

5.2.3 Respondent validation

Appropriate discussions with qualitative participants have taken place regarding the evaluation findings, to ensure that the data has been interpreted correctly (Lennie 2006). Study participants’ reactions to the analyses will be considered as further findings that require analysis, to limit collusion, as the evaluator’s view of the content will inevitably be different from that of the participants due to differing roles and perspectives (Mays & Pope 2000; Barbour 2001).

5.3 Reflection on qualitative data collection process

Initially it was difficult to adjust to the role as facilitator in the interview and focus group process, evading semantically impacting words and ensuring minimal directiveness, especially with quieter personality types. With practice, however, the evaluator was successful at utilising open-ended questions, long pauses, probing and the repetition of words and phrases to encourage conversational flow.

Individual interviews with Group participants allowed an opportunity to explore issues that may have been too sensitive or subtle to delve into or embellish upon in a focus group setting, resulting in the emergence of rich data. Interviews also helped compensate for the fact other aspects of life may have contributed to the GEM responses. Interviews with key informants and service providers helped the evaluator to gain a thorough understanding of program processes and outcomes, with information gathered covering descriptions of inputs such as program plans and principles of operation and reflections on program processes, outcomes and unforeseen impacts.
The evaluator intended there to be one group interview with service providers, however due to varying work and personal timetables, individual interviews were conducted. Each interview offered quality, unique insights that were incredibly valuable in the content analysis phase.

During the focus groups, participants confirmed the appropriateness of the evaluator’s planning decision to form two groups based on communication styles (Bloore, Frankland et al. 2001: 42; Lloyd-Evans 2006: 157-8). After ‘validating the expression of differences’ (Morgan 1992: 185) at the outset of the first focus group that consisted of the most vocal women, the evaluator had minimal involvement; and the group proceeded to converse about their perceptions of the group with limited prompting and all members were strong enough to project their views and voice over the others. It was an ideal focus group, full of animated, interactive discussion (Bloore, Frankland et al. 2001: 42). The value of having friendship connections within one focus group was also revealed, as often one participant would explain her view and then would facilitate the conversation by encouraging others to share their own. This allowed the participants to delve deeper into their personal opinions through the inspiration and prompting offered by their friends. Management of the group was required however, to keep conversation on-topic, ensure all voices were heard and to limit the number of speakers talking concurrently (Bloore, Frankland et al. 2001: 48-50). Repetition of phrases was used to elicit whether all members in the group agreed with the previous speaker’s opinion (Bloore, Frankland et al. 2001: 48-49).

The second focus group consisted of quieter members of the pARenT Group. Valuable data emerged including views that varied greatly from the first focus group; such views would either have not been voiced or heard if spoken had these participants been in the first, more vocal group (Bloore, Frankland et al. 2001:48). Furthermore, the women in the second focus group were much more talkative in their individual interviews than in the focus group, which also reflects the nature of group interactions in the overall pARenT Group (Kitzinger 1994; Bloore, Frankland et al. 2001: 50).

There were a large number of views of the program shared by the different stakeholder groups, and also many profound views held alone by stakeholder groups; this revealed to this researcher the importance of an evaluation process in hearing previously unspoken perceptions; and beginning a conversation between the different groups that can lead to heightened awareness of and promote action concerning aspects that are working as well as those that need improving.

5.4 Strengths and weaknesses of research approach

A study has demonstrated that the ASQ:SE may not be an appropriate tool for measuring infant (0-4 years) social and emotional functioning. Scores have been found to be associated with questionnaires relating to maternal psychological distress, demonstrating a close link between mother’s psychological state and their ratings of infant and emotional functioning (Salomonsson & Sleed 2010). The ASQ:SE was used in this study as it is used by the area health service.

The GEM’s demographic information page (Section 1) could have gathered important data more effectively, for example, asking for birthdates rather than age; how participants found out about the program; the approximate date that they started rather than length of time at the program, and the names of education courses previously enrolled in.

5.5 Success factors achieved and further sought in this program in order to make a difference with young parents and their children

Findings reveal that parents perceive the program to be valuable for their own personal development as well as their child’s. The socialisation and confidence-building elements of the program described by all respondents appear to be instilling a sense of empowerment in the pARenT Group participants, expressed by parents as personal growth and new-found strength. The data revealed a vague pathway of growth steps, with some participants at the lower end of the path (often corresponding with younger age), some in the middle and others now feeling strong enough within themselves that they want to give back to their community. This reflects the pathway found in qualitative analysis of data on the impact of another intervention, the Family Wellbeing Program (Tsey 2010), as Haswell et al. (2010) explain:
As participants gain more understanding of their identity, spirituality, emotions and relationships, they are more effective in engaging with community organizations and activities to enhance their external environment, and achieve greater calmness and security in their lives.

The program incorporates important elements of successful programs for Aboriginal and Torres Strait Islander young people, such as creating a safe place, providing opportunities for people to develop their own strengths and skills to promote their sense of wellbeing, fostering the growth of positive communication and relationships among participants, facilitating access to and use of practical services and knowledge and enhancing participants’ voice and sense of pride and capacity in personal, group and cultural achievements (Wallerstein 1992; Tsey & Every 2000; Tsey, Wilson et al. 2007; Tsey 2010). The evidenced capacity for art programs to transform individuals, engage and enrich community and provide social, health, educational, and economic benefits (Johnston 2001; Eakin 2003; Argyle & Bolton 2005; Macnaughton, White et al. 2005; White 2006; Camic 2008; Putlant 2008; Dyer & Hunter 2009; White 2009; Stuckey & Nobel 2010), would also contribute to the empowering potential of the pARenT Group.

More funding support would enable this program to reach its potential and allow its impacts to be sustained. Additional material and human resources would assist in the development of a second program for teenage parents, allowing this vulnerable group access to the benefits of a safe, social and stimulating environment such as the pARenT Group, which nurtures confidence and resilience. Furthermore, the PIO could be supported by an Aboriginal community worker, enriching the cultural experience of the group; and the assistance of additional staff would provide extra opportunity for health and family planning education, healthy lifestyle modelling through activities such as healthy cooking courses, and further opportunities for interactive play between parents and children in a supported, stimulating environment.

6. Conclusion

The inclusive research approach of this study, as described in this report, has enhanced the study’s potential to determine Ngala Nanga Mai pARenT Group Program outcomes as well as to contribute to the empowerment of the Aboriginal community involved. The tools used were culturally appropriate, and the qualitative methods engendered voice and were strengthened by rapport between the evaluator and the participants, increasing the validity of the findings. Aligned with principles of self-determination, respect and development of Aboriginal knowledge, this model of research is sufficient to be sustained throughout the remainder of the study and potentially implemented in other Aboriginal health research projects.

With the present prevalent need for empowering approaches to assist Aboriginal communities in recovering from the transgenerational impacts of colonisation, paternalism and disempowerment (Laliberté, Haswell-Elkins et al. 2009; Tsey 2010), baseline findings described in this report provide evidence to support the confirmation of social, parent-focussed Arts in Health programs such as the pARenT Group as effective approaches to improving the quality of lived experience and health outcomes for Aboriginal young parents and their children. Government policies need to increase their support of programs such as the pARenT Group.
7. Appendices

7.1 Additional information about the Growth and Empowerment Measure

The GEM was developed by and for Aboriginal people, from their own experiences and descriptions of the process and impact of empowering change within themselves, their family and community (Haswell, Kavanagh et al. 2010). The themes and wording used in questions emerged from the analysis of 50 in depth interviews and was improved and refined through discussions about empowerment with Aboriginal communities in Alice Springs, Yarrabah, Hopevale and Cairns, with Aboriginal people sharing their ideas about what the measure should ask about and how it should look. It has been used to evaluate the Family Wellbeing Program, a program designed to empower Indigenous Australian participants in order to enhance their capacity to more effectively address the social determinants of their health (Tsey 2010).

The GEM incorporates three instruments: the Emotional Empowerment Scale (EES14), which aims to ‘capture the extent to which the person is able to feel and show specific signs of well-being in their everyday life’; the 12 Empowerment Scenarios (12ES), which ‘aim to measure functional aspects of empowerment’, and an extended version of the Kessler 6 Psychological Distress Scale (K6) to detect risk of distress-related mental disorders (Kessler, Galea et al. 2008; Haswell, Kavanagh et al. 2010).

Individual items from the EES and 12S are grouped into subscales; i.e., important aspects of empowerment (Haswell, Kavanagh et al. 2010). EES subscales include ‘inner peace’ and ‘self-capacity to engage confidently in the world’, and 12S subscales include ‘healing and enabling growth’ and ‘connection and purpose’. An observation of an individual’s average results for items within a subscale can indicate where that person is along the pathway to achieving empowerment in that area of their life.

Some adjustments were made to 2 of the 3 GEM scales. The 12S included only 10 of the 12 original scenarios, so as to increase the tool’s relevance to the Group and to also reduce the time required for completion. The standard K6 had an additional 2 questions to assess frequency of happy and angry feelings (Haswell, Kavanagh et al. 2010), informed by findings from the development of the National Aboriginal and Torres Strait Islander Health Survey and the experience of the authors which emphasised the importance of these specific emotions in Indigenous health and wellbeing (AIHW 2009). The length of the childhood surveys was unable to be altered due to copyright.
### Table 13: Division of items into subscales

<table>
<thead>
<tr>
<th>Scale:</th>
<th>Emotional Empowerment Scale (EES)</th>
<th>Empowerment Scenarios (12S)(^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscale:</td>
<td>Self Capacity</td>
<td>Inner peace</td>
</tr>
<tr>
<td>Items within each subscale:</td>
<td>5. Satisfaction with opportunity and what I’m doing</td>
<td>2. Feeling skilful and able to do things that are important</td>
</tr>
<tr>
<td></td>
<td>7. Voice, can speak out and explain my view, people listen</td>
<td>4. Happy with self and life</td>
</tr>
<tr>
<td></td>
<td>11. Centred and focused on meeting needs of self and family</td>
<td>11. Dealing with judgement and criticism</td>
</tr>
<tr>
<td></td>
<td>12. Feeling calm and relaxed</td>
<td>13. Feeling safe and secure, can face whatever is ahead</td>
</tr>
<tr>
<td></td>
<td>14. Dealing with anger</td>
<td></td>
</tr>
</tbody>
</table>


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\(^4\) Standard GEM contains 12 scenarios (Haswell, 2010); only ten scenarios were used in this survey.
8. References


Australian Institute of Aboriginal and Torres Strait Islander Studies (2000). Guidelines for ethical research in Indigenous studies. Canberra, AIATSIS.


Black, A. (2007). Evidence of effective interventions to improve the social and environmental factors impacting on health: Informing the development of Indigenous Community Agreements. Canberra, Office for Aboriginal and Torres Strait Islander Health.


CWPHU (1997). 'When will you understand us?' Voices of Central West Aboriginal women. Aboriginal Women's Business Project Report, Central West Public Health Unit.


Haswell, M., Tsey, K., et al. (Submitted). "Developing a highly valid measure of growth and empowerment with Aboriginal Australians."


Herceg, A. (2005). Improving health in Aboriginal and Torres Strait Islander mothers, babies and young children: a literature review. Canberra, Department of Health and Ageing; Office for Aboriginal and Torres Strait Islander Health.


SPSS (2009). PASW® Statistics 18 Chicago, IL, SPSS Inc.


