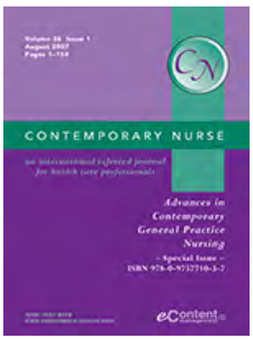

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Expanding roles of Aboriginal health workers in the primary care setting: Seeking recognition

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Expanding roles of Aboriginal health workers in the primary care setting: Seeking recognition

ABSTRACT

The work of Aboriginal health workers (AHWs) in the primary care setting is discussed, emphasising that partnership with non-Indigenous health providers such as nurses and general practitioners brings complementary skills together to improve the health care available to Aboriginal clients, and to decrease the cultural and communication barriers to delivering such health care. The diverse skills and responsibilities of AHWs, which include clinical, health promotion, education and leadership roles, are illustrated. The current focus on increasing AHW educational opportunities, and the need to recognise AHWs as core health professionals and equal members of the health care team is presented. The increasing recognition of the role of AHWs in providing cultural mentorship for non-Indigenous colleagues is discussed.

KEY WORDS

Aboriginal health worker; general practice; primary care; cultural mentorship; partnership with non-Indigenous health workers

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INTRODUCTION

Aboriginal health workers are an important part of the health care workforce and the primary health team. They often work in partnership with non-Indigenous nurses and general practitioners, a partnership which has its strongest benefit in promotion of effective communication and health care management with Aboriginal clients.

The work of Aboriginal health workers (AHWs)

is strongly affected by the setting in which they work. This article is written from the point of view of AHWs and general medical practitioners (GPs) working in a large Aboriginal community-controlled medical service in Western Sydney, formerly named Daruk Aboriginal Medical Service, but now renamed as the Aboriginal Medical Service Western Sydney (AMS WS). The historical background, the varied educational and training pathways and the diverse work roles of AHWs will be examined. The need for increased numbers and improved recognition and training opportunities for AHWs will be discussed. Several case studies illustrating the daily work of different AHWs at our service are presented.

Historical background

The beginnings of AHWs as a professional group in Australia goes back to the 1950's when Aboriginal people, usually women, were employed as leprosy workers and later as medical assistants in the Northern Territory. At that time their role is said to have mainly been cultural brokerage. This preceded the international recognition in the 1970s of the importance of using Indigenous workers to deliver effective primary health care within Indigenous communities (Curtin Indigenous Research Centre 2001) and the subsequent establishment of Aboriginal community-controlled Medical Services in Australia.

Development of AHWs' professional standing and use of clinical skills in Australia has continued to grow, particularly through the expansion of Aboriginal Medical Services, of which there are currently over 130 (National Aboriginal Community Controlled Health Organisation 2006). These vary in size from small services without medical practitioners to large multi-disciplinary services with multiple GPs and visiting allied health and specialist services, but common to all is the central role of the AHW.

Diversity of AHW roles

The work roles of Aboriginal health workers are very varied, depending on their interests and the local needs. A universal and primary role is that of cultural brokerage (Williams 2001; Bird & Henderson 2005), essentially assisting Aboriginal people and non-Aboriginal health care providers to communicate better, and allowing Aboriginal people and mainstream services to interact more effectively by overcoming cultural barriers.

Extensive clinical skills are required in many settings, with AHWs taking responsibility for clinical care such as immunisations, pap smears and health checks (Mitchell & Hussey 2006). AHWs may have a prominent role in consulting and individual patient health education, including home visits, and management of chronic disease and skin problems (Thomas, Heller & Hunt 1998).

Health promotion is an important AHW responsibility (Rose & Jackson Pulver 2004). AHWs run many different health promotion programs, including programs around child health, drug and alcohol issues, and healthy lifestyle programs (Moore et al. 2006; Rowley et al. 2000).

AHWs are frequently called upon to provide leadership and advocacy for their community (Rose & Jackson Pulver 2004). They also have a pivotal role as educators about their community and as cultural mentors (James Cook University 2003). Cultural mentors support the learning and day to day work of non-Indigenous health professionals, usually nurses and doctors, in their efforts to effectively communicate and work with Aboriginal people. Many Aboriginal community-controlled health services offer training placement to nursing and medical students and GP registrars. At AMS WS we would supervise approximately 50 students and registrars throughout the year in placements ranging from 1 day to 1 year. They all require thoughtful, supportive cultural teaching and mentorship. Non-Indigenous nurses and doctors of

many years experience also need cultural mentorship to assist them in providing effective health care to their Aboriginal clients. This may be provided by AHW colleagues or community members, and allows a non-Aboriginal health care worker to be accepted by the community and to be guided and supported in their ongoing work within that community. This central AHW role has been under-recognised and under-supported by training and funding, though recognition of its importance is beginning to grow (Australian General Practice Training 2004).

As workers at AMS WS, we see daily that AHWs are clinicians, family support workers, health promotion officers, cultural mentors, researchers and managers, and often this is just in a day's work for one worker. AHWs have a holistic health approach, with a strong focus on respect, support and advocacy for their clients in their family and community context. They are rarely off duty, called upon outside the workplace to provide education and support to their community. AHWs use their knowledge of health, of individuals and of their community to provide client support and effective health care which often goes beyond the medical model of health care.

The cultural mentorship of non-Indigenous health professionals is important in establishing effective partnerships in the Aboriginal health setting. Valuing, supporting and developing AHWs' skills as cultural mentors is essential in order to give more non-Indigenous health professionals the opportunity to benefit from the cultural knowledge they bring to health care.

Educational and training background

There are many different educational pathways for AHWs. Some AHWs have undertaken vocational training programs at the certificate and diploma levels, through Registered Training Organisations in capital cities and rural and remote locations, including within Aboriginal-community controlled health services (Briggs 2004). Some may have been trained up through their organisations in a variety of educational programs specific for their needs, but without much opportunity to convert this into official recognition at a certificate or diploma level. Some have undertaken training as enrolled nurses, particularly useful in rural areas where the training is hospital-based and there may not be an Aboriginal Medical Service (Mitchell & Hussey 2006). Some AHWs pursue university-based training to enhance specific skills (Rose & Jackson Pulver 2004).

Lack of understanding by employers and health care worker colleagues of the wide range of AHW roles, skill sets and training may have contributed to inadequate career pathways and remuneration for AHWs, a problem which has existed for some time. Surveyed AHWs in South Australia expressed concerns that there was a lack of recognition of AHWs as professionals and a lack of understanding of the AHW role, with differences in pay and in required qualifications between employers (Dollard et al. 2001). There is a feeling amongst AHWs that their career opportunities and the remuneration they receive do not recognise their diverse skills and what is expected of them (King 2001; Mitchell & Hussey 2006). It has also been a concern that there is inadequate opportunity and encouragement, not only in wage recognition but also in opportunities to access higher health education (Rose & Jackson Pulver 2004).

Work is currently being undertaken to delineate the national AHW competency standards and further develop the range of educational programs available to AHWs (Briggs 2004). In NSW the Aboriginal Health and Medical Research Council (AH&MRC) has been running AHW training at the certificate and diploma level through distance education since 2002, while awaiting building of the Aboriginal Health College in Little Bay, Sydney, where it is planned to commence a full on-site educational program in 2008 (Aboriginal Health and Medical Research Council 2006).

Working in partnership with AHWs in the health care team

In Aboriginal Medical Services AHWs frequently work in partnership with non-Indigenous nurses. At AMS Western Sydney, the practice nurse is Aboriginal, however many of the other nurses such as the community nurse, mental health nurse and midwife are not, but work with Aboriginal health workers in their different roles. It is important to recognise this is a partnership of equals, and it is not the case that an AHW is subordinate to a nurse (Jackson, Brady & Stein 1999; King 2001).

Similarly, in the AMS model of health care delivery, an AHW is working with a GP, possibly as a manager of the GP, and certainly not in the GP's employ. This loss of autonomy of practice may be confronting to some (Panaretto & Wenitong 2006). However this model of shared client management, under the direction of an elected community board, is integral to successful Aboriginal community-controlled delivery of primary care services, and recognised to be a key to effective health care delivery for Aboriginal and Torres Strait Islander communities (National Aboriginal & Torres Strait Islander Health Council 2003).

The emphasis on true partnership does not negate the fact that an AHW may rely on the clinical supervision of doctors and nurses in some of their duties. The same doctors and nurses rely on the AHW to provide a cultural supervision, and to facilitate the clinical care they seek to provide to their Aboriginal clients.

The greatest strength of the partnership model of health care delivery in the Aboriginal setting, where non-Indigenous health care providers work closely with an AHW, lies in the opportunity for improved communication with the Aboriginal client. Aboriginal clients may feel more confident in disclosing information to a peer, and the communication may be more correct due to shared understandings (Cass et al. 2002). The language used by AHWs may also be more appropriate. Aboriginal clients may see the advice of an AHW as more applicable to them, and therefore pay more attention. Peer education is recognised as an effective way to engage people, whereas advice from an 'expert' usually does not change behaviour (Ritchie 1991; Wallerstein & Sanchez-Merki 1994). On the other hand, there may be situations where a non-Indigenous person may be felt to be a more appropriate confidante, as many AHWs have strong family ties within a community and may not feel comfortable discussing some confidential matters.

AHWs also have a strong role in explaining and trying to overcome cultural and other barriers to proposed management plans which the patient may not discuss with their non-Indigenous doctor or nurse. In practice this may be as simple as the AHW advising the nurse or GP that the reason a client does not want to go to hospital is due to a previous bad experience, or that they will not purchase the recommended medication because they cannot afford it this week.

There is evidence that increasing the numbers of AHWs employed in remote communities is independently associated with improved diabetes care (Si et al. 2006). At this point of time it is unusual for AHWs to work with GPs outside the Aboriginal community-controlled setting, though there are Medicare incentives to do so, such as the Practice Incentives Program and the Enhanced Primary Care item numbers around multidisciplinary care planning (Bird & Henderson 2005).

For all the known benefits of engaging AHWs and other Aboriginal workers in health care delivery, there are not enough Aboriginal people working in our health system. In 2001 there were 8.16 health care workers who were Aboriginal or Torres Strait Islanders per 1000 Aboriginal and Torres Strait Islander people, compared with 22.84 non-Indigenous health workers per 1000 non-Indigenous people (Australian Institute of Health and Welfare 2005).

We need to vastly increase the numbers of Aboriginal people training in all the different health professions, as well as train up AHWs to fill the current AHW workforce shortfall, estimated by the Australian Medical Association to be 2000 in 2004 (Australian Medical Association 2004).

Conclusion

Aboriginal health workers are core members of the health care team within Aboriginal Medical Services and have the potential to be employed more widely in general practice and other primary care settings. AHWs may work in clinical and coordinating roles similar to practice nurses, or may take on other clinical or health promotion roles that complement and enhance the work performed by nurses and GPs in the primary care setting. A partnership between non-Indigenous health workers and AHWs brings complementary skills together to improve the health care provided to Aboriginal clients and is recognised as best practice in delivery of health care to Indigenous people.

AHWs have diverse roles and educational backgrounds according to local needs and opportunities. They frequently provide clinical services, health promotion and education, as well as leadership and advocacy for their community. Overcoming cultural, communication and socioeconomic barriers to health care for Aboriginal clients and cultural mentorship for non-Indigenous colleagues are key roles.

Increased educational opportunities and appropriate career pathways and remuneration are a priority of Aboriginal organisations and are urgently needed to allow the ongoing development of AHWs as a profession and to attract more Aboriginal people into this important work. Valuing, supporting and developing the cultural mentorship role of AHWs will have great benefits for non-Indigenous health professionals in their work with Aboriginal people. Recognition of AHWs as core health professionals and equal members of the health care team is vital for effective health care delivery to Aboriginal clients.

To inform the readers, the following case histories exemplify the diverse and expanding roles of AHW.

Case history 1: Opportunistic health care: Always on call

Joyce, the healthy heart AHW, was doing some shopping on Saturday morning with her young granddaughter when she saw Anne. Anne had been coming in weekly as part of a smoking cessation program Joyce was running at AMS Western Sydney with a non-Indigenous nurse on outreach from the Area Health Service, but had missed the last clinic. She stopped to chat and Anne told her she'd had some stresses with her daughter and had started smoking again a few days earlier. They talked about the situation and what Anne wanted and Anne decided to come in on Monday to see Joyce to restart the smoking cessation program and see what could be done to help with her daughter.

Case history 2: Client support, often outside the usual medical model

Elaine, a senior AHW and the clinic coordinator, received a phone call from Karen asking to be picked up from hospital as she was being discharged. Elaine knew she had been taken there a day earlier with chest pain, because she had rung AMS Western Sydney about her pain before she rang the ambulance. Elaine was surprised Karen was being discharged so quickly as Elaine knew that, although Karen was only 38, she had a stent put in 3 years earlier for treatment of ischaemic heart disease. Karen also had a history of anxiety and depression, and was quite socially isolated, with most of her family living several hours drive away. On deeper questioning Karen admitted she was discharging herself against medical advice and was meant to be having an angiogram the next day. Her dog

had recently had puppies and there was no one to feed them. Elaine drove to the hospital, counselled Karen about the importance of staying in hospital and got her keys, bought the dog food and fed the dogs so that Karen would continue treatment of her heart disease. She rang Karen every day to support her through her health crisis.

Case history 3: Peer education

Athol has worked as the mental health worker at AMS WS for 6 years. He runs the Men's group, who meet regularly including at camps and in social settings, to share support and educational activities. He also provides education through regular visits to detention centres for youth and adults.

Case history 4: Comprehensive health programs

Donna is the hearing AHW. She coordinates a holistic ear health program which includes screening at AMS Western Sydney and in primary schools, and case management of clients with ear disease or hearing impairment from diagnosis through to specialist management. A visiting audiologist and Ears, Nose and Throat surgeon, as well as allocated hospital bookings are part of this program.

Case history 4: Managers and community representatives and leaders

Frank commenced as a Field Officer at the AMS Redfern in 1980 before undertaking and completing the inaugural AHW Training Course at the AMS Redfern in 1984. He commenced work at AMS Western Sydney as an AHW on secondment from the AMS Redfern when AMS Western Sydney first opened its doors as Daruk AMS in 1987. During the course of his career he has been involved in extensive representation of his local community, and has held representative positions at State and National levels with the peak organisations AH&MRC (Aboriginal Health & Medical Research Council of NSW) and NACCHO (National Association of Aboriginal Community Controlled Health Organisations). He has been the CEO of AMS Western Sydney on 3 occasions, leaving and returning twice over the past 18 years. He holds many other management and advisory roles in the areas of Aboriginal health policy, research, health promotion, Aboriginal health worker training and advocacy to improve the health and wellbeing of Aboriginal communities.

Case history 5: Cultural mentorship

George, a GP registrar in the first few weeks of a 6 months training placement at Daruk, is worried and confused when his patient decides to leave the consultation and not discuss any further her complex medical and social problems. Not only does he feel upset as he has always felt he had good communication skills, he is worried as the patient is potentially very ill. After discussion of the medical issues with his supervising GP, he consults Elaine, his cultural mentor, about the communication issues he encountered in this consultation. It is agreed that he will videotape some consultations in the next week and, with the permission of the clients, review them with Elaine to specifically discuss cross-cultural communication skills in the Aboriginal setting. In the meantime, Elaine contacts his patient to ensure appropriate health management can be initiated.

Case history 6: Participatory health promotion

Louise, the diabetes AHW, is very pleased to have a phone call from Helen asking if she can be picked up to attend the women's exercise group, 'Tidda girls', that night. Helen has been coming to the diabetes cooking classes facilitated by Louise and Ros, an Aboriginal nutrition teacher from Mt Druitt TAFE. Over that time she had changed from an anxious, depressed woman who felt embarrassed to leave her home because of her obesity, and was now ready to

increase the number of health promotion activities she attended at Daruk.

Ethics approval

This article has been approved by the CEO of the AMS WS as well as the workers who have allowed their case histories to be presented. Clients have been deidentified, both by name and changing of medical details. Written consent has been obtained from Aboriginal Health Workers involved, and will be appropriately stored.

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• • • ANNOUNCING • • •

Orphaned by the Colour of My Skin: A Stolen Generation Story

by Mary Terszak

Published OCTOBER 2007; ISBN: 978-1-921348-08-2; vi + 122 pages

'I need to emphasise that my time in The Home of the Good Shepherd caused me mental trauma, which I feel destroyed my soul as a person.

Some of the children cannot understand the child that I became. I became a very different person in that I caused physical and mental abuse to other children, which means that today I live with the terrible regrets of being a kid and locked up in a horrible situation that was foreign to me.

I hope that my readers will understand and that others can see why I acted in the way that I did. I am not happy with what I became and I have had to live with this till today. Being able to tell this story is the foundation of my recovery and well-being.' AUTHOR

In an invasive, paternalistic, federal public policy environment for Indigenous communities, this book provides an in-depth account of one person's experiences as a 'Stolen Generation' Aboriginal Australian.

Told from the heart, the book speaks in the raw voice of a grandmother reflecting on her life, focusing on her childhood experiences, subsequent perceptions and life stories.

The book presents a rare autobiographical journaling of the psychological impact of institutionalisation on an Indigenous woman, her search for family, community and identity, her psychological breakdown and her personal reconstruction through telling her story in a supportive educational environment.

As an Appendix, the author provides us with a critical analysis and autoethnography – using her story as a case study – that provides deep insights into the personal experience of dealing with forced institutionalisation and social engineering to assimilate Aboriginal people.

'I certainly hope that my story will highlight the importance of how life has been for children who have been affected by such atrocities. We hear of how it has been for the Canadian Residential schools and the American Indians as similar to our own experiences here within Australia. History gives us the sadness of the Armenian, Darfur, Jewish and Kurdish situations of genocide – and in other countries. So why can't we as Aboriginal people now disclose how Australia has treated its own people?' AUTHOR

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