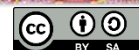




University of the  
Sunshine Coast

# Aboriginal and Torres Strait Islander Health Worker/Practitioner Continuing Education Needs Analysis

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*We acknowledge the Traditional Custodians of the land on which we work and live and recognise their continuing connection to land, water and community. We pay our respects to all Elders, past, present and emerging.*

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## **1 RESEARCH HIGHLIGHTS**

- These Aboriginal and Torres Strait Islander health workers were passionate about their role and clearly understood their scope of practice.
- The knowledge, skills and attributes of a good quality health worker were described in depth by Aboriginal and Torres Strait Islander health workers.
- The continuing education needs of these Aboriginal and Torres Strait Islander health workers were directly related to their contexts and scope of practice and the standard of care that they aspired to deliver.
- Continuing education curricula that is derived from the needs of the target audience contributes to self-determination for the participants.

## **2 PURPOSE AND SCOPE**

The aim of this study was to explore the continuing education needs of Aboriginal and Torres Strait Islander health workers/practitioners from two Aboriginal and Torres Strait Islander primary healthcare services in the Wide Bay region of Queensland, Australia.

## **3 INTRODUCTION**

Aboriginal and Torres Strait Islander healthcare workers/practitioners are vital to the health and wellbeing of their communities. Continuing professional development for Aboriginal and Torres Strait Islander health practitioners is regulated as a standard for annual licensing to practice. Yet, the same standard does not apply to the Aboriginal and Torres Strait Islander health workers who hold a Certificate III qualification, even though continuing education is recognised as essential to enable safe and effective practice. In this context continuing health education can contribute to Closing the Gap on health disparities for Indigenous Australians but needs to be relevant to practice and available to practitioners. Furthermore, the Aboriginal and Torres Strait Islander

health worker/practitioner is in the best position to determine their education needs. However, despite increases in the Aboriginal and Torres Strait Islander practitioner workforce, education programs that focus on the needs of the Aboriginal and Torres Strait Islander health worker/practitioner role are limited. This report presents the findings a needs analysis study undertaken to explore the continuing education needs of a group of Aboriginal and Torres Strait Islander health workers in the Wide Bay region of Queensland Australia.

## **4 BACKGROUND**

The health status of Aboriginal and Torres Strait Islander people continues to be a national priority, with a whole of government commitment to Closing the Gap and people employed in health worker roles are key to that campaign (Commonwealth of Australia 2008). Leading to the Aboriginal and Torres Strait Islander health worker having an expansive scope of practice with varied skill mixes within their workforce (Leditschke and Maher 2011). Health outcomes of Aboriginal and Torres Strait Islander people's results from a complex interaction of socio-economic, environmental, socio-political, specific risk and access to primary health care factors (National Aboriginal and Torres Strait Islander Health Council 2003, Queensland Health 2010, National Aboriginal and Torres Strait Islander Health Worker Association 2014). Indigenous health issues are complex and need sensitive, comprehensive responses (Clapham, Digregorio et al. 1997).

The Aboriginal and Torres Strait Islander health worker/practitioner role is vital to every aspect of the health and well-being of the Indigenous community (Albany 2010). They are the 'backbone of community controlled health services (Kuipers, Harvey et al. 2014). Indigenous health workers provide primary health care directly and as promotional activities (Clapham, Digregorio et al. 1997). In this role, Aboriginal Torres Strait Islander Health workers bridge the gap between Western and Traditional health practices(Clapham, Digregorio et al. 1997). In recognition of the role, The Aboriginal and Torres Strait Islander health workforce was identified for national registration in 2012 following the work of

Leditschke and Maher (2011). The workforce analysis undertaken by Leditschke and Maher (2011) mapped the location and contexts of the health workers and identified significant diversity in their scopes of practice, interdisciplinary interactions and skills mixes.

To be a registered Aboriginal and Torres Strait Islander Practitioner, the applicant must have completed the certificate IV approved qualification and identify as Aboriginal and/or Torres Strait islander and be accepted by the community (Aboriginal and Torres Strait Islander Health Practice Board of Australia 2012, Australian Health Practitioner Registration Authority 2016). Additionally, the registrant must complete 60 hours of continuing professional development over three years with a minimum of ten hours education in any one year (Aboriginal and Torres Strait Islander Health Practice Board of Australia 2012). At least 45 hours of the continuing education must meet the AHPRA requirements for 'formal CPD activities' and does not include the first aide certificate that the practitioner must also hold (Aboriginal and Torres Strait Islander Health Practice Board of Australia 2012). These requirements are clear for registered practitioners making them accountable for their continuing education. However, there are other Aboriginal and Torres Strait islander health workers employed in similar roles but who are educated to a certificate III level and not registered nor regulated to these standards. They too require continuing education (Rose 2014).

Despite the essential contributions Health Workers make to the health and welfare of Aboriginal and Torres Strait Islander communities their numbers are few compared to other's in the health industry (Australian Institute of health and Welfare 2009). The short tenure and low numbers of Indigenous workers with degrees suggest "a huge need to enhance indigenous participation in health workforce training, and to develop strategies for certification and recognition of the wide range of non-course-based training being undertaken" (Humphreys, Wakerman et al. 2007). Additionally, sustaining the health sector focus on wellness, prevention and primary healthcare requires more than increasing the numbers of health workers (Health Workforce Australia 2011). For example, the

Aboriginal and Torres Strait Islander health workers skills need to match community needs (Health Workforce Australia, 2011). Factors such as governance, funding, infrastructure and workforce are interlinked in processes that contextualise health service models (Humphreys, Wakerman et al. 2007). Therefore, any proposal for a model of healthcare reform, should consider the education needs of the workforce. Therefore, meeting the Aboriginal and Torres Strait islander health worker continuing education needs must factor into all processes intending to build Aboriginal and Torres Strait Islander health service and capacity for practice; particularly in regional/rural areas (Perlgut 2005).

#### **4.1 The Aboriginal and Torres Strait Islander health workforce**

Indigenous people represent 1.9% of the total population aged 15 years and over (Australian Institute of health and Welfare 2009). In 2006, there were 4,891 Aboriginal and Torres Strait Islanders employed in selected health-related occupations, representing 1% of the health workforce (Humphreys, Wakerman et al. 2007). Of these there were 100 Indigenous medical practitioners, including 40 who were medical specialists of some kind, representing only 0.2% of people employed in these occupations.

The health occupations with the largest number of Indigenous workers were registered nurse (1,107), Aboriginal and Torres Strait Islander health worker (965) and nursing support worker (442) (Australian Institute of health and Welfare 2009). The health occupations with the highest proportion of Indigenous workers were Aboriginal and Torres Strait Islander health worker (96%), health promotion officer (11%) and environmental health worker (3%) (Australian Institute of health and Welfare 2009). Aboriginal and Torres Strait Islander health workers may be employed as specialists in such areas as alcohol and drug treatment, mental health, diabetes, eye and ear health, and sexual health, or they may work as generalist members of primary care teams, or as hospital liaison officers (Australian Institute of health and Welfare 2009).

## **4.2 Continuing education needs**

Regulation of a workforce assists the constituents by guiding them to engage in continuing education and could also encourage education providers to target certain professions.

Continuing professional development is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives

(Aboriginal and Torres Strait Islander Health Practice Board of Australia 2012).

Workforce shortages and maldistribution has impeded the development of primary health care services and their incumbent workforces in Australia (Wakerman and Humphreys 2011).

Innovations in primary health services in rural and remote Australia have enhanced access, effectiveness and sustainability of healthcare delivery in “diverse settings in which the need for care is great and existing health outcomes poor” (Wakerman and Humphreys 2011). However, little has been done to address the ongoing education needs of the unregulated health workers in the changing circumstances (Community Services and Health Industry Skills Council 2015). Thus, leaving those who are not recognised as professionals; those health workers who hold certificate III qualifications, who are also a vital workforce as unattended in the continuing education market.

## **4.3 Education providers**

Vocational Education and Training (VET) accreditation is determined by the Australian Skills Quality Authority (2016) for courses that comply with the standards for VET accreditation 2012 and the Australian Qualifications Framework (AQF) (Australian Skills Quality Authority 2016). Accreditation of a course is formal confirmation that the course:



- is nationally recognised
- meets an established industry, enterprise, educational, legislative or community need
- provides appropriate competency outcomes and a satisfactory basis for assessment
- meets national quality assurance requirements
- is aligned appropriately to the AQF where it leads to a qualification (Australian Skills Quality Authority 2016).

Once VET accreditation is achieved, a national code is allocated and the course is listed on the national register located at [www.training.gov.au](http://www.training.gov.au).

A VET accredited course can be accredited for all qualification types recognised under the AQF that are eligible for delivery within the VET sector, including:

- Certificate I, II, III and IV
- Diploma and Advanced Diploma
- Graduate Certificate and Graduate Diploma.

Additionally, accredited VET courses can only be delivered by Registered Training Organisations (RTOs) that own the course or have permission from the course owner to deliver the accredited course and have the accredited course on their VET scope of registration' (Australian Skills Quality Authority 2016, Australian Skills Quality Authority 2016).

Whereas, higher education that is offered by tertiary education providers, while assessing higher order competencies, also has limitations for the Aboriginal and Torres Strait Islander student (Stuart and Gorman 2015).

Educational programs offered by the vocational education sector provide an articulation pathway to higher education programs (Rose 2014). However, these Certificate level programs assess limited competencies and are unlikely to equip Health Workers with the range of knowledge and skills, such as rapport building, liaising and interacting with medical staff, and written communications that other formal, higher education can (Rose 2014).

#### **4.4 Delivery of education**

Education for Aboriginal and Torres Strait Islander students should be delivered in modes that meet their specialised styles of learning in order to generate knowledge to translate to practice. Face-to-face interaction has been valued more than internet-based education (Humphreys, Wakerman et al. 2007, Rose 2014). Opportunities for face-to-face interaction facilitates the formation of supportive networks (Best and Stuart 2014, Stuart and Gorman 2015). Secondly, rural and remote health workers generally prefer opportunities to have CPD/CPE offered locally or regionally (Humphreys, et al 2007).

#### **4.5 Barriers to continuing education**

Lack of access to continuing education for rural practice by rural practitioners has been identified as a major disincentive (Humphreys, Wakerman et al. 2007). Innovative recruitment and education solutions are required to encourage and support Aboriginal and Torres Strait Islander health workers to remain and participate in their regional health services in order to close the workforce distribution gaps evident in rural and remote areas (Health Workforce Australia 2011).

Formal continuing education that focusses on enhancing clinical knowledge and skills, can be provided by recognised educationalists such as universities and vocational training organisations (Giri, Frankel et al. 2012). Informal learning that occurs as less structured, integrated on-the-job training through diverse learning opportunities can also be systematically achieved through designing a participant-centred curriculum and accessing education offered by various modes (Weston 2011). Health worker education requirements are influenced by location and working conditions and those in working in areas outside of urban centres do not have the same opportunities as their peers (Giri, Frankel et al. 2012).

## **4.6 Contextualising curriculum content**

Barriers to curriculum content can be encountered for Indigenous peoples when Aboriginal ways of knowing and doing, are not validated nor embedded into education processes and products (Yavu-Kama-Harathunian and Tomlin 2008). Traditionally, education gaps are experienced by Aboriginal Torres Strait Islander health workers as a result of the non-specific education modalities being used by mainstream providers (Clapham, Digregorio et al. 1997). There is a need to embed Aboriginal ways of knowing and doing into continuing education to make the curriculum content accessible and relevant the educational aspirations of the participants (Clapham, Digregorio et al. 1997).

Furthermore, the involvement of the Indigenous community in developing the curriculum provides opportunity for actualisation of Aboriginal aspirations (Williams 2001). Moreover, if the modes of continuing education development and delivering refer to the Aboriginal terms of reference that ‘...encompass cultural knowledge, understanding and experiences that are associated with a commitment to Aboriginal ways of thinking, working and reflecting..’ then reconciliation in this space can be realised (Yavu-Kama-Harathunian and Tomlin 2008, p. 52).

## **4.7 Summary**

The ‘Closing the Gap’ campaign has made some impact on improving the health of some ATSI people by making Aboriginal and Torres Strait Islander health services more available (Queensland Health 2010). Aboriginal and Torres Strait Islander health workers have particular education needs. The role of education and training in relation to the retention of Aboriginal primary health care workers is a major issue in remote health settings. An important underlying consideration is its availability and whether it is carried out in an appropriate way. Education and training are important both at the undergraduate level as well as after graduation.

## 5 METHODOLOGY

Two regional Aboriginal and Torres Strait Islander primary healthcare services in south east Queensland, Australia were purposefully selected for this study based on their location within the Central Queensland, Wide Bay, Sunshine Coast PHN region. Traditional owner Elders were consulted during the creation of these primary health services that embody the spirit of reconciliation, unity and inclusion (Galangoor Duwalami Primary Healthcare Service 2016). Participants from the Aboriginal and Torres Strait Islander health workforce and their direct managers of these organisations were invited to participate.

This participatory action research used interviews, focus groups and a survey to engage the participants in discussions about the education needs of Aboriginal and Torres Strait Islander health workers. The health workers prioritised the education topics to create a participant derived education curriculum. Appreciative inquiry was used as a framework to underpin this study so that the most valued and valuable aspects of the education needs could be explored from the participant point of view. Consultation commenced with a request to the community for this study to be undertaken. Once the project was endorsed by the communities and organisational managers; staged data collection commenced with invitations to the health workers to participate in focus groups and for their supervisors to participate in separate interviews.

In order to establish my credibility within this report, it was important for me to situate myself as a person who has a special interest in supporting and increasing the number of Aboriginal and Torres Strait Islander people working in healthcare (Williams 2001). I am the niece of Uncle Ted and Aunty Cetress Rickards, Uncle Ray, and Aunty Eva, from Kamilaroi Country. I grew up knowing the challenges and issues for Aboriginal people in rural areas. My sensitivity to the special concerns for Aboriginal and Torres Strait Islander people's health and wellbeing has guided my cultural compass to actively protect and promote cultural lore. My growing awareness of the Eurocentric

basis in healthcare has reinforced my ways, so as to demonstrate culturally safe and ethical practice throughout this study (Williams 2001, Toombs 2012). Firstly, through community support and then by ethical approval (HREC Approval no: A/16/827) that was gained before any engagement with the participants commenced.

The contributions of all the participants were acknowledge as valuable. Their time and efforts to participate were appreciated. Refreshments were provided at the focus group meetings that were held during break times or after working hours. The participants were reminded that this was their story and that they were the experts in discussing their needs as they relate to their practice (Reid and Taylor 2012).

Group 1 consisted of the health service managers who were responsible for supervising the Health Workers. The managers were interviewed separately and were asked about their perceptions of the education needs of the Health Workers and how best to meet those needs.

Group 2 consisted of the Aboriginal and Torres Strait Islander health workers who were invited to participate in a focus group by an expression of interest in the form of an information sheet and consent form. The focus group discussions with the Aboriginal and Torres Strait Islander health workers used an appreciative inquiry framework. A visioning activity was conducted at the beginning of the focus group discussions. The participants were asked to imagine the best Health Worker and describe the knowledge, skills and attributes that the imaginary Health Worker possessed. The interviews and focus group questions explored the continuing education needs of the Aboriginal and Torres Strait Islander Health Workers with the focus on what was needed to be the best Health Worker.

The topic of conversation included their description of the knowledge, skills and attributes of the “best” Aboriginal and Torres Strait Islander health worker.

Group 2 then went on to list the education that the “best” health worker would need to be the best. The interview and focus group data were combined and clustered to generate list of education topics.

Following the analysis of the Stage 1 data a survey was produced from the findings. The survey included a list of education topics. The participants were requested to prioritise the list numerically in order of their preference for education to meet their needs. Space was available on the survey for them to explain the reason for their ranking. Lastly, they were asked to provide details of education providers that they knew of, who could meet their identified needs and include any other information that they wanted to contribute to the study.

The results of the survey were collated and used in the final education program that was design and is attached as Appendix 3. The language of the survey was reviewed by a representative from Group 1 to ensure it would be relative to the participants. Once the survey was reviewed and endorsed, it was provided to each facility where it was distributed to the health workers by an independent employee. That is, someone who was not a participant in the study. For example an administration officer situated at the front counter.

All Aboriginal and Torres Strait Islander health workers employed in both facilities were offered the survey. The survey included clear instructions and a plain language statement of intent. Completion of the survey was explained as voluntary and the responses were anonymous.

This study was funded by the Central Queensland, Wide Bay, Sunshine Coast PHN; endorsed by the Aboriginal and Torres Strait Islander communities and supported by the Aboriginal and Torres Strait Islander primary health care services.

## 6 FINDINGS

### 6.1 Contexts of practice

An assortment of Aboriginal and Torres Strait Islander primary health services are collectively available in the Wide Bay region. They include:

- Aboriginal and Torres Strait Islander health checks
- Chronic Disease management
- Diabetes education
- Health lifestyles program
- Child Health
- Immunisations
- Maternal Health
- Post-natal care
- Paediatric services
- Ear, Nose & Throat Specialist
- Psychiatrist
- Psychologist
- Paediatrician
- Ophthalmologist
- Optometrist
- Endocrinologist
- Dietician
- Podiatrist

One of the organisations involved in this study was a non-government, community-run and charitable organisation dedicated to delivering whole-of-person integrated health, wellbeing and family services across Bundaberg and the Wide Bay/Burnett (Health and wellbeing services, 2016). The other was described as a community controlled primary health service, collaborating with health partners to address the burden of disease and close the gap in Aboriginal and Torres Strait Islander health (Galangoor Duwalami Primary Healthcare Service 2016).

Both organisations use a Multidisciplinary Care Team (MDCT) model that includes:

- Registered Nurse,
- Allied Health Support,
- Medical Services and
- Health Workers

The MDCT model of these primary health services involved case-management to provide healthcare support to clients with multiple chronic diseases. Indigenous health workers have a broad scope of practice including child health workers undertaking health assessments, hearing and health check screenings (with the Registered Nurse) and promoting a range of core services including;

- Nutrition and physical activity
- Injury prevention
- Immunisation
- Support during pregnancy: antenatal and postnatal
- Social/emotional development

The health workers sometimes partner with schools to identify child health needs, including delivery hearing checks and health education.

The role of the Healthcare Workers was described by their organisations as ensuring a smooth delivery of health and wellbeing services to the client and responding to the communities' diverse needs. The Aboriginal and Torres Strait Islander health workers offer support, advocacy, education and transport as well as undertaking health assessments and providing other health services required by the patient. The services are tailored to the client needs and the Aboriginal and Torres Strait islander health worker/practitioner sometimes attend appointments with the client at other community organisations.



## **6.2 Aboriginal and Torres Strait Islander Practitioner preliminary education**

To better understand the educational scope of the Aboriginal and Torres Strait Islander practitioner role, a scoping review of some certificate IV Aboriginal and Torres Strait Islander Primary Health Care Practice curricula was undertaken. The accredited education providers of the Certificate IV qualification were listed on the website of the Australian Health Practitioner Registration Authority (2016). At the time that this phase of the study was undertaken, the providers listed were Batchelor Institute, Health Industry Training, Marr Mooditj Foundation Inc and TAFE NSW (Australian Health Practitioner Registration Authority 2016). TAFE QLD is not listed by AHPRA but is included in Table 1 as an example of some of the differences between an accredited and non-accredited courses.

The website of these RTO's were reviewed for the courses they included in the Aboriginal and Torres Strait Islander health practitioner program. The course codes and education provider details were entered onto an Excel spreadsheet (Appendix 1). Courses were shaded green in the provider's column to indicate commonality with other providers. As an example, 'Provide nutrition guidance for specific health care' was delivered by all RTO's and was coloured green in all five columns. The colour red was used to highlight courses that were unique to a specific education provider, for example, 'Communicate and work in health or community services' was coloured red and only offered at TAFE NSW.

## **6.3 Group 1 – interviews**

The interview participants were unanimous in their praise of the Indigenous health workers. They recognised and acknowledged the crucial role that the health workers have in supporting the health service to meet the needs of the community. In particular, the health worker was identified as the client advocate and pivotal to enabling client engagement with the service. The health workers are the ones who 'motivate the client to attend to their health needs.' The Group 1 participants' described the health worker as 'ordinary people', with a

'willingness to learn' who were 'privy to local knowledge, lore and culture' and 'knowing everything about the client.' Characteristics attributed to the 'best' health workers by Group 1 included; calm, flexible, empathetic, sensitive, compassionate, trustworthy and persistent without being pushy.'

Group 1 listed practical skills such as 'dressings', 'documentation', 'spirometry' and 'health assessments' in their analysis of continuing education needs of the health worker. Some professional skills they listed included 'actively listening to clients to identify their needs', 'establishing relationships', 'recognising the scope and boundaries of the role' and 'writing skills'. The organisational requisite training that Group 1 mentioned included 'legislation' and 'scope of practice'.

One major concern raised by all Group 1 participants was the scope of practice restrictions placed on the health workers in this region. They explained that even though the preliminary education included the 'Medication Assist' course that the organisations could not allow Group 2 to work to this scope because they are not considered services to be in isolated practice areas by the Health Drugs and Poisons regulation 1996. Group 1 explained that this limitation impacted negatively on the health worker's capacity to practice and coordinate the continuity of care for the client. Additionally, they mentioned that the time between face-to-face interactions with the education providers was too long when the certificate IV program was delivered as block release mode.

Second to this concern was the lack of access to role appropriate continuing education for the health workers and exclusion of them from clinical education. For example, one Group 1 participant described the negotiation with the local health service to gain access to an education session about audiometry as a 'fight to get them in.' This education related directly to the scope of the health workers but was targeted at nurses. Initially, this participant was denied access by the provider for the health workers to attend this education. However, with persistence, health workers from this organisation were allowed to attend parts

of the training but only one health worker was permitted to attend the session where audiometry equipment was demonstrated.

The participants in Group 1 were mostly RN's working in clinical roles with managerial duties. There was a general consensus amongst Group 1 that health workers should have access to educational activities similar to those offered to nurses because some of the health worker duties were synonymous with enrolled nurses and some with registered nurses duties. Group 1 listed the best modes of education delivery for Group 2 as including 'face-to-face', 'in-house small group in-services' combined with 'telehealth' and 'skype sessions' that were supported by 'on-line education' and 'tutors'.

#### **6.4 Group 2 – focus group**

Group 2 participants were initially provided an overview of the study intent and design. An introduction to the process of appreciative inquiry enabled the researcher to explain the prospective visioning enacted by the questions and conversations. The first activity invited Group 2 to imagine themselves in the role of their chosen career. The participants were asked to write down their 'ideal' job. This was a secret ballot and in organisation 1, there was no further discussion. However, in organisation 2 where the group was smaller the explanation of the visioning activity triggered immediate discussion and the participants freely shared their aspirations.

##### **6.4.1 Career aspirations – 'I really want to do it', 'It's overwhelming', 'I just feel shamed'**

This visioning exercise invoked a positive atmosphere amongst Group 2 participants. Table 1 is the collated list of the career aspirations of Group 2.

| <i>Table 1 – Aboriginal and Torres Strait Islander Health Worker career aspirations</i> |                                |
|---|--------------------------------|
| Studying medicine   | Registered Nurse / Midwife x 2 |
| Registered Nurse x 2  | Midwife                        |
| In health   | Health worker                  |
| Counsellor  |                                |

As mentioned previously, some participants talked about their career aspirations and how they were once enrolled at university in ‘RN courses.’ However, they described it as ‘Too much’ because of family, personal and work commitments and they had all withdrawn from the program. One explained; ‘It’s the time, it’s the finances.’ Another said ‘For me it’s knowing where to go and who to talk to. It’s so overwhelming to walk into that campus and not know who to speak to and even just knowing what you need to do for your courses.’ This conversation developed, ‘For me it can stop me from coming to campus because I don’t put myself out there. I just feel shamed going up there and not knowing where to go or who to talk to. I feel like – Oh turn around. I have a friend up there that I usually call and ask her to organise something. Once a year I’ve been up there because I really want to do it but it’s just I can’t. If this would come to me, I’d sign up straight away. They could get a group of us hey?’

#### 6.4.2 The best health worker is: – ‘Deadly’

The participants were asked to describe the characteristics of an imaginary best health worker. They were encouraged to think about this person or themselves and to describe the skills that would be demonstrated when the job was being done well. For example; ‘Thinking about the best healthcare worker or yourself when things are going well; what is it that you are doing well? They listed the following characteristics of the best health worker.

| <i>Table 2: Attributes of the best Aboriginal and Torres Strait Islander health worker/practitioner</i> |  |
|---|--|
| Adaptable   | Home visits                                      |
| Advocate  | Educator   |
| Broad knowledge   | Knowledge of services and community              |
| Clinical Skills   | Networking                                       |
| Comfortable   | Passionate (for community, job and with clients) |
| Compassion  | Patient  |
| Competent   | Planner  |
| Consistent in role  | Proactive  |
| Culturally appropriate  | Mentor   |
| Deadly (explained as meaning awesome and including all other attributes)                                | Punctual   |

|   |   |
|---|---|
| Dedicated                                       | Rapport and trust                               |
| Delegator / good coordinator                    | Reliable  |
| Empathetic (appropriate emotion)                | Resourceful                                     |
| Empowering clients                              | Role knowledge - duties and scope               |
| Flexible (able to refocus when taken off track) | Role model                                      |
| Focussed  | Self-confident / and confident to ask questions |
| Follow guidelines                               | Support   |
| Goes above and beyond for the client            | Surrounded by support                           |
| Good communicator                               | Team player                                     |
| Hard worker                                     | Understanding                                   |
| Holistic  | Works to their scope of practice                |

In brief, Group 2 participants reinforced that a 'Deadly' health worker would have 'knowledge of their role' and be 'consistent by following guidelines and knowing their scope of practice.' However, they described having to follow guidelines as 'it sucks'. They were referring to how processes such as referrals can sometimes impede the pathways of client engagement with a health service. Following on from the visioning activity, Group 2 were asked to discuss the education required to gain the knowledge, skills and attributes for the 'Deadly' health worker to do their job to the standard described earlier.

### 6.4.3 Preliminary education

When asked to describe the knowledge, skills and attributes of an exceptional health worker Group 2 talked about the certificate III and certificate IV qualification as the foundational skills set required for their role. However, there are gaps in this education according to them. The general consensus was that 'We don't have enough knowledge about chronic diseases to be able to educate the patients. Like how to educate the patient and patient condition's interventions and assessing for risk factors.' One participant asked the group 'Does anyone know about how to assess for cardiac disease risk factors?' 'We could be providing real interventions', was the conclusion to this discussion.

The problem was explained as; 'In our Cert IV it does not elaborate on chronic diseases. Does not go in-depth into diabetes, cardiac, respiratory and renal disease.' Another example of preliminary education limitations also related to child development where the participant said 'The health worker role is not fully utilised. Being able to know the milestones in child development and being able to confidently say: "No that's not normal", and being able to document that. Or educating the parents.' The health workers were concerned for the clients that significant health issues were being missed due to their lack of knowledge and capacity to act.

Furthermore, reflecting on their certificate course they also described the pressure of study as 'it can get overwhelming. Someone comes in and says; 'I'm gonna come back and see you next week and in that time I want you to have this and this done. There's a big stack of books and we don't know where to start.' To manage the study load while working fulltime and with family and personal commitments, the participants suggested that, 'Life would be easier if we had someone to talk to about our studies. 'Cos sometimes the tutors can talk about how to write something but I need more than that. I need someone who can talk the talk.'

#### **6.4.4 Working to the educated scope – 'If you don't use it, you lose it'**

Following the discussion about the certificate qualification and when asked what the participants needed to do their job well, one health worker said; 'A change in Government. A refresher course.' This participant explained this comments by; 'we've done our certificate but we can't use it because of the State Government not letting us assist with medications and if you don't use it. You lose it.' This conversation was about the Medications Assist course that the practitioners complete in the certificate IV program but are restricted from practicing to this educated level because of the restriction placed on them by the Queensland Government (2016), Health (Drugs and Poisons) regulation 1997.

Furthermore, Aboriginal and Torres Strait Islander health workers/practitioners have a broad scope of practice encompassing diverse range of activities with dynamic requirements. When discussing knowledge, skills and attitudes Group 2 agreed; 'You have to have knowledge of the daily tasks. We do different things in our roles.' They said; 'In our day-to-day duties, we do a lot of different duties.' At this stage the group listed some skills. For example; 'ECG's', 'spirometry', 'hearing tests' and 'wound management'. One participant concluded this part of the discussion by saying, 'We could go on forever.'

Communication was discussed in-depth as a core skill that the best health worker would use to empower patients. For example, 'The best health worker would be able to communicate with the patient in a way that they could come up with their own solutions.' However, clients and workloads can impact on the capacity of the health workers to practice in the ways they intend. It was suggested that 'Some patients are hard to empower.' Additionally, 'we tend to get caught up in clinical rather than being with that person, who is there because they need patient education and help with empowering them to control their chronic disease. We get caught up with clinical stuff.'

When asked to explain the aspects of communication that were important, Group 2 raised 'internal communication skills' as another continuing education topic required. 'We have awesome RN's who support and teach us', they said but 'We get nervous to ask hard questions of other health staff.' For example, 'honestly, the GP's don't know and they go whatever you reckon nurse.' Group 1 explained that they relied on each other to help raise questions with GP's particularly if the GP was new to the organisation and the health workers were yet to establish a relationship with them. After this, they were asked about how the health worker might acquire the skills mentioned. This enabled further exploration of the knowledge that underpins the skill. Finally, they were asked about the attitude that would be needed for the health worker to develop or demonstrate the skills of 'communication'.

Likewise, when Group 2 mentioned a 'Knowledge of services and community,' they were asked to explain the skills and attitude required to gain that

knowledge. This part of the discussion raised the idea of being able to network with other services, communicate effectively with them and 'fishing for information' about other services'. Group 2 agreed that this is a common activity for them. For example, 'You see a client with needs and you go looking for ways to fix it.' Likewise, when asked 'What do you need to feel about record keeping to do it well?', the response was 'Not crap!', which attracted general laughter and unanimous agreement.

Group 2 brainstormed in this way and related the conversation to the knowledge and skills that they themselves need to maintain their competency to practice. This focus group discussion produced a list that included clinical practice skills such as 'spirometry', 'wound care' and 'ECGs'. Along with personal skills such as 'communication', 'networking' and 'time management'. In addition, the participants identified professional skills such as 'advocacy', 'motivational interviewing', 'confidentiality' and 'patient education.' The lists of education topics by Groups 1 and 2 were collated and condensed according to similarities in topics to produce the survey discussed in Section 6.5.

#### **6.4.5 Barriers to continuing education – 'We're not eligible'**

The most significant finding from the focus groups was the lack of targeted continuing education to this group. Moreover, the exclusion of the Aboriginal and Torres Strait Islander health workers from available clinical education that related to their practice was disturbing. Interaction with others in pursuit of meeting their continuing education needs was a high priority for these participants.

Accessing continuing education in regional areas presents its own barriers that are beyond the scope of this study. However, these participants experienced a unique set of obstacles to accessing education. The explained; 'there's a lot of education that is relevant to us but you apply and get knocked back because it's for nurses. Like we're doing a lot of that stuff [patient care activities] in the clinic but we're not eligible because we're not a nurse, which I find really frustrating because I'm doing it here. Why can't I do the training with the



nurses?’ This comment reflects an opinion expressed by a Group 1 participant who had to ‘fight’ to get health workers enrolled into a locally delivered audiometry in-service course.

#### **6.4.6 Best modes of continuing education delivery – ‘We like to interact with each other’, ‘I learn on the job. I’d smash it out’**

These participants are not averse to continuing education. On the contrary, they were willing and wanting to embrace it. In relation to further study it was suggested that to assist the participants to succeed, the tutors need to be content experts. For example; ‘Once I’m studying, I really enjoy it. It’s just the getting there that is the problem’ and ‘sometimes the tutors can talk about how to write something but I need more than that. I need someone who can talk the talk. I need the tutor to explain each step for me.’ Additionally, if the education were made available on-site it would be easier for these participants to engage and succeed. ‘I learn on the job. I’d smash it out,’ said one participant who aspired to be an RN/Midwife but had withdrawn from the program.

Face-to-face delivery of education was by far the most preferred mode from the perspective of these participants. Reflecting on the certificate qualifications; ‘The block sessions of the certificate were perfect [for some] for getting the work done and not having to bring it home.’ Conversely, the integrated approach was a difficult experience. For example, ‘the pre-reading was too much’ for one participant who ‘enjoyed going to TAFE and the classroom stuff.’ Additionally, another struggled and said ‘I struggled with the big pile of books and I thought, I’m not gonna get through this. Until my supervisor arranged for the guy to bring one book at a time. Five books was too overwhelming.’ In this context, frustration was experienced about this limitation.

Other suggestions for the best modes of delivery were: group-based activities, on-site training, online learning with tutor support, workshops, mentoring programs and side-by-side assessments of clinical skills. Hands on training was unanimously ascribed to by these participants but they also suggested that time

away from clinical responsibilities was necessary for adequate learning. Lastly, one innovative suggestion was for the health worker to video record themselves performing a task and have that video appraised by a tutor. This participant reflected; 'I love constructive criticism'. Then others in this focus group joined in with 'Yeah so do I' and 'yeah because we're not all perfect.'

Despite the mode of teaching, these participants suggested that 'self-confidence comes from knowing your stuff. You've gotta have the knowledge and skills and be comfortable in your role.' Translation of knowledge and skills from the teaching and learning environment was recommended as requiring a 'supportive culture that builds our confidence and helps with our competence.' 'You need to have confidence in knowing what you're gonna say to others and your medical terms too.'

In general, the Group 2 participants had aspirations for careers in health that were beyond the role of they currently held. They could quickly and comprehensively described the skills and attributes of a good quality health worker as including caring, compassion, communication and commitment. Their preliminary education provided them with foundational knowledge and skills but gaps such as, chronic disease prevention, patient education and child development were identified as continuing education needs for these participants. Additionally, the mode of delivery of the preliminary education did not suit everyone. Furthermore, at least one course in the preliminary program curriculum did not relate to the practice of these Aboriginal and Torres Strait Islander health workers.

## **6.5 Group 2 – survey**

The education topics mentioned in the interviews and focus groups were clustered as described previously in Section 5. The list was used within a survey that was distributed to Group 2. The topic themes represented aspects of communication, clinical skills, client needs, legislation and duty statement, documentation, teamwork and research skills.

The survey was organised to reflect the topic themes in relation response to how the participants referred to the education in the focus groups. For example documentation was listed with time management and research skills because as discussed in Section 6.4.3, the health workers related documentation to being thorough and organised to meet client and organisational requirements.

An 88 % response rate was achieved from the 9 surveys that were distributed. The excellent return rate could be in response to an idea that was raised by Group 2 who commented about ‘Someone is interested in us.’ Alternatively, it might have been because a chocolate snack bar was offered to each participant upon completion of the survey.

Some participants found it difficult to prioritise the education topics and some did not prioritise all topics or use conventional numbering. For example one participants responded on the survey; ‘ I found it real hard to out in an order of what was more important as I believe all of these aspects are important for a health worker to understand.’ Others expressed this concept by ranking more than one topic as number 1, 2 or 3. Likewise, some surveys did not have a number beside each topic.

## **6.6 Education priorities**

The survey findings identified the respondents’ education needs prioritised in the order of what they valued most. Following is a summary of the topics that these participants identified and the order in which they were prioritised. The education priorities of these participants were;

- Chronic diseases
- Documentation (how, what, when); Objective and effective record keeping
- Effective communication (active listening, rapport, appropriate and confident questioning)

- Client assessment (history taking/questioning techniques/knowing the client); Identifying and prioritising client needs/goal setting
- Patient education (primary health care); Patient risk factors
- Empowering the client
- Skills/equipment update (ECGs, spirometry, wound care, audiometry and terminology)
- Health worker duty statement/role/scope of practice
- Legislation (record keeping and compliance)
- Medications/medication assist
- Having difficult conversations (for example, discussing trauma)
- Teamwork (delegation and coordination)
- Managing crisis

Appendix 2 shows the distribution of the topics from the conventional and unconventional survey rankings.

## **6.7 Reasons for the ranking of the education topics**

In general, the participants referred to improving the patient care experiences as the reason for ranking the education topics as high priorities. For example, 'More education to me to be confident in educating the patient' was a reason given for prioritising the topic of 'Chronic disease'. Likewise; 'Patient education empowers the patient and allows them to make informed decisions' about 'Patient education'. Additionally, it was reasoned about 'Communication' that it was 'Good to have a refresher to update skills in communication and equipment.' One participant suggested that 'Without effective communication and empowering the client, I don't believe you can successfully carry out your duties to help the client.'

## **6.8 Continuing education available in the Wide Bay region**

The survey respondents reported about the education available as; 'None', 'I don't know of any – however training does get forwarded from time-to-time via email but they are sometimes not available for health workers. More for nurses'

and two respondents had researched the local area for education providers of topics relevant to them. One advised that 'Health Industry Training is the only one [education provider] that I know of locally' and the other said 'I've researched this and there is nothing in Bundaberg for us'

Reflective of the dissatisfaction about the restricted scopes of practice related to Medication assisting that was mentioned by Groups 1 and 2, this participant wrote 'Because of QLD legislation, we (Aboriginal Practitioners) are limited to what we can do in our role. It would be great if A/P's could use all of our skills that we have trained to do.' The survey offered the participants an opportunity to add any further information and following is the only comment received in this section of the survey.

## **6.9 Incidental findings**

Engaging a university-based researcher with Aboriginal and Torres Strait islander health workers in genuine conversations about their career aspirations and continuing education reignited some participant's desire to complete further education. For example, one participant wrote on the survey 'Currently in the process of applying to getting Cert IV Primary Health Care.' Two participants spoke in the focus group of recommencing the Bachelor of Nursing program and one of them has recommenced their enrolment in the Bachelor of Nursing program. Similarly, an enrolled nurse health worker, not involved in this study but aware of through talking to others, independently approached the researcher for advice about nursing and has since enrolled with a local university. So while, not an aim of this project, it is certainly a significantly positive outcome that three local Aboriginal and Torres Strait Islander people have moved closer to achieving their career aspirations since becoming aware of this study.

## **7 DISCUSSION**

Aboriginal and Torres Strait Islander health workers are recognised for the important strategic role they play in closing the gap (Commonwealth of Australia

2008, Kuipers, Harvey et al. 2014). The skills and scope of practice of health workers varies relative to the context of practice and community demographics because in order to close the gap regionally placed Aboriginal and Torres Strait Islander primary health care services must provide a comprehensive ranges of services (Commonwealth of Australia 2008). Multidisciplinary team approaches involving diverse health professional roles are used to respond clinically and culturally in regional areas (Galangoor Duwalami Primary Healthcare Service 2016, Indigenous Wellbeing Centre 2016).

Even though, Closing the Gap is everyone's business; Aboriginal and Torres Strait Islander Primary Health Services and the Health Workers employed by them provide essential services (Commonwealth of Australia 2008). The health workers contribute to the smooth delivery of health and wellbeing services to their communities (Galangoor Duwalami Primary Healthcare Service 2016, Indigenous Wellbeing Centre 2016). Therefore, educating the Aboriginal and Torres Strait Islander health workers to work to their full scope of practice is needed.

### **7.1 The role of the Aboriginal and Torres Strait Islander Healthcare practitioner**

Aboriginal and Torres Strait Islander Health Workers are at the forefront of health services where the significance of Health is a cultural construct is realised (Queensland Health 2010). The Health Workers strive for person-centred approaches to provide holistic care within their educational scope. Additionally, these Health Workers could describe what they needed to know to do their job well. However, limiting their authority to practice to their full educational scope is dissatisfying and leads to professional frustration. Similarly, limitations to practice scopes have been identified in other sectors of the health care workforce where taskforces and strategies have been implemented to encourage and facilitate full scope functioning (Queensland Government 2013, Queensland Government 2015). Furthermore, education needs are contextually based, related to the individual's scope of practice and

personal capacities as well as changing community demographics and service capabilities.

The pivotal role that Aboriginal and Torres Strait Islander health workers have in 'Closing the Gap' on health disparities in their communities is under-utilised when they are governed by laws that restrict them from working to their scope. Furthermore, limiting the practise, unnecessarily transfers workload to others. For example, these participants were educated to assist with medications but due restrictions related the Health Drugs and Poison (regulation) 1996, their practice in Queensland is restricted and they were not permitted to handle medications. They reported that this delegation impacts negatively on seamless delivery of safe and effective care and is 'stifling'. The participants in this study suggested a change to this situation would contribute to 'consistent', in other words seamless care.

## **7.2 Education providers**

Regionally-based education providers are in prime position to support the continuing education of a regionally-based healthcare workforce. Specifically related to the Aboriginal and Torres Strait Islander workforce, a strengthening of their governance of education programs and pathways through genuine consultation and bringing the participant community into the decision making process, enables self-determination (Graham 2011). Any continuing education program that puts Aboriginal and Torres Strait Islander people in 'control of the solutions' will be meaningful to them and their role (Graham 2011, p. 15). This was a strategy reflected in the strategic plan of the National Aboriginal and Torres Strait Islander Health Worker Association (2014) where it was recommended that the issue of educating Aboriginal and Torres Strait Islander Health workers is not the sole responsibility of peak bodies but all Australians. However, the experiences of the participants in this study was that they were sometimes excluded from education that was relevant and available in their local area.

### **7.3 Education needs**

Preliminary education such as the Certificate IV Aboriginal and Torres Strait Islander Healthcare Practitioner program is foundational for the Aboriginal and Torres Strait Islander health care workforce. Employers and accrediting bodies have expectations of its quality and standards (Australian Government Productivity Commission 2005, Community Services and Health Industry Skills Council 2015, Australian Health Practitioner Registration Authority 2016). However, inconsistencies are apparent when the curricula of multiple programs are compared. Furthermore, Aboriginal and Torres Strait Islander health care workers are educated to a scope that in Queensland they cannot enact, except in isolated practice areas (Queensland Government 2016).

### **7.4 Career aspirations of Aboriginal and Torres Strait Islander health care workers**

One way of improving Indigenous Health delivery is to have greater representation of Indigenous people in health professions (Queensland Health 2010). The Health Workers in this study have aspirations to progress into a diverse range of health disciplines. Supporting these participants to reach their career goals would be advantageous to improving health outcomes for Aboriginal and Torres Strait Islander people in this community. In respect to further education the issues of loneliness, discrimination and lack of emotional and financial support that have been associated with drop-out rates of Aboriginal and Torres Strait Islander people who enter health education programs such as nursing must be addressed (Best and Stuart 2014, Stuart and Gorman 2015).

Actively engaging Aboriginal and Torres Strait Islander people in formal education will help them to gain skills and qualification that could potentially enhance their career path and improve their lifestyle (Toombs 2011). Toombs (2011) recommends teaching resilience to ATSI students in order to support them to remain engaged in education. Toombs (2011, p.26), poignant



commentary of ‘our students have the right to thrive, to reach their full potential and to have positive impacts on others.’

Additionally, Best and Stuart (2014) identified four elements of a supportive framework for Indigenous nursing and midwifery students that they argue were pivotal to successfully graduating 80 students from higher education programs between 2000-2012. Best and Stuart (2014) drew upon their experiences as Indigenous nursing academics and students respectively, to embed Indigenous perspectives into university processes for marketing, recruitment, curriculum design and student retention support services. The initial recruitment strategy that Best and Stuart (2014) used to encourage Indigenous persons into the nursing program was to visit community-controlled Aboriginal and Torres Strait Islander health workers health services by these Indigenous academics (Best and Stuart 2014). Following recruitment the Helping hands program included multiple student-centred strategies specifically targeting the cultural and learning needs of these Indigenous persons. Building on the success of the Best and Stuart (2014) initiative to engage multiple regional stakeholders would help to embed pathways for future enhancements in ATSI learning journeys.

## **7.5 Continuing education programs in regional areas**

Learning frameworks exist for nurses and midwives (Queensland Government 2015) and doctors (The Royal Australian College of General Practitioners (RACGP) 2016) but many other health workers, including the Aboriginal and Torres Strait Islander health workers are neglected in this way (Community Services and Health Industry Skills Council 2015). There is more that could be done to build capacity in continuing education for health workers (Humphreys, Wakerman et al. 2007, Kuipers, Harvey et al. 2014, Oliver-Baxter, Brown et al. 2015). For example the phn Central Queensland Wide Bay Sunshine Coast (2016) host a web page titled ‘Health professionals education notes’, which could also include instructive design on how to use the notes. As it currently is, the notes on ‘Motivational Interviewing’ include a static PowerPoint, an interview template and a list of references (phn Central Queensland Wide Bay

Sunshine Coast 2016). Similarly, the University of the Sunshine Coast (2016) advertises regular workshops including topics relevant to these participants but the detail on the website is limited.

Continuing education is effective if it is clearly relevant to the practice of the participants, based on participant needs, has provision for reinforcement in practice and is linked to RTO faculty to create a seamless progression (Wakerman and Humphreys 2011, Giri, Frankel et al. 2012, Queensland Government 2015). Partnerships between local secondary and primary health services and education providers has been proven to successfully increase recruitment and retention of Aboriginal and Torres Strait islander peoples in health education programs (Bond 2010, Best and Stuart 2014). Furthermore, if these collaborative work towards developing continued education pathways then retention of Indigenous people as frontier in health services is possible. Strengthening workforce to respond to the burden of disease and therefore closing the gap is crucial (Commonwealth of Australia 2008, Health Workforce Australia 2011, Leditschke and Maher 2011).

Developing education that is specific to the participants and provided in ways that are accessible enables communities to growing their own health workforce (National Aboriginal and Torres Strait Islander Health Worker Association 2014, Rose 2014). Furthermore training local people, enhances local capacity and builds social capital (Toombs 2011, Giri, Frankel et al. 2012, Best and Stuart 2014).

## **7.6 A research strategy to honour Aboriginal and Torres Strait Islander perspectives**

Lastly, but importantly, one point of difference in this study was through combining appreciative inquiry with participatory action research the Aboriginal and Torres Strait Islander health workers were positioned as the experts in determining the best ways to develop and sustain educational solutions for these research issues (Bushe 2011, Toombs 2012). Participatory action

research is a Western methodology that is recognised by Aboriginal and Torres Strait Islander researchers as aligning with supportive, culturally safe practices and an Aboriginal terms of reference (Williams 2001, Yavu-Kama-Harathunian and Tomlin 2008).

Reciprocity with the Aboriginal and Torres Strait Islander community was enacted in this study through the appreciative inquiry framework. Community representatives guided the research ideas before any action was undertaken, so that the relevance of the project to meeting the needs of the participants was authentic. After establishing the possible benefits to the community, this study commenced with the endorsement of the Aboriginal and Torres Strait Islander health worker community (Toombs 2012). The focus groups discussions generated a community viewpoint of the best practice and the necessary education to support and enhance it. Together, they designed modes of educational engagement to best suit their learning styles. The survey that followed provided an opportunity to prioritise the education and to complete the action research cycle. The curriculum that emerged was derived from these participants and endorsed by their communities. This study was genuinely, designed, developed and done with the involvement and inclusion of Aboriginal and Torres Strait islander people. Thus, using a process that has been recommended by Clapham, Digregorio et al. (1997) and (Williams 2001) as genuine. From this point of view, the outcomes of this study belong to these communities and I thank them for their generosity in sharing their stories.

## **8 IMPLICATIONS**

Barriers to continuing education such as has been experienced by the participants in this study can be demotivating and disenfranchising. Given the unique and essential nature of the Aboriginal and Torres Strait Islander health worker/practitioner role, the lack of attention to their continuing education could be contributing to a widening of the gap between them and their health industry counterparts. Enabling Aboriginal and Torres Strait Islander health workers to function to their capacity and be supported, like all other health workers, to engage in activities for their continued development can lead to improved

experiences for client and clinician. Furthermore, integrating the Aboriginal and Torres Strait Islander health workers education with other clinicians in interdisciplinary programs could strengthen professional relationships while resolving the problem of limitations to available education (Weston 2011).

## **9 LIMITATIONS**

The roles and scope Aboriginal and Torres Strait Islander health workers/practitioners and therefore their education needs relate directly to their context of practice. For these reasons, the findings from this study are specific to this region. Likewise, the health needs of the Aboriginal and Torres Strait Islander community relate directly to Country and Culture.

Additionally, this was a small qualitative study in a regional area with participants from two Aboriginal and Torres Strait Islander primary care health services. However, this study used research processes and tools that can be applied to any setting.

## **10 RECOMMENDATIONS**

Developing an 'On-country continuing education program' that uses Aboriginal and Torres Strait Islander terms of reference is the main recommendation from this study. In order to achieve this it is also recommended that an Aboriginal and Torres Strait Islander reference group is established at the outset to guide and inform program development and pedagogical processes. Active engagement from other key stakeholders such as the PHN, primary and secondary health services, VET providers and higher education institutions will be necessary to form committed networks for establishing innovative education links and learning pathways for Aboriginal and Torres Strait Islander Health Workers. Regionally placed opportunities for a culturally grounded continuing educational programs can be created from these community partnerships. Thus, demonstrating real reciprocity at the outset and safe stewardship of

Aboriginal and Torres Strait Islander persons towards further education (Clapham, Digregorio et al. 1997, Toombs 2012, Best and Stuart 2014).

Organisational factors such as, time-out to learn are recommended to help with successful and sustainable continuing education programs. Common collaborative learning through establishing a work-based Aboriginal and Torres Strait Islander health worker yarning program has been found to facilitate practice based discussions and strengthen connections with community. Additionally, drawing from specific online resources such as Australian Indigenous Health InfoNet (2015) to create locally grown work-based activities such as the yarning program will help Health Workers to share their knowledge and skills which can enhance collaborative and collegial education of others (Weston 2011).

Furthermore, to strengthen the purpose of any health worker education initiative and make meaningful the outcomes of these activities, evaluative key performance indicators that have contextual cultural, educational and health service value should be developed and clearly linked to the education program. A further phase of this project should include implementation of the education curriculum produced from this study.

Additionally, this action research project should be evaluated and repeated annually because the benefits will be realised only if the identified needs are met. Therefore, in relation to the dynamics of continuing education needs; a recommendation from this study is that each educational intervention be formally evaluated by the participants. In addition, an annual and ongoing participant perspective needs analysis be carried out by the employing organisations, the PHN and/or the education providers. The reference group can authorise the appropriate person with this task to avoid over surveying of participants.

Further analysis of the results of this study to identify the essences of the topics could provide for a more meaningful syllabus. For example 'effective communication' was discussed as including listening, rapport, questioning and

culture.’ Education of each one of these sub-topics needs to be contextualised for the Aboriginal and Torres Strait Islander health worker role if they are to be culturally and educationally relevant.

## **11 CONCLUSION**

Sincerest appreciation is expressed to the Aboriginal and Torres Strait Islander health workers, their supervisors and employing organisations for sharing their stories and showing how continuing education can be improved in this region. Thank you also to the Central Queensland, Wide bay and Sunshine Coast PHN for funding this participatory action research. Lastly, thank you to the University of the Sunshine Coast for supporting me to undertake this study and engage with these inspirational people. This study has reinforced the essential role that the Aboriginal and Torres Strait islander health worker has in caring for the community who utilise the primary health care services and in closing the gap for Indigenous Australians. The education needs of the health workers are underserved with few local providers and limitations placed on them to attend education focussed on other health professionals. Addressing this issue in regional areas can improve health care knowledge and skills and thus enhance service delivery. This study contributes to the valuable work done by others in support of closing the traditional education gaps experienced by Aboriginal and Torres Strait islander people. It is my hope that this study will initiate further developments in this area. In closing, I share with you a verse from Uncle Ted.

‘If you have a desire,  
To do a good deed,  
Reach out the hand,  
To those in need’



Uncle Ted Rickards

## 12 APPENDICES

### Appendix 1 – Courses offered in a variety of Certificate IV Aboriginal and Torres Strait Islander Primary Health Care Practice Programs

| Code       | Course   | Education Providers |                          |              |                      |
|------------|--|---------------------|--------------------------|--------------|----------------------|
|            |  | Batchelor           | Health Industry Training | Marr Mooditj | TAFE NSW<br>TAFE Qld |
| HLTAHW022  | Address social determinants of Aboriginal and/or Torres Strait Islander health                 |                     |                          |              |                      |
| HLTAHW020  | Administer medication  |                     |                          |              |                      |
| HLTAHW017  | Assess and support client's social and emotional well being                                    |                     |                          |              |                      |
| HLTAHW016  | Assess client's physical wellbeing   |                     |                          |              |                      |
| CHCCOM005  | Communicate and work in health or community services   |                     |                          |              |                      |
| HLTIN301C  | Comply with infection control policies and procedures  |                     |                          |              |                      |
| HLTINF001  | Comply with infection prevention and control policies and procedures                           |                     |                          |              |                      |
| HLTAHW019  | Deliver primary health care programs for Aboriginal and/ or Torres Strait Islander communities |                     |                          |              |                      |
| HLTAHW006  | Facilitate and advocate for the rights and needs of clients and community members              |                     |                          |              |                      |
| CHCNET404B | Facilitate links with other services   |                     |                          |              |                      |
| HLTAHW010  | Identify community health issues, needs and strategies   |                     |                          |              |                      |
| BSBMED301  | Interpret and apply medical terminology appropriately  |                     |                          |              |                      |
| HLTVHS001  | Participate in workplace health and safety   |                     |                          |              |                      |
| HLTAHW023  | Plan, develop and evaluate health promotion and community development programs                 |                     |                          |              |                      |
| HLTAHW018  | Plan, implement and monitor health care in a primary health care context                       |                     |                          |              |                      |
| HLTAID003  | Provide first aid  |                     |                          |              |                      |
| HLTAID003  | Provide first aid (This unit is not offered by Health Industry Training)                       |                     |                          |              |                      |
| HLTAHW034  | Provide healthy lifestyle programs and advice  |                     |                          |              |                      |
| HLTAHW028  | Provide information and strategies in chronic condition care                                   |                     |                          |              |                      |
| HLTAHW030  | Provide information and strategies in eye health   |                     |                          |              |                      |
| HLTAHW418B | Provide information and strategies in hearing and ear health                                   |                     |                          |              |                      |
| HLTAHW021  | Provide nutrition guidance for specific health care  |                     |                          |              |                      |
| CHCICS408B | Provide support to people with chronic disease   |                     |                          |              |                      |
| HLTAAP001  | Recognise healthy body systems   |                     |                          |              |                      |
| CHCCS020   | Respond effectively to behaviours of concern   |                     |                          |              |                      |
| CHCICS406B | Support client self-management   |                     |                          |              |                      |
| HLTAHW037  | Support the safe use of medications  |                     |                          |              |                      |
| HLTAHW007  | Undertake basic health assessments   |                     |                          |              |                      |
| BSBWOR204  | Use business technology  |                     |                          |              |                      |
| HLTAHW005  | Work in Aboriginal and/or Torres Strait Islander Primary Health care context                   |                     |                          |              |                      |
| CHCLEG001  | Work legally and ethically   |                     |                          |              |                      |
| CHCDIV001  | Work with diverse people   |                     |                          |              |                      |
| CHCCS400C  | Work within a relevant legal and ethical framework   |                     |                          |              |                      |

#### Legend

|   |                                    |
|---|------------------------------------|
|  | Course common to multiple programs |
|  | Course unique to one program       |

### Appendix 2 – Education topics ranked by survey participants

| Education Topic  | Total number of responses per topic | Topic attracting most 1's in rating |
|--|-------------------------------------|-------------------------------------|
| Chronic diseases   | 8                                   |                                     |
| Documentation (how, what, when); Objective and effective record keeping  | 5                                   | 1                                   |
| Effective communication (active listening, rapport, appropriate and confident questioning)   | 6                                   | 1                                   |
| Client assessment (history taking/questioning techniques/knowing the client); Identifying and prioritising client needs/goal setting | 7                                   |                                     |
| Patient education (primary health care); Patient risk factors  | 7                                   | 2                                   |
| Empowering the client  | 6                                   | 2                                   |
| Skills/equipment update (ECGs, spirometry, wound care, audiometry and terminology)   | 6                                   | 2                                   |
| Health worker duty statement/role/scope of practice  | 5                                   |                                     |
| Legislation (record keeping and compliance)  | 5                                   |                                     |
| Medications/meds assist  | 5                                   |                                     |
| Having difficult conversations (for example, trauma)   | 5                                   | 2                                   |
| Teamwork (delegation and coordination)   | 4                                   | 2                                   |
| Managing crisis  | 3                                   | 2                                   |

## Appendix 3 – Indigenous Health Worker Education Program

| 2016 Indigenous Health Worker Education Program |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
|   | JANUARY  | FEBRUARY  | MARCH  | APRIL  | MAY   | JUNE                                   |
| <b>Topic requested</b>                          | Chronic diseases   | Documentation (how, what, when); Objective and effective record keeping | Effective communication (active listening, rapport, appropriate and confident questioning)                                 | Client assessment (history taking/questioning techniques/knowing the client); Identifying and prioritising client needs/goal setting | Patient education (primary health care); Patient risk factors         | Empowering the client                  |
| <b>Possible local provider</b>                  | <i>Nurses for Nurses (Webinar); Australian College of Nursing (Distance Education); Australian College of Rural and Remote Medicine (Online); Australian Online Courses (Online)</i> | <i>Australian Online Courses (Online); Nurses for Nurses (Webinar);</i> | <i>Nurses for Nurses (Webinar); Australian College of Nursing (Distance Education); Australian Online Courses (Online)</i> | <i>No local provider</i>   | <i>PHN</i>  | <i>No local provider</i>               |
|   | JULY   | AUGUST  | SEPTEMBER  | OCTOBER  | NOVEMBER  | DECEMBER                               |
| <b>Topic requested</b>                          | Skills/equipment update (ECGs, spirometry, wound care, audiometry and terminology)   | Health worker duty statement/role/scope of practice                     | Legislation (record keeping and compliance)  | Medications/meds assist  | Having difficult conversations (for example, trauma); Managing crisis | Teamwork (delegation and coordination) |
| <b>Possible local provider</b>                  | <i>Medical equipment representatives</i>   | <i>Employer</i>   | <i>No local provider</i>   | <i>VET Education provider</i>  | <i>LEARN program</i>  | <i>No local provider</i>               |
| <b>LEGEND</b>                                   |  | <i>Resident Conditions</i>  |  |  |   |  |
|   |  | <i>Communication</i>  |  |  |   |  |
|   |  | <i>Practice Skills</i>  |  |  |   |  |



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