CSIRO PUBLISHING

RESEARCH PAPER
https://doi.org/10.1071/PY21293

Australian Journal of Primary Health

LA TROBE UNIVERSITY

Enhancing interprofessional practice through the co-design of a holistic culturally and developmentally informed First Nations child health assessment

Natasha Reid[A,*], Wei Liu[B], Shirley Morrissey[C], Marjad Page[D], Theresa McDonald[D], Erinn Hawkins[B,C], Andrew Wood[E], Michelle Parker-Tomlin[B,D], Grace Myatt[D], Heidi Webster[B], Bridget Greathead[D], Doug Shelton[F], Sarah Horton[D], Mary Katsikitis[G] and Dianne Shanley[B,C]

For full list of author affiliations and declarations see end of paper

*Correspondence to:
Natasha Reid
Centre for Children's Health Research, 62 Graham Street, South Brisbane, Qld 4101, Australia
Email: n.reid1@uq.edu.au

Received: 20 December 2021
Accepted: 4 October 2022
Published: 14 November 2022

Cite this:
Reid N *et al.* (2023)
Australian Journal of Primary Health, **29**(1), 30–37.
doi:10.1071/PY21293

ABSTRACT

Background. This qualitative study explored staff experiences of co-designing and implementing a novel interprofessional (IP) First Nations child health assessment (the helpful check), developed in partnership with a remote North-Queensland Aboriginal Community Controlled Health Organisation. **Method.** Eleven staff across two teams (family health and allied health) were involved in co-designing and implementing the child health assessment and associated IP practices. Interviews were undertaken using a semi-structured interview template and were audio recorded and transcribed verbatim. Data were analysed using thematic analysis. **Results.** Three overarching themes were developed: (1) connect teams by building strong relationships; (2) leave space for helpful check processes to evolve; and (3) integrate helpful check processes into routine practice to sustain change. **Conclusions.** Results demonstrate how the incorporation of IP practices into a remote primary healthcare setting led to perceived benefits for both the health service staff and clients.

Keywords: Aboriginal, culturally appropriate, fetal alcohol spectrum disorder, interprofessional practice, health assessment, neurodevelopmental conditions, primary health care, Torres Strait Islander.

Introduction

Aboriginal Community Controlled Health Organisations (ACCHOs) provide high-quality, culturally responsive services led by First Nations communities (National Aboriginal Community Controlled Health Organisation 2018). A key mechanism for identifying and monitoring health needs is the annual health assessment for First Nations people. In providing these health assessments for children, it is essential they are culturally safe, review developmental needs, and utilise interprofessional (IP) practice, enabling holistic care.

Culturally informed primary healthcare

Culturally appropriate health care encompasses respect for First Nations people and 'their rights to uphold and strengthen cultural values, beliefs, traditions and customs, and empowerment to develop their institutional structures' (Salmon *et al.* 2018, p. 28). Principles for culturally appropriate health assessments include providing positive experiences that are respectful and culturally safe, that health assessments are completed *with* people, not *to* people, and are provided in the context of established and trusting relationships (National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners 2018). To our knowledge, there are no recommended questions for standardised data collection regarding consideration of cultural connections during assessments. Cultivating strong cultural connections is a preventative solution for a wide range of physical and mental health concerns

(Garvey *et al.* 2021; Verbunt *et al.* 2021) and a key feature of ACCHO service delivery (Harfield *et al.* 2018). If health providers could identify families who would like to strengthen cultural connections and develop referral pathways to Elders and support networks in the community, this could facilitate holistic approaches to supporting child health and wellbeing. Notably, Aboriginal Health Workers/Practitioners (AHW/Ps) are best placed to take the lead on collecting and utilising information regarding child and family cultural connections.

Developmentally informed primary healthcare

General practitioner (GP) guidelines and health assessment templates for Aboriginal and Torres Strait Islander people encourage primary healthcare professionals to review children's developmental needs. However, these templates are often limited to a checklist for children aged 6 months to 5 years and include open-ended questions regarding learning and development for children aged >5 years. Although use of parent-report measures is recommended, advice regarding how to integrate this information to holistically screen, assess and support child development is lacking (National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners 2018). Thus, even though ACCHOs are ideally positioned to play a greater role in identification and support of children with developmental concerns, particularly in rural and remote areas where specialist services are limited, the current approach and infrastructure are barriers to implementing best practice recommendations.

IP practice in primary healthcare

Recognised as an important part of primary healthcare service delivery (Brown *et al.* 2021), IP teams are viewed as 'best practice' for assessment, diagnosis, and management of complex and chronic conditions (Hill *et al.* 2020). Despite recognised benefits, IP care is not universally implemented in primary healthcare settings. Although ACCHOs typically employ multi-disciplinary teams, practitioners often work within their own 'silos', even when co-located. Although there is some interaction between staff when responding to referrals, the extent to which staff have a shared vision for culturally safe care and engage in IP collaboration is varied and setting-specific.

Present study context and aim

To address the limitations of current child health assessments, researchers partnered with a remote North West Queensland ACCHO to co-design an optimised child health assessment (named the 'helpful check' by the ACCHO) that utilises and extends the existing framework for child health assessments laid out by the Australian Government Department of Health and national peak bodies. Specifically, the helpful check addresses the need for: (1) ensuring cultural responsiveness of the health assessment; (2) early identification of neurodevelopmental concerns; (3) incorporating IP collaboration, improved referral pathways and follow-up for families; and (4) effective health assessment data collection to understand the needs of the community and improve clinical service delivery now and into the future. The current study gathered feedback from the ACCHO staff regarding the process of co-designing and implementing the health assessment. This study formed part of a broader project aimed at supporting the integration of neurodevelopmental assessments in remote communities (Reid *et al.* 2021, 2022; Shanley *et al.* 2019).

Methods

Research design

A qualitative descriptive design (Sandelowski 2000) was used to understand the ACCHO staff experiences of co-designing and implementing the helpful check.

Research setting

The project was undertaken in partnership with Gidgee Healing, the local ACCHO. Gidgee Healing has the largest provider land area covered by a single ACCHO in Queensland, spanning approximately 640 000 km^2.

Participants

Eleven staff members from Gidgee Healing, including six from the family health team (i.e. one GP, three AHW/Ps, one Nurse and one Midwife) and six from the allied health team (i.e. two Speech and Language Pathologists, one Occupational Therapist, one Dietitian and one Exercise Physiologist) participated in the study. This was the total number of staff available to participate in the research study, as this was all the staff at the service who were involved in the co-design and delivery of the helpful check processes. Throughout the interviews, staff referred to the 'project team' who were collaborating with the ACCHO in the co-design process and included researchers, specialist practitioners, and a project manager.

Helpful check process

The helpful check provides a comprehensive review of cultural, physical, developmental, and socioemotional health (for further details see Reid *et al.* 2021, 2022) and is led by AHW/Ps, with input from the GP, but can also involve other health professions, such as nurses, midwifes and allied health. Three IP case conferences are incorporated, as

clinically indicated: (1) the *Rock Case Conference*, includes the family health team who meet weekly to make immediate clinical decisions, and decide which cases require follow up and should be brought to subsequent meetings; (2) the *Water Case Conference*, includes the family health team and the allied health team who meet weekly to progress required allied health assessments, review and interpret results and undertake intervention planning/referrals; and (3) the *River Case Conference*, includes the family health team, allied health team and specialist providers (by tele-health). This team meets monthly to undertake case discussions, diagnostic formulations and support planning/referrals. See Fig. 1 for an overview of the health check process.

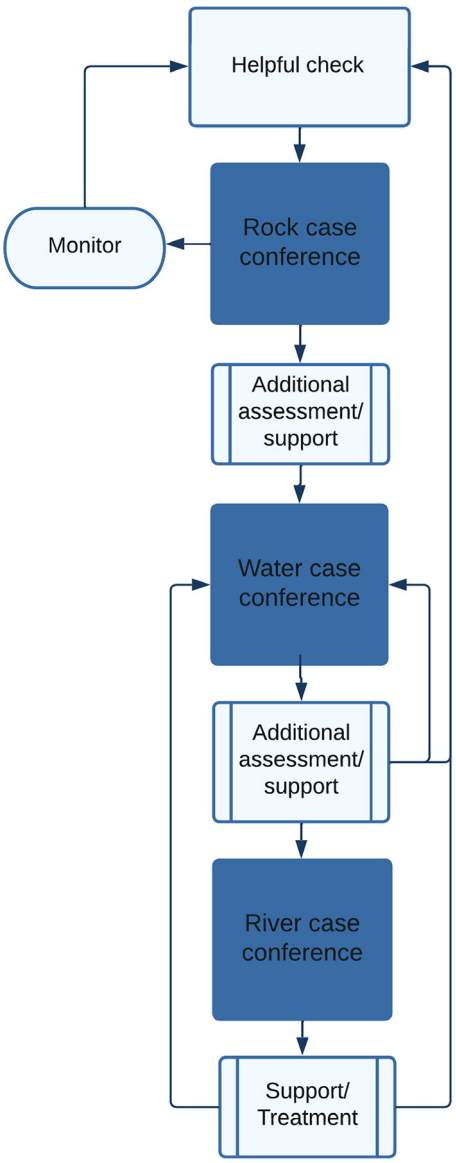

Fig. 1. Overview of the health check process.

Data collection

A semi-structured interview schedule was developed to collect information from staff (Supplementary material File S1). Interviews contained questions and prompts based on participant responses to facilitate the collection of rich data, while also allowing the interviews to extend to other areas that participants felt were important. A member of the research team (WL) contacted the health staff and invited them to participate in an interview and then arranged a suitable time at the participant's convenience. All participants who were contacted agreed to be interviewed. Interviews lasted from 30 to 60 min and were conducted via phone or video call, depending on participant preference. One researcher (SM) completed the staff interviews. Interviews were recorded and transcribed verbatim, with all identifying information removed.

Data analysis

Interview transcripts were analysed by one researcher (NR) using a six-phase thematic analysis approach: (1) familiarising yourself with the dataset; (2) coding, which involved both semantic and latent coding and was both inductive and deductive; (3) generating initial themes; (4) developing and reviewing themes; (5) refining, defining and naming themes; and (6) producing the report (Braun and Clarke 2021). As per Braun and Clarke (2021), analysis was undertaken by one researcher. Other authors reviewed and contributed to the refinement of theme names. QSR International's qualitative software package (NVivo 12) was utilised for phases 2 to 5.

Reflexivity statement

Data were collected approximately 3 years after the broader project had commenced (Shanley *et al.* 2019). One female member of the research team conducted the interviews (SM) and had minimal prior relationship with participants. A different female researcher (NR) undertook the analysis, but was not involved in the interviews, as they had more of a prior relationship with the participants, having worked together with the staff and other members of the project team to co-design and refine the health check process. This researcher was provided with anonymised transcripts to complete the analysis. The researcher who undertook the analysis had detailed knowledge regarding the health check co-design process and the wider community context, having been involved with the health service, which informed the analysis process. The remaining authors were a combination of university-based researchers and specialist practitioners who also had established relationships and knowledge of the wider community context from being involved in the co-design process and ongoing project with the health service staff, and local health service staff (interview participants involved in the co-design and implementation

of the health check). Over the course of the broader project, the researchers developed strong connections with several Elders and community members who provided guidance as part of a Community Advisory Group. Members of this group have generously contributed valuable insights regarding the local community context that informed the interpretation of the current findings. The members of the Community Advisory Group were also consulted on the presentation of the current study results.

Ethical considerations

Consent to conduct the research was obtained from the Kalkadoon Prescribed Body Corporate, which represents the Traditional Owners of the land on which the project was undertaken. Consent was also obtained from the Gidgee Healing executive board and the Griffith University Human Research Ethics Committee (Ref. No.: 2019/807). Written consent was obtained from all participants. Consent to record the interviews was re-confirmed at the commencement of the interviews and participants were reminded that the interviews would be de-identified. Participation was voluntary and participants were free to withdraw at any time.

Results

Three overarching themes were developed through the thematic analysis.

Theme 1: connect teams by building strong relationships

Staff highlighted a range of ways the project had facilitated relationships and communication, and how this influenced IP practice. Staff noted enhanced relationships and communication between: (1) the primary healthcare and allied health teams; (2) the project team and ACCHO staff; (3) the project team and the community; and (4) the health service and the community.

Subtheme 1: relationships and communication between the primary healthcare team and the allied health team

Staff reported the co-designed health assessment process increased IP communication and collaboration between the primary healthcare and the allied health teams. For example, one staff member stated:

> It feels like one big team because we definitely have the speechies [i.e. speech and language pathologists] on-board so we talk a fair bit and it feels like it's not them and us, that's allied health and family health, we're all just [Gidgee Healing] a whole. (P7)

IP case discussions were noted as a key mechanism for building and maintaining relationships. IP case discussions enabled regular communication and facilitated learning from and about each other. For example, one participant communicated:

> I've really quite enjoyed the Aboriginal Health Worker aspect to it, and I find that as well that just hearing them phrase how they communicate information, just gives you ideas, gives you ways on how to broach a conversation. (P4)

Staff highlighted that IP interactions improved the working environment between teams within the organisation. Specifically, staff discussed how previously the teams were in different parts of the building, separated by a locked door, creating a barrier that limited contact. With the project's emphasis on working together to co-design the health check, and acknowledgement of a need for greater interactions, the door between the teams was opened. This opening of the door led to increased formal (e.g. meetings) and informal (e.g. eating lunch together) contact. For instance, one participant stated:

> But for me definitely those walls are broken down, that door is now open all the time, people are constantly coming and going and Primary Health isn't segregated. (P11)

Subtheme 2: relationships and communication between the project team and staff

Many staff highlighted the importance of the relationships and communication that had occurred between the project team and the staff. This facilitated the co-design and implementation of the health assessment process. One participant stated:

> It was really good, really supportive and they [the project team] didn't mind if we humbugged them 20 times a day. They were really good to work with and you know they made things so easy for us. (P3)

Staff also commented that relationships with the project team brought together a wide range of professionals, facilitating timely provision of services for families. For example, one participant stated:

> A lot of families who have really struggled with getting a diagnosis or getting faster follow-up have been very thankful and appreciative of the speed at which everything happens with this project... Things are actually happening because everybody's together in one place with a paediatrician, a GP and psychologist. (P5)

Subtheme 3: communication and relationships between the project team and the community

Staff also highlighted the important contribution relationships between the project team and the community played in supporting the co-design and implementation of the health check. One participant stated:

> I think the one thing that [project member name] and the team have done well is they have really made strong connections, not only physical, but also spiritual with the main stakeholders and Elders here. (P9)

Subtheme 4: the relationships between staff and the community

Several staff members communicated how the health service was still establishing itself in the community. Consequently, the need for the health service to continue building relationships and improve communication with the community in general, and with respect to the co-design and implementation of the new health assessment, was highlighted. Specifically, health service staff noted how increased community education and engagement could facilitate the successful implementation and sustainment of the new health assessment. As stated by one staff member:

> Just keep educating the community that the health assessment is a lot different to the one that we were previously getting at [health service name]. I reckon for it [the health assessment] to stay, one, definitely have it in our system and better education to our communities. (P7)

Theme 2: leave space for helpful check processes to evolve

Staff identified a range of strengths and challenges pertaining to the evolving nature of the health assessment process. The strengths included staff viewing the co-design process as truly collaborative. Staff also noted the ability to be responsive to initial family feedback and how the project team was open to this feedback as a strength. For example, one participant stated:

> I think the whole [project] team was very open and eager to get input from everyone, and I think I definitely felt like I could always give feedback and I think it was good having regular checking in. (P5)

Staff commented on how their own learning and experience, particularly observing and learning from each other, contributed to improved implementation of the health assessment and, subsequently, improved care for clients. One participant said:

> I remember sitting in on the [health assessment] sessions and the way that the health workers asked the questions was respectful and appropriate in a way that I hadn't thought to ask questions before. So yeah that kind of helped me I guess in how to ask difficult questions . . . (P6)

There were also challenges regarding the evolving nature of the health assessment. For example, in the early stages of the project, staff reported that changes were made to the health assessment without wider consultation with all the health service staff. Additionally, challenges were noted around the initial structure and organisation of IP meetings, which were described as resulting from staff not knowing each other, understanding each other's roles, or the contributions of different disciplines. For example, as reported by one participant:

> I think it gets tricky where people don't really know who everyone is and have those relationships and open communication pathways. But the building of those things through this project has made a big difference. (P5)

Theme 3: integrate helpful check processes into routine practice to sustain change

Due to the remote location, staff highlighted the high levels of turnover and noted that to ensure sustainability, continued work was required to further embed the helpful check process into the health service. As one participant stated:

> I think the thing with everything out here, I think the turnover of staff is what is a big factor in defeating a lot of projects. Just making it [the helpful check process] a part of what happens at Gidgee, which I think it is becoming. (P1)

Staff were optimistic about sustainability of the health assessment and discussed multiple strategies to support further integration. This included: improved interface with practice management software (i.e. Best Practice), completion of staff manuals and online training modules, increased training across the health service, and ongoing consultation with the project team. For example, one staff member stated:

> I think we need to train the doctors and have it [the helpful check process] embedded and have it as an everyday thing like the health assessment in BP [Best Practice]. I think that is the main thing that we need to continue working on and getting that completed. (P3)

Discussion

The present study gathered feedback from ACCHO staff regarding their experiences of co-designing and implementing a novel child health assessment process (the helpful check). Feedback from staff outlined the key successes and

challenges, which included the importance of: (1) strong relationships; (2) allowing room for new practices to evolve; and (3) integrating the helpful check process into routine practice for sustainability.

The first theme aligned with previous research highlighting that team communication and sharing a common philosophy can influence the effectiveness of IP collaboration (Mulvale *et al.* 2016; Wranik *et al.* 2019; Brown *et al.* 2021; Seaton *et al.* 2021). The review by Seaton *et al.* (2021) of allied health professionals' perceptions of IP collaboration in primary healthcare identified the physical environment as a barrier or facilitator to collaboration. Specifically, Seaton *et al.* (2021) noted opportunities for frequent informal communication as being essential for IP collaboration. Brown *et al.* (2021) identified both formal and informal practices as the key pillars of IP collaboration in primary health care. In line with this, staff in the current study reported both formal IP case conferences and informal practices such as eating lunch together as being important in facilitating relationships and communication.

The second theme was consistent with one of Brown *et al.*'s (2021) key pillars of IP collaboration – recognising, appreciating, utilising, and expanding team members' scope of practice. Participants in the current study highlighted the benefits conferred through working with colleagues from different disciplines. Allied health staff reported improvements in their ability to provide culturally appropriate services through observing and learning from the AHW/Ps. The family health team reported benefits in learning about assessments and supports their colleagues could provide, which through the IP case discussions, facilitated more targeted referrals and follow-up plans.

The final theme highlighted the vital need for addressing sustainability, which may have been at the forefront of the current participants' minds due to the geographical barriers and historical challenges of retaining staff in this remote setting. Previous research has identified barriers to the sustainability of evidence-based practices in community-based settings, such as lack of funding, leadership and staff challenges and organisational climate (Hailemariam *et al.* 2019). Further collaboration and consideration of the most appropriate strategies to facilitate sustainable partnerships with the ACCHO staff will be required.

Implications for future practice and research

When co-designed in partnership with ACCHO staff, child health assessments can incorporate and enable collaborative IP practice. This has implications for how we support children more broadly in remote settings. Many assessments and support programs for children often require input from multi-disciplinary or interprofessional teams. Enhancing how these teams function within primary healthcare ensures that we capitalise on the knowledge and expertise that exists in these settings, and do not rely as heavily on specialists, who are scarce and costly, to support high prevalence conditions. The themes outlined from this study found to be key to successful IP integration can be applied across a broad range of primary healthcare settings [e.g. formal (case conference) and informal (hallway) opportunities for staff to connect and engage with each other], given organisational support to shift in this direction.

The implications of IP collaboration on more comprehensive and timely client care were noted by staff. Identifying children with developmental concerns earlier enables earlier supports to be provided. A recent associated study (Reid *et al.* 2022) documented positive family feedback regarding the health check process, in that all caregivers reported the health check was culturally appropriate, and the majority (85.2%) also found it helpful. Staff feedback from the present study found the IP practice led to increased knowledge of other colleagues' disciplines, and practice improvements by observing and learning from others. Given that the helpful check process was well received by staff and caregivers, future research would benefit from assessing whether implementation of the helpful check process can influence child and family outcomes with standardised and culturally appropriate psychometric measures (e.g. Garvey *et al.* 2021).

The current study also contributes to the priority areas identified as part of The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (Aboriginal and Torres Strait Islander Health Workforce Working Group 2017) by demonstrating how IP practice can improve workforce skills and capacity and support the sector to provide culturally safe and responsive workplace environments. Additionally, the present study illustrates the importance of co-design, which could guide the development of future primary healthcare initiatives in other remote ACCHOs.

Limitations

Coronavirus disease 2019 (COVID-19) restrictions on travel to the remote community meant interviews had to be completed via video or telephone calls. It is possible more in-depth information could have been gathered through attending the health service and interviewing staff face-to-face on country and/or through more culturally appropriate 'yarning circles'. Future research with larger and more diverse samples undertaken in-person would be beneficial to further validate the current study findings.

Conclusion

This study provides valuable insights from staff involved in co-designing a novel approach to integrating IP collaboration

into primary healthcare provision in a remote ACCHO setting. Qualitative data highlights how staff valued strong relationships involving good communication, space to allow the new practices to evolve, and for the helpful check process to be woven into routine practice so that it is sustained over time. By weaving IP practice into primary healthcare, this study highlights how it is possible to capitalise on the knowledge and expertise of diverse staff in remote settings, to lessen the burden on specialists, and to support children to receive more comprehensive, timely care closer to home.

Supplementary material

Supplementary material is available online.

References

Aboriginal and Torres Strait Islander Health Workforce Working Group (2017) National Aboriginal and Torres Strait Islander health workforce strategic framework 2016–2023. Prepared for the Australian Health Ministers' Advisory Council by the Aboriginal and Torres Strait Islander Health Workforce Working Group. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/4A716747859075FFCA257BF0001C9608/$File/National-Aboriginal-and-Torres-Strait-Islander-Health-Workforce-Strategic-Framework.pdf

Braun V, Clarke V (2021) 'Thematic analysis: a practicial guide.' (Sage Publishing)

Brown JB, Mulder C, Clark RE, Belsito L, Thorpe C (2021) It starts with a strong foundation: constructing collaborative interprofessional teams in primary health care. *Journal of Interprofessional Care* **35**, 514–520. doi:10.1080/13561820.2020.1787360

Garvey G, Anderson K, Gall A, Butler TL, Whop LJ, Arley B, Cunningham J, Dickson M, Cass A, Ratcliffe J, Tong A, Howard K (2021) The Fabric of Aboriginal and Torres Strait Islander wellbeing: a conceptual model. *International Journal of Environmental Research and Public Health* **18**, 7745. doi:10.3390/ijerph18157745

Hailemariam M, Bustos T, Montgomery B, Barajas R, Evans LB, Drahota A (2019) Evidence-based intervention sustainability strategies: a systematic review. *BMC Implementation Science* **14**, 57. doi:10.1186/s13012-019-0910-6

Harfield SG, Davy C, McArthur A, Munn Z, Brown A, Brown N (2018) Characteristics of Indigenous primary health care service delivery models: a systematic scoping review. *Globalization and Health* **14**, 12. doi:10.1186/s12992-018-0332-2

Hill AE, Nelson A, Copley JA, Quinlan T, McLaren CF, White R, Castan C, Brodrick J (2020) Real gains: development of a tool to measure outcomes for urban First Australian children accessing culturally responsive interprofessional therapy. *Journal of Interprofessional Care*. doi:10.1080/13561820.2020.1801611

Mulvale G, Embrett M, Razavi SD (2016) 'Gearing Up' to improve interprofessional collaboration in primary care: a systematic review and conceptual framework. *BMC Family Practice* **17**, 83. doi:10.1186/s12875-016-0492-1

National Aboriginal Community Controlled Health Organisation (2018) 'National framework for continuous quality improvement in primary health care for Aboriginal and Torres Strait Islander People 2018–2023.' (National Aboriginal Community Controlled Health Organisation: Canberra)

National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners (2018) 'National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people: evidence base.' (RACGP: Melbourne, Vic.)

Reid N, Hawkins E, Liu W, Page M, Webster H, Katsikitis M, Shelton D, Wood AP, O'Callaghan FV, Morrissey SA, Shanley DC (2021) Yarning about fetal alcohol spectrum disorder: outcomes of a community-based workshop. *Research in Developmental Disabilities* **108**, 103810.

Reid N, Page M, McDonald T, Hawkins E, Liu W, Webster H, White C, Shelton D, Katsikitis M, Wood A, Draper B, Moritz K, Shanley DC (2022) Integrating cultural considerations and developmental screening into an Australian First Nations child health check. *Australian Journal of Primary Health* **28**(3), 207–214.

Salmon M, Doery K, Dance P, Chapman J, Gilbert R, Williams R, Lovett R (2018) Defining the indefinable: Descriptors of Aboriginal and Torres Strait Islander Peoples' cultures and their links to health and wellbeing. (Aboriginal and Torres Strait Islander Health Team, Research School of Population Health, The Australian National University: Canberra, ACT, Australia)

Sandelowski M (2000) Whatever happened to qualitative description? *Research in Nursing & Health* **23**, 334–340. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Seaton J, Jones A, Johnston C, Francis K (2021) Allied health professionals' perceptions of interprofessional collaboration in primary health care: an integrative review. *Journal of Interprofessional Care* **35**, 217–228. doi:10.1080/13561820.2020.1732311

Shanley DC, Hawkins E, Page M, Shelton D, Liu W, Webster H, Moritz KM, Barry L, Ziviani J, Morrissey S, O'Callaghan F, Wood A, Katsikitis M, Reid N (2019) Protocol for the Yapatjarrathati project: a mixed-method implementation trial of a tiered assessment process for identifying fetal alcohol spectrum disorders in a remote Australian community. *BMC Health Services Research* **19**(1), 649.

Verbunt E, Luke J, Paradies Y, Bamblett M, Salamone C, Jones A, Kelaher M (2021) Cultural determinants of health for Aboriginal and Torres Strait Islander people – a narrative overview of reviews. *International Journal for Equity in Health* **20**, 181. doi:10.1186/s12939-021-01514-2

Wranik WD, Price S, Haydt SM, Edwards J, Hatfield K, Weir J, Doria N (2019) Implications of interprofessional primary care team characteristics for health services and patient health outcomes: a systematic review with narrative synthesis. *Health Policy* **123**, 550–563. doi:10.1016/j.healthpol.2019.03.015

Data availability. Data sharing is not applicable as no new data were generated or analysed during this study.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This project is supported by a grant from the Australian Government Department of Health under a Drug and Alcohol Program grant (H1617G038).

Acknowledgements. We greatly appreciate the support provided by the Community Advisory Group: Aunty Karen West, Aunty Joan Marshall, Uncle Alec Marshall, Aunty Topsy Rose, Aunty Evelyn Neade, Aunty Betty Jack, Aunty Julianne George, Ms Kerry Major and Aunty Edna Punch. Without your ongoing advice and support, this project would not be possible. We also thank the Gidgee Healing family health team and allied health team for their contribution to the development and implementation of the culturally appropriate health assessment and associated interprofessional collaborative practices.

Author affiliations

[A]University of Queensland, Child Health Research Centre, Brisbane, Qld, Australia.

[B]Griffith University, Menzies Health Institute of Queensland, Gold Coast, Qld, Australia.

[C]Griffith University, School of Applied Psychology, Gold Coast, Qld, Australia.

[D]Gidgee Healing, Mount Isa, Qld, Australia.

[E]University of the Sunshine Coast, School of Health and Behavioural Sciences, Sunshine Coast, Qld, Australia.

[F]Gold Coast University Hospital, Women's and Children's Health Services, Gold Coast, Qld, Australia.

[G]Flinders University, College of Education, Psychology and Social Work, Adelaide, SA, Australia.