Consultations Report: Aboriginal Health Practitioners

December 2019

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NSW GOVERNMENT

1. Contents

2. Acronyms and frequently used terms

Aboriginal Health Worker	AHW
Aboriginal Health Practitioner	AHP
Aboriginal health workforce	This is a collective term to refer to any Aboriginal staff member working for NSW Health regardless of their role. It includes AHW, AHP as well as Aboriginal managers and those in Aboriginal Workforce teams.
Australian Health Practitioners Regulatory Agency	AHPRA
Models of Care	MoC
New South Wales	NSW
Local Health Districts	LHD
University of New England	UNE

3. Executive Summary

This project aimed to identify the barriers to the adoption of Aboriginal Health Practitioners (AHPs) in the NSW Health workforce, and to provide advice on what actions might increase the uptake of this role. This was achieved through consultation with approximately 50 Aboriginal people in the health workforce, human resource managers, and workforce managers and workforce development managers. The summary of findings and suggested responses are as follows.

There is currently an insufficient understanding of the clinical nature of the role and how it would work safely and effectively within a collaborative clinical environment. Often this was described as a lack of support from the Nursing workforce to establish positions within clinical teams; or that the Registered Nurses or Midwives within their teams were not happy for the Aboriginal Health Practitioner to practice independently.

Due to Aboriginal communities placing high demands on their Aboriginal Health Workers and no additional pay for Aboriginal Health Practitioners, it was identified that there was some reluctance to take on new clinical skills as this may place higher community demand and pressure on the Practitioner. Aboriginal Health Workers also identified that there is a need for cultural supervision to support workers in these situations, and often the cultural supervision is inadequate or absent.

Suggested Action: to work collaboratively with the Nursing, Midwifery and Allied Health professions to refine a model of clinical supervision for all levels of skill of Aboriginal Health Practitioner (novice to expert). This should include an explanation of the dual supervision model so that there is a clear understanding of both the clinical and cultural supervision that will be required by the Aboriginal Health Practitioner.

There is a need for Aboriginal health workforce assessment planning for Aboriginal Health Practitioners, which was highlighted as one of the actions that had not taken place in many districts visited. Aboriginal Health Worker roles should all be assessed for the level of clinical intervention required for their client profile, including accurately assessing whether Aboriginal Health Workers were actively practicing clinically. Where the role scope is identified as needing to include clinical practice those staff members should be offered the opportunity to transition to an Aboriginal Health Practitioner role, including an obligation of the health service to support the individual in the attainment of relevant qualifications and the review of the service model and model of care to ensure the entire multidisciplinary care team is appropriately engaged

Suggested Action: there has been a successful assessment and planning activity conducted in Hunter New England Local Health District that identified all Aboriginal Health Workers and assessed based on the activities they performed, whether they should be offered the opportunity to transition to the Aboriginal Health Practitioner role and who should remain in the Aboriginal Health Worker role. Those who choose not to transition to an Aboriginal Health Practitioner role would need to cease practicing clinically or be prepared to transfer to another AHW role to enable the role to engage as an AHP fully. This resource and method of assessment should be shared with other Local Health Districts so that they may conduct the same activity.

There was a mixed view amongst those consulted on the merits of an Aboriginal Health Practitioner role, and there was a degree of scepticism that this was "just the next thought bubble" of the Ministry of Health of which Aboriginal people had seen many times before. Some Aboriginal people were proud to be in positions that had their peoples name in its title and aspired to be in an independent clinical Aboriginal Health Practitioner. Others viewed it as "limiting" or "racist" as it did not have a progression or pathway beyond the Certificate IV qualification.

Suggested Action: is to promote the pathway to the Bachelor of Community Services (Aboriginal Community Care), a Management Pathway, which has been mapped by the University of New England. Also, to acknowledge and communicate to the Aboriginal Health Workforce more generally that TAFE Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care or TAFE Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Cert. IV), will have limited credit for Nursing, Medical and Allied Health degrees because it does not contain the required level of foundation science within that year of study.

It was raised by Aboriginal people who had completed the Cert. IV Practice that they undertake a unit of study in medication administration; however, they are not able to administer post-registration as the AHP position is not listed in the to the NSW Poisons Act and Regulation. In the Western Australia system in the regulation of medications under *Poisons and Medications (2016) Medicines and Poisons Authorisation of health professionals, Part,7 Authorisation of Aboriginal and Torres Strait Islander health professionals*. This allows for Aboriginal Health Practitioners to possess and administer prescribed schedule 2, 3 and 4 medications.

Suggested Action: seek further advice on process and issues with changes to the *Poisons and Therapeutic Goods Regulation NSW (2008*), under Appendix C 'Persons

authorised to possess and use substances', to allow for Trained and Registered Aboriginal Health Practitioners to be included as a Health Professional under the Poisons Act.
There was only a small number of Aboriginal Health Workers transitioning to Practitioners that we consulted. However, a large proportion of them noted a delay in registration with AHPRA of up to three months.

Suggested Action: is that NSW Health seeks advice and support from the two leading training agencies and AHPRA to identify what are the major causes in delays in registration and what can be done to remove or minimise the delays.

Three current Aboriginal Health Practitioner models are emerging, and there are others in the pipeline.
Roles emerging

1. Chronic disease management
2. Maternal and Infant health
3. Allied health (podiatry and other roles)

Roles being planned (rural and regional)

4. Ambulatory and Urgent care
5. Satellite assessment and referral clinic

Roles being talked about

6. Renal dialysis
7. Women's Health
8. Drug and Alcohol
9. Domestic Violence Worker
10. Diabetes education
11. Palliative care
12. Audiometry

It was noted that we were not documented models of care or position descriptions that currently able to be shared.

Suggested Action: Seek the support of the Agency for Clinical Innovation to a) Support the collaborative clinical development of Models of Care for Aboriginal Health Practitioners and b) run an Aboriginal Health Practitioner specific Model of Care and position development Redesign School.

There is a firmly held view that as the rate of pay is not higher than the rate that is paid to an Aboriginal Health Worker that there is no incentive to change into those roles.

There was an argument that there was a greater responsibility for the patient's wellbeing when conducting assessments and clinical observations. Also, there would likely be a higher demand for Aboriginal Health Practitioners from their local communities for clinical care and that this responsibility should be rewarded.
When you consider the first part of the argument that there is greater clinical responsibility, this argument for increased rates of pay is difficult to support as an Enrolled Nurse has an almost equal clinical responsibility, however, as there is a known preference for Aboriginal people to be treated and cared for by 'their mob', and that aboriginal cultural knowledge that AHPs hold is valued by their communities and thus we must consider this additional demand on the AHP positions by their communities.

Suggested Action: Consider making an application at the NSW Health Service Aboriginal Health Workers' (State) Award and Public Hospitals (Professional & Associated Staff) Conditions of Employment (State) Award review to add additional allowances for community demand. In particular for those for AHPs working in isolation and regional communities.

Aboriginal Health Practitioners were aware of the additional cost of annual registration and the cost of mandatory continuous professional development required to maintain AHPRA Registration.

Suggested Action: Consider making an application at the next NSW Health Service Aboriginal Health Workers' (State) Award and Public Hospitals (Professional & Associated Staff) Conditions of Employment (State) Award review for the addition of allowances for 1) registration and 2) continuous professional development.

Workers noted that they were limited by the award in their ability to work in a clinical environment and be able to obtain an out of hours shift work penalties should they be in an environment where an Aboriginal Health Practitioner was able to work in a team such as a Hospital or Multi-Purpose Service.

Suggested Action: Consider making an application at the next Aboriginal Health Practitioner award review for an addition of a provision to work shift work with associated penalty rates.

Local Health Districts that have supported Aboriginal Health Workers to make the transition have been able to support the AHPs with clinical training hours and access to CPD hours, however individuals wishing to register and transition are struggling to navigate the process without a high cost to themselves and their families.

Aboriginal health workers undertaking the Certificate IV in clinical practice noted that it was limiting not being able to access funding to release them from their current role to participate in the hours required for clinical training. It was noted, however, that some of the hours may be able to be conducted in a current workplace.

Also, the handful of Aboriginal Health Workers who were able to release themselves from work found it challenging to access placements and to obtain the necessary hours of clinical experience. They suggested that they also are given access to clinical placements the same way that training nurses use ClinConnect to access placement hours.

Suggested Action: NSW Health consider funding for work release hours for Aboriginal Health Workers currently employed to undertake clinical training hours where they have an identified AHP role on completion of their required clinical hours.

3.1 Jane's Story

Jane is a Bundjalung woman from across the Queensland border, she has worked in health all of her career, as an Aboriginal Health Worker or as an Aboriginal Health Practitioner. Jane enjoyed study and learning and had been successful in all the courses she has completed. She chooses to work with Aboriginal people to improve their health and is proud to be in a role that is targeted and titled as 'Aboriginal'.
Jane completed her Cert. VI Practice and registered as an Aboriginal Health Practitioner in her previous job in another jurisdiction and worked there for two years as a clinician, focusing on Chronic Disease Management in the Aboriginal community.
Jane told me her story of how her role as an Aboriginal Health Practitioner has worked.

Management
Jane was part of the community generalist chronic disease management team and reported to a non-Aboriginal Nursing Manager. In that team, there was a physician, a Clinical Nurse Consultant, two nurses and herself. She had similar performance measures and expectations as the other nursing members of the team in terms of the numbers of clients and reporting referral responsibilities.
Jane would present her clients to the team at the weekly team meetings and discuss issues with the management of her clients. Collaboratively they would adjust the frequency that she was seeing stable clients and how many new clients she would take on.

Assessment and Observation
Unlike other members of her team who received their referrals from GPS or hospital doctors and nurses, Jane received many of her referrals form the Aboriginal '48 hour' follow up' service or directly from members of the community who identified themselves or their family members as not coping with their long term medical condition.
Jane used the same assessment tools that the community chronic disease management team used as well as the same vital sign observation forms.

Referral
When clients told Jane they were sick, when she observed vital signs that were outside of normal ranges or when she identified client needs that she was not able to address, Jane used the same escalation path as her nursing colleagues. She would discuss the clients' condition immediately with the teams' doctor, and they would together decide the most appropriate clinical path to take.

Jane spoke of the many different paths that she had taken with her clients: sometimes if they would not go to the hospital she would arrange home visits, sometimes she would take them to the GP and help the GP to understand the client's situation and then support them with follow up medical management and feedback to the GP. She described this as the part of the role that she found most satisfying.

Supervision

Jane's clinical supervisor was the Clinical Nurse Consultant. She had a good relationship with her, and she was the person she called most often when she was uncertain about an Aboriginal client's condition. Jane also had a monthly meeting with the Clinical Nurse Consultant where they would complete her annual clinical skills credentialing, talk about difficult management conditions and reflect on the things that were clinically challenging and the things that were working well for Jane's clients.

Jane also had a monthly catch up with a senior Aboriginal Supervisor in her district to talk about how she was working with the community as Jane, while she was accepted by the community, she was not from their country. They talked about the expectations of the community and how her manager could support her as sometimes the demands and expectations of her were high.

Jane's Aboriginal Supervisor was also able to advocate for her with her manager when she has cultural responsibilities which may take her away from her work.

Ongoing professional development

When Jane started as an Aboriginal Health Practitioner, she was concerned about the cost of the training required to maintain her AHPRA registration. This proved to be an unnecessary concern because as soon as she joined the Chronic Disease Team, she found that she was included in the teams' ongoing in-service program and in the hospital medical specialties that were connected to the community health centre where she worked. The team also paid for her to attend a conference or training program once each year.

Other roles

Jane also participates in many Health Screening Programs run by the Aboriginal Health team and by the community health team in which she works. She found it improved her profile with the Aboriginal community and led her to find more clients that need her support to manage their chronic disease.

Jane's future

Jane aspires to do two things; to continue to develop her skills so that she may be able to provide cultural and clinical supervision to new Aboriginal Health Practitioners in her team; and to support and encourage other Aboriginal Health Models to be developed in high need areas like renal dialysis for Aboriginal People.

Nb. This story is a compilation of the stories of several Aboriginal People, all names and places have been changed. The purpose of the story is to describe a desired future state.

4. Consultation Overview

This project aimed to improve the health and wellbeing of Aboriginal people in NSW through the better utilisation of Aboriginal Health Practitioners (AHP) within NSW Health hospitals and health services. By understanding the barriers to improved AHP utilisation; strategies, models of care and support can be developed to overcome those barriers. The availability of AHP within a health service is then expected to improve access and/or utilisation of that service by the Aboriginal community. This project is part of a broader program of work undertaken by the Aboriginal Health Workforce Unit in the development of the NSW Health AHP Clinical Framework.

Initial consultation was undertaken on the 11th July 2019, at the Annual 'Stepping Up' Forum sponsored by the NSW Health Workforce Planning and Talent Development Branch.

The objective of the workshop was to;

1. Gain access to a large group of Aboriginal and non-Aboriginal health workers who would be confident in providing an opinion on-
    a. Why AHP positions are not being taken up at a higher rate in NSW Health?; and
    b. What are the barriers to establishing AHP positions?
2. What can you, your health service, or the workforce branch do to increase the number of Aboriginal Health Practitioners?

As there was a very active and lively discussion on the barriers, the question two discussion was incomplete and was held over to the consultation with individual managers, workers and practitioners. Subsequently, individual consultations were offered to the Managers of the Aboriginal Workforce and Aboriginal Health. These offers were made through correspondence from the NSW Health Director of Workforce, and it was noted that this work was a part of the ongoing work of the Aboriginal Workforce Unit, Workforce Planning & Talent Development branch, to promote Aboriginal Health Practitioners.

The goals of the consultation were:

- Raising the profile of the AHP workforce
- Identifying the actions and behaviours that lead to an AHP workforce that is empowered to achieve organisational goals
- Supporting LHDs and Specialty Networks to develop models of care and position descriptions that are appropriate to utilise this workforce
- Identify strategies for improving the utilisation of AHP within key areas of the health service.

5. Scope

The scope of the consultation was twofold:

- to identify what barriers exist to the employment of AHP from the perspective of AHP staff as well as managers of diverse health services, and
- to use the findings from the consultations along with best practice and published literature to document Models of Care for AHP along with supporting documentation and position descriptions.

6. Limitations

While we were quite successful in identifying key themes that were broadly agreed upon as barriers and what response was most likely to increase the numbers of AHPs, there were limited documents available for models and position descriptions.

As noted by Hill[1] et al. in 2018, there are still very few people who have completed training and registration, only 11 AHP at the time of publication had registered in Queensland. Therefore Queensland is still in the early stages of understanding the contribution that Aboriginal and Torres Strait Islander health practitioners make in improving the health of their communities. Hill[2] et al. identifies five areas that require further understanding:

- the importance of conducting a comprehensive student selection process,
- the benefits of working collaboratively between the university and vocational education training sectors,
- the need to continue to strengthen partnerships between higher education and health industry,
- the need for flexible funding and training models that enable adequate learning support, and
- the identification of a significant unmet training need.

A significant observation is that NSW appears to be in a similar situation to Queensland, as we are still in early days of recognising and promoting the contribution that the Aboriginal Health Practitioner role can make to improving health. Thus this report identifies the many barriers which exist when building a new clinical position into a capable, and safe clinical workforce.

7. Consultation Findings

7.1 Establishing a new clinical role

It was striking that the Aboriginal health workforce interviewed were so open in disclosing that they were conducting clinical assessment and monitoring, and have done so for many years. It

[1] Hill KL, Harvey N, Felton-Busch CM, Hoskins J, Rasalam R, Malouf P, Knight S. The road to registration: Aboriginal and Torres Strait Islander health practitioner training in north Queensland. Rural and Remote Health 2018; 18: 3899. https://doi.org/10.22605/RRH3899

[2] ibid

is important to note that the work undertaken clinically is not in scope of those working as AHWs, however many have been trained over the years by clinicians. It struck me, the interviewer with a clinical background, that this workforce has innovated and adapted to meet the needs of their community with clinician support. They, however, have not been in a position to be supported thought the ongoing clinical supervision, credentialing and having the appropriate referral pathways routinely established within the ways in which they work.

7.1.1 Clinical safety for practitioner and patient

It can be observed that those in the Aboriginal health workforce are practising clinically without the supports of day to day supervision as is afforded to Nurses and Doctors working in clinical teams, and without the established clinical support networks that Allied Health professions have established for clinical supervision over many years. Moreover, they take on a personal risk by practicing without qualification or clinical supervision if there happens to be an adverse incident with a patient under their care. The action of establishing clinical supervision expectation would contribute to the development of trust in the safety and competency of this new clinical workforce with the broader clinical community.

7.1.2 Understanding and acceptance of clinical supervision

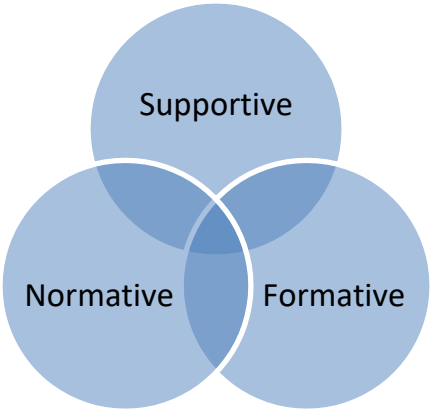
There is a limited understanding of clinical supervision in the Aboriginal health workforce, where it was understood, it is perceived to be constant observation or to be “having someone looking over your shoulder all of the time.”

7.1.3 What should clinical supervision look like

Clinical supervision is a well-established method among most healthcare professions. Some benefits have been reported as “development of clinical skills to support the quality and safety of patient interventions, professional accountability, and competence.”[3] Medicine and Nursing have clear hierarchical structures with supervision (within a hospital setting) provided through seniority for junior staff. Allied Health staff, however, due to the disparate model of care they provide, have needed to develop an alternative model more appropriate to their working arrangements. Aboriginal Health Workers have a similar working arrangement in which they may not be working closely with other AHW, making supervision difficult.

[3] Dawson, M., Phillips, B. & Legget, S. (2013) ‘Clinical Supervision for Allied Health’, *Journal of Allied Health, vol 42, no 2, pg 65-73,* pg 65.

There is not an agreed definition of clinical supervision. However, Fitzpatrick in a 2012 systematic review defined clinical supervision within an Allied Health context as; "*Supervision is any activity where more experienced health professionals provide less experienced health professionals with opportunities that enable these health professionals to achieve learning, to receive support, and to improve the quality and safety of their practice"*[4]. This definition highlights three separate but interrelated elements of supervision; learning, support and practice improvement. These three elements were present in much of the research, with different studies focusing on one element more heavily than the others. These elements fit into Proctor's Model for Clinical Supervision (1988), which was the most commonly used model in the literature. Proctor identified three components of effective clinical governance which could be applied to any professional group within a healthcare setting:



- **Supportive:** focuses on the individual's experience such as stress, workplace issues and burn out.
- **Formative:** focuses on skills, clinical interventions, best practice, upskilling and training.
- **Normative:** focuses on policy, codes of practice, ethics and confidentiality[5].

The benefit of Proctor's model is that it is applicability to various professional groups as it is flexible and broad enough to reflect the different work practices and arrangements. This is also a limitation as it is a theoretical model and does not provide guidance in how to do clinical supervision well, only that it should include the three elements from the model[6].
From a 2013 systematic review of clinical governance for Allied Health professionals, the authors found there was little evidence to demonstrate a superior method for providing clinical supervision. Supervision can be 1:1 or in a group setting; it can occur fortnightly or monthly for any duration, and it was demonstrated to be as equally valid. The authors also found inconsistent results with staff training and the use of a model or guide for clinical supervision.

[4] Fitzpatrick, S., Smith, M. & Wilding, C. (2012) 'Quality allied health clinical supervision policy in Australia: a literature review', *Australian Health Review, vol 36, pg 461-465,*pg 462.
[5] Snowdon, D., Millard, G. & Taylor, N (2015) 'Effectiveness of clinical supervision of Allied Health Professionals, *Journal of Allied Health vol 45, no 2, pg 113-121*
[6] ibid

The authors concluded that the provision of a framework for both Supervisors and Supervisees would be beneficial[7].

Under the *Aboriginal Health Worker Guidelines for NSW Health (2018)* Clinical supervision can be provided by:

- Registered Nurse/Midwife
- Allied Health Professional
- Oral Health Professional
- Doctor
- Senior Aboriginal Health Worker.

The Guidelines also provide several components of effective clinical supervision specifically for the supervision of Aboriginal Health Workers, which relates to the process of supervising rather than what supervision may include. The components are:

- "understanding the roles and responsibilities of Aboriginal Health Workers
- understanding the clinical units of competence of the Aboriginal Primary Health Care qualification
- setting clear expectations of the supervisory relationship
- using supervision contracts
- maintaining supervision documentation
- evaluating the effectiveness of supervision
- setting learning goals
- facilitating reflective practice
- providing a culturally safe and respectful work environment."[8]

Clinical supervision has clear requirements and expectations of both the Supervisor and the Supervisee which need to be met.

Suggested Response: Seek the assistance of Nursing and Allied Health Workforce Directors to develop a model of clinical supervision that will suit Aboriginal Health Practitioners work style patterns and demands.

[7] Dawson, M., Phillips, B. & Legget, S. (2013) 'Clinical Supervision for Allied Health', *Journal of Allied Health, vol 42, no 2, pg 65-73,* pg 65.

[8] NSW Ministry of Health (2018) 'Aboriginal Health Worker Guidelines for NSW Health, https://www.health.nsw.gov.au/workforce/aboriginal/Pages/aboriginal-health-worker-guidelines.aspx, pg 28

7.1.4 Cultural Supervision

At the initiation workshop, the Aboriginal people readily identified the importance of using Aboriginal knowledge and having Aboriginal Supervision. On consultation, this was taken to mean having a supervisor that is not necessarily your manager, but a person with a shared life experience that can support an Aboriginal staff member when they have community and family demands, or workplace demands that they need support to manage. Alternatively, as expressed by one interviewee; "*Helping the Aboriginal person walk in the two different worlds*."

7.1.5 Community demand

Through the consultations Aboriginal staff spoke of how Aboriginal communities are placing high demands on their Aboriginal health workforce, it was identified that there was some reluctance to take on new clinical skills as this may place higher community demand and pressure on them. Aboriginal health workforce also identified that there is a need for cultural supervision to support workers in these situations, and often the cultural supervision is inadequate or absent.

7.1.6 How would Cultural Supervision fit with Clinical Supervision

Much of the research studying cultural supervision for Aboriginal people working in health has focused on Social Workers, Counsellors and those working in mental health services. The most common challenge identified in these studies is the challenge Aboriginal staff have "balancing their workplace and community obligations when, for most, their clients and workplaces are in their home community"[9]. In this study on Aboriginal and Torres Strait Islander mental health practitioners, participants referred to 'the blur', describing the "struggle with the unavoidable tension between the often-conflicting obligations of the community and the profession"[10]). 'The blur' has been described as a challenge unique to Aboriginal health practitioners in which current clinical supervisor models do not accommodate.

The few studies which have examined the role of cultural supervision all acknowledged the vital role supervision plays in staff retention and professional development[11]. The studies also found that knowledge of the community and an understanding of the challenges facing Aboriginal Health Workers in their dual roles as community members and staff members were vital for

[9] Jeffrey R. Nelson, James Bennett-Levy, Shawn Wilson, Kelleigh Ryan, Darlene Rotumah, Wayne Budden, Dean Beale & Janelle Stirling (2015) 'Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models', *International Journal of Mental Health, 44:1-2, 33-45,* pg 34.
[10] ibid*,* pg 36.
[11] Scerra, N. (2012) 'Models of supervision: Providing effective support to Aboriginal staff' *Australian Aboriginal Studies, 2012/1*

effective supervision[12]. A number of supervision models were explored which were explicitly designed to support Aboriginal people working in a variety of health roles currently in operation in Australia and New Zealand.

The two most commonly discussed models were:

Dual supervision: This refers to an Aboriginal worker having two Supervisors providing different forms of support. In Nelson, et al. 2015 study of Aboriginal mental health practitioners, participants preferred this model as it enabled participants to "facilitate more objective appraisals of client concerns, to strategise and plan with clinical and cultural assistance and address matters of personal wellbeing in a safe and supportive environment"[13]. The dual model allows a Cultural Supervisor to support the Supervisee with issues more specific to working with the Aboriginal community, such as boundary violations, confidentiality, families as clients and expectations to work beyond their scope of practice[14]. It then enables the Clinical Supervisor to provide support aligned with Proctor's model of supervision; professional development, skills and competency assessments, workplace issues and codes of practice and policy compliance. There is overlap between the scope of supervision to be provided by a clinical supervisor and a cultural supervisor, particularly pertaining to matters of confidentiality and workplace issues. Having clear roles and responsibilities for the supervisors which are agreed and understood by all parties may ensure the supervisee understands whom to speak to for specific issues they experience. However, in Scerra's 2012 literature review of supervision for Aboriginal staff, they found that it is crucial that cultural supervision is not seen as an 'add-on' and "should be considered as an integral part of the clinical supervision received"[15]

Peer reciprocal supervision: This refers to peer supervision in which "supervision occurs among colleagues in similar roles"[16]. This model moves away from traditional top-down, hierarchical supervision; instead, supervision is a shared dialogue in which the roles change between participants. This was found to be a useful model within a rural context in which Aboriginal staff working across different professional areas can come together, share experiences and connect professionally. The use of storytelling and narratives was also discussed which may work effectively within a peer supervision model.

Peer supervision could be used in a dual supervision model, in which clinical supervision is provided, and cultural supervision occurs with peers. In particular workplaces, a peer supervision approach may be more effective, such as a rural setting in which peer supervision may also operate as a Community of Practice for a range of different Aboriginal roles.

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[12] Jeffrey R. Nelson, James Bennett-Levy, Shawn Wilson, Kelleigh Ryan, Darlene Rotumah, Wayne Budden, Dean Beale & Janelle Stirling (2015) 'Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models', *International Journal of Mental Health, 44:1-2, 33-45*

[13] ibid, pg 41.

[14] ibid

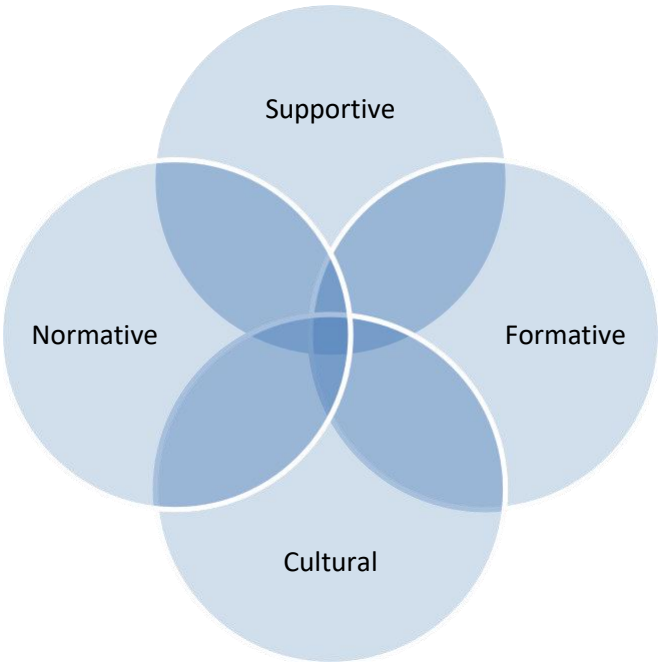
[15] Scerra, N. (2012) 'Models of supervision: Providing effective support to Aboriginal staff' *Australian Aboriginal Studies, 2012/1,* pg 83.

[16] ibid, pg 80.

7.2 Supervision requirements for Aboriginal Health Workers

There is a range of requirements for the supervision of Aboriginal Health Workers which cross four realms; supportive, normative, formative and cultural. The Supervisor supporting the AHP across these areas may vary depending on the organisation and the Supervisee.

Training for Supervisors and Supervisee on individual roles and responsibilities and scope of supervision will need to occur. Participants can then agree locally on what each supervisor is responsible for, what support is provided and the method and frequency of that support.



Critical features of supervision for AHPs:

Supportive: personal support and understanding[17], managing workplace issues, workload and burnout[18].

Formative: clinical competency, skills and training[19], professional support and development[20]

Normative: policy, codes of practice[21], ethics, confidentiality, relationship management

Cultural: Community understanding, managing 'the blur'[22].

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[17] Jeffrey R. Nelson, James Bennett-Levy, Shawn Wilson, Kelleigh Ryan, Darlene Rotumah, Wayne Budden, Dean Beale & Janelle Stirling (2015) 'Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models', *International Journal of Mental Health, 44:1-2, 33-45*

[18] Snowdon, D., Millard, G. & Taylor, N (2015) 'Effectiveness of clinical supervision of Allied Health Professionals, *Journal of Allied Health vol 45, no 2, pg 113-121*

[19] ibid

[20] Jeffrey R. Nelson, James Bennett-Levy, Shawn Wilson, Kelleigh Ryan, Darlene Rotumah, Wayne Budden, Dean Beale & Janelle Stirling (2015) 'Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models', *International Journal of Mental Health, 44:1-2, 33-45*

[21] Snowdon, D., Millard, G. & Taylor, N (2015) 'Effectiveness of clinical supervision of Allied Health Professionals, *Journal of Allied Health vol 45, no 2, pg 113-121*

[22] Jeffrey R. Nelson, James Bennett-Levy, Shawn Wilson, Kelleigh Ryan, Darlene Rotumah, Wayne Budden, Dean Beale & Janelle Stirling (2015) 'Aboriginal and Torres Strait Islander Mental Health Practitioners Propose Alternative Clinical Supervision Models', *International Journal of Mental Health, 44:1-2, 33-45*

All four areas of supervision overlap and interrelate and need to occur simultaneously. The role of a cultural supervisor may provide support across all four areas, but particularly the 'supportive' and 'cultural' realms. What is essential however is that there is a "clear, understandable structure"[23] which is understood by the Supervisors and the Supervisee, with roles and responsibilities clearly delineated.

Based on the literature, the supervision of AHP should be:

- **Flexible**; to accommodate the various work arrangements of AHPs
- **Informed**; training for both the Supervisors and Supervisee needs to occur to outline the expectations of both parties
- **Planned**; An agreed supervision arrangement should be made between the supervisors and supervisee which determines the mode of supervision, frequency and style to be adopted
- **Open**; in which the AHP feels they are able to discuss matters with their Supervisor honestly
- **Responsive**; the roles and responsibilities of AHP differ to that of other health professionals that the Supervisor may also be supervising, it is important they tailor their support and guidance to the reflect the needs and competencies of AHPs.

Suggested Action: Consider the development of an additional component of the clinical supervision guide and agreement that will assist Aboriginal Supervisors to support isolated Aboriginal health practitioners.

7.3 Aboriginal Health Workforce Planning and Assessment

When discussing Aboriginal health workforce planning, it was evident that the focus has been on increasing the number of Aboriginal people in the health workforce. While this is important, analysis has been absent and assessing what tasks and activities the Aboriginal workforce currently do. This information is needed to understand what categories and skills are needed and how the Aboriginal workforce should be located across the LHD.

To ensure there is appropriately future-focused workforce plan for the Aboriginal health workforce there will need to be a more strategic workforce planning exercise conducted by Aboriginal workforce leaders, and It should include the critical elements of a strategic workforce plan as identified by the Mercer group (2009)[24]:

[23] ibid, pg 39

[24] Mercer (2009), Implementing Strategic Workforce Planning in Asia, The right people in the right places: Reducing business risk through effectiec workforce planning. Retrieved from

- Integrate business and budget planning
- Dialogue with senior executives
    - Business Strategy
    - Workforce strategy
- Output “directional” numbers
- Longer planning period: two to five years
- Multiple scenarios considered
- Action plans to close the gap between the current and desired state

The Aboriginal staff that we consulted with noted that there was a lack of clarity as to whether it was the Aboriginal health managers or other health service managers that were accountable for both advocating for the development of AHP roles and also assessing and planning for where AHP roles should be established.

It was noted that where the AHP roles have been established in both Western NSW and Hunter New England Local Health Districts (LHD) both had undertaken engagement with their AHWs and conducted an assessment[25] of their current scope of activities. The LHDs then assessed the staff against their locally designed Framework[26] for role delineation of practice to determine whether they were acting as primary healthcare workers or whether they were acting as health practitioners. Those who met the AHP requirements were then encouraged to undertake the practitioners Cert. VI Practice course. An excerpt can be seen in the Appendices of this document.

There is a clear need for planning that includes assessment of where the workforce is undertaking clinical tasks and define which task should be primary care focused and where there is a need for a clinical role. The assessment should include:

- Assessing the scope of current practice
- Defining the need for primary care and need for clinical care
- There is a need to establish a detailed description of the process of the transition pathway for AHWs to AHPs
- Need for a pool of position descriptions that relate to the models of care provided

Suggested Action:

1. Aboriginal Workforce Planning guide
2. Role descriptions, including
    - Model clinical supervision & agreement
    - Model cultural supervision & agreement

https://www.mercer.com › dam › mercer › attachments › workforce-sciences

[25] Hunter New England Local Health District (2016) Aboriginal health Worker Assessment Tool.

[26] Hunter New England Local Health District (2017) Aboriginal Health Workers and Aboriginal Health PractitionersFramework v2.

3. A recruitment process model that allows for transitioning workers

7.4 Responses to role changes

7.4.1 Scepticism of Aboriginal Health Workforce

Many Aboriginal people inform me that there have been many initiatives and projects in the past where the AHW has been asked to participate and be the conduit to accessing Aboriginal people in Aboriginal communities. There is a view from many that this is just another initiative to help them engage and does not truly empower the Aboriginal worker to lead the provision of healthcare.

Though some people who had the view that the Aboriginal health workforce is still not valued as a provider of health for Aboriginal people, there is still some mistrust of mainstream healthcare to truly establish active positions and models of care in partnership with Aboriginal knowledge and Aboriginal workers.

7.4.2 Position availability

Aboriginal health workforce identified a catch 22 situation where current AHWs were reluctant to train for an AHP roles and also aspiring AHPs were also reluctant to train for the roles as no positions were being advertised and therefore there was considerable uncertainty about whether they were able to find work and therefore, of course, support their families.

7.4.3 Strengths and limitations of the role

Throughout the consultation, I inquired about whether the AHP position was a valuable position that Aboriginal staff would like to take on. There were mixed views on this, and they fell into two different groups shown below;

Limitations of the Aboriginal Practitioner position

The first group noted that for an AHP, there was no currently existing pathway for that clinical role. They viewed it as a role that was limiting to Aboriginal people. Some Aboriginal people interviewed believe that this could be viewed as racism.

Strengths of the Aboriginal Heath Practitioner

The second group were passionate about an Aboriginal titled position. They believed a role which included the word Aboriginal was something they would be proud to have, and proud to be able to use as it signifies someone committed to caring for and treating Aboriginal people clinically.

7.4.4 Recognition of Prior Learning

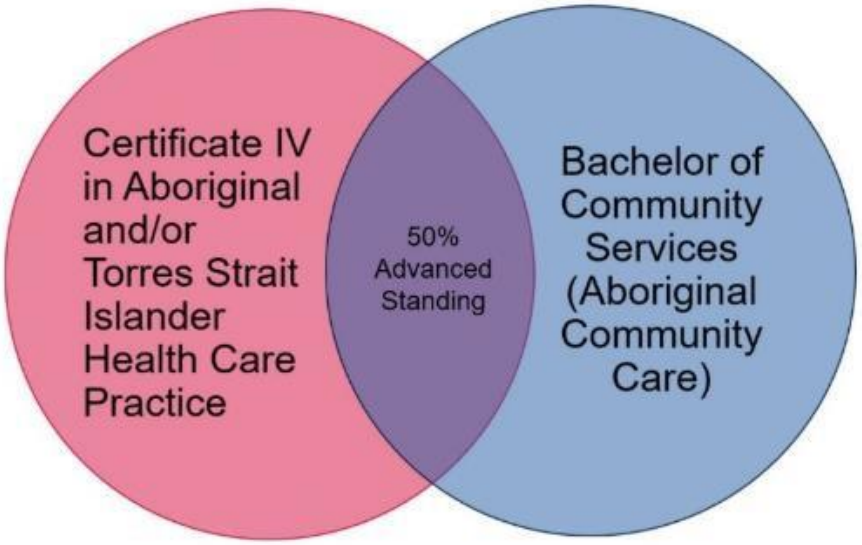
Of those who wanted to have career opportunities that may evolve from the AHP, they identified that there was currently no University level Recognition of Prior Learning in a clinical field (RPL). Aboriginal health workforce would like to have a university pathway that is accessible in regional locations and is accessible to Aboriginal people with minimal time away from country.
It was also noted that recognition for prior learning should also be acknowledged by university degree providers for the clinical hours that an individual may have done including those done in the Defence Force.
The Associate Dean of University of New England (UNE) and Lead in Nursing at the School of Health who had done mapping of studies for the recognition of prior learning for Bachelor Degree in Community Services and Primary Health Care. Advised, there could not be equal credit and recognition of prior learning for Nursing and allied health degrees, and in her view, as the Cert IV practice does not have as much foundational science as is required in first year of nursing and allied health degrees, the credit would be minimal and that Aboriginal people considering nursing would be better consider Enrolled Nursing.

Suggested Action: Engage the appropriate University that operates regional clinical schools to establish RPL for 1) people who have completed the Certificate IV and 2) people who have clinical practice experience

Through consultation with the NSW Department of Education it was discovered that that UNE has been working with the Department of Education to develop an Aboriginal Primary Health Care Pathway; a tailored and supported pathway for Aboriginal students with certificate III or IV qualifications into a Bachelor Degree in Community Services and Primary Health Care.[27]
There needs to be recognition of prior learning for Aboriginal Health Workers and Aboriginal Health Practitioners to a) Create more education/career options for people with a Certificate IV in ATSI Health Care Practice and b) address the shortage of AHPs and Aboriginal people in management roles.
UNE's pilot aimed to create further education and career options for people who have completed a Certificate IV in Aboriginal and/or Torres Strait Islander Health Care Practice.

[27]The NSW tertiary pathways project: lessons to date Report 2018, Higher Education, External Affairs and Regulation, https://education.nsw.gov.au/public-schools/tertiary-pathways/media/documents/Tertiary-Pathways-Lessons-Learnt-20190129.finalA.pdf

There is a current and predicted future shortage of AHPs and Aboriginal and Torres Strait Islander people in management roles in health and community services.
UNE has delivered a unique articulation pathway for holders of the Certificate IV in Aboriginal and/or Torres Strait Islander Health Care Practice. Students with either of the Certificate IV qualifications will be able to apply for and receive 50% advanced standing into the Bachelor of Community Services (Aboriginal Community Care) at UNE. This means that students can complete their Bachelor degree in 18 months of full-time study or three years part-time. The project has developed a comprehensive methodology for mapping the VET qualification to the university degree.
To support the transition from vocational to higher education, students undertaking the degree will be supported by UNE's Oorala Aboriginal Centre.
The Curriculum Committee at UNE approved the articulation pathway in April 2019[28]



UNE's Aboriginal Healthcare tertiary pathway model.

UNE is in the process of developing a marketing and communications strategy to promote the articulation pathway, intending to recruit students for Trimester 3 (November) 2019. Should UNE fail to recruit enough students, the intake will occur in Trimester 1 2020.

7.5 Medication Administration

It was raised by Aboriginal staff who had completed the Certificate IV Practice, that they were completing a unit of study in medication administration, which they were not able to put into

[28] NSW Tertiary Pathways Project 2019, https://education.nsw.gov.au/public-schools/tertiary-pathways/lessons-learnt-paper/addendum#University3

practice post-registration in NSW. In the Western Australia health system in the regulation of Poisons and Medications 2016[29]; *Medicines and Poisons Authorisation of health professionals, Part, 7 Authorisation of Aboriginal and Torres Strait Islander health professionals;* allows for Aboriginal Health Practitioners to possess and administer prescribed schedule 2, 3 and 4 medications.

Suggested Action: Seek further advice on process and issues with changes to the NSW Poisons and Therapeutic Goods Regulation 2008[30], under Appendix C 'Persons authorised to possess and use substances', to allow for Trained and Registered Aboriginal Health Practitioners to be included as a Health Professional under the Poisons Act

7.6 Models of Care

There are three current models of Aboriginal Health Practice emerging, and there are others in the pipeline.

The research completed up until this phase of the project will inform the development of Models of Care (MoC) to support AHP's working within the five target service areas; Emergency Department, renal, Drug & Alcohol, diabetes services and paediatrics. The MoC should be evidence-based using current best practice and literature from other comparable services within NSW Health as well as from other jurisdictions. The themes from the consultations should also inform the MoC to address the identified barriers and challenges to AHP recruitment.

Roles emerging

1. Chronic disease management
2. Maternal and Infant Health
3. Allied health (podiatry and other roles)

Roles being planned (rural and regional)

4. Ambulatory and Urgent care
5. Satellite assessment and referral clinic

Roles being talked about

6. Renal dialysis
7. Women's Health
8. Drug and Alcohol

[29] WA Medicine and Poisons Regulation 2016
https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_29809.pdf/$FILE/Medicines%20and%20Poisons%20Regulations%202016%20-%20%5B00-a0-02%5D.pdf?OpenElement

[30] NSW Poisons and Therapeutic Goods Regulation 2008
https://www.legislation.nsw.gov.au/#/view/regulation/2008/392/appc

9. Domestic Violence Worker
10. Diabetes Education
11. Palliative care
12. Audiometry

7.6.1 Waiting for models to be developed

There are many people consulted who were well aware of the role of the AHP and had attended the roadshows in 2017 where the positions were introduced. However many people were still waiting for more information on how the positions would work within existing models or how positions would work in new models of care for Aboriginal people.

The process for developing a model of care[31] is well defined by the NSW Health Agency for Clinical Innovation (ACI) and should be used when developing an AHP Model of Care. The most significant elements to reinforce in that there is a process for the identification of the problem and the need to design the solution with the Aboriginal health workforce and the community leading the process.

The ACI has recently been involved in the Healthy Deadly Feet Project being led by the NSW Ministry of Health. This is an excellent example of how MoH and ACI worked together to address an identified problem assist in identifying how the AHP role could work positively for podiatry.

Suggested Action: Seek the continued support of the Agency for Clinical Innovation for a targeted Aboriginal Health Practitioners model of care redesign school that will develop priority models

Key elements of the model that need to be included in an Aboriginal Health Practitioner Model of Care are suggested to be:

1. Service objective and the health problem being addressed
2. Referral sources
3. Community and self-referral clinical considerations
4. Clinical supervision
    i. Competency assessments
    ii. Reflective practice requirements
5. Assessments and forms and related escalation pathways

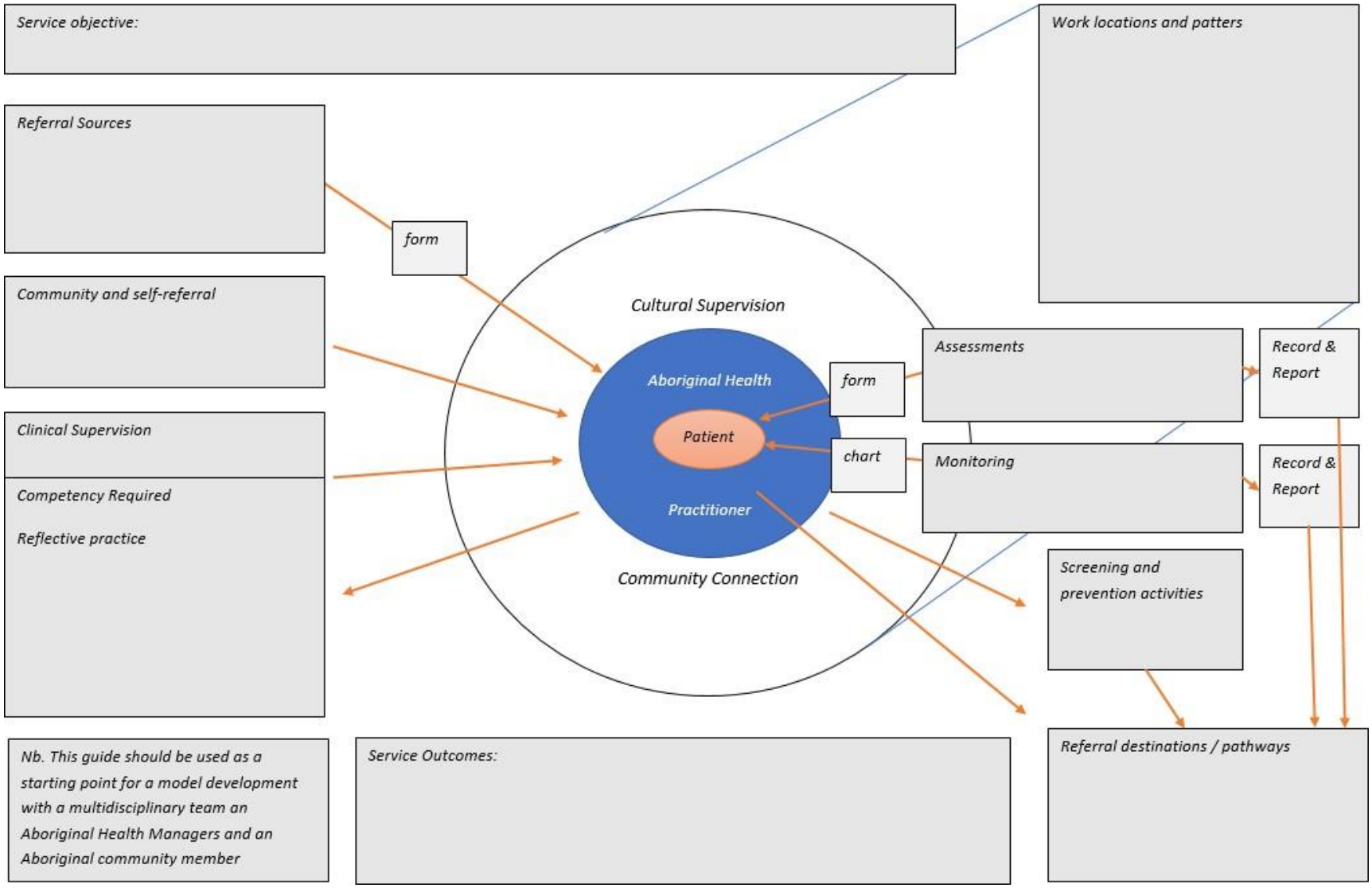
[31] Agency for Clinical Innovation, (2013) *Understanding the process to develop a Model of Care An ACI Framework,* https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

6. Monitoring/ observation and charts and related escalation pathways
7. Community connections and supports
8. Patient records management
9. Work patterns and locations
10. Screening and prevention activities
11. Common on-referral pathways and destinations
12. Service outcomes expected and workload management

The graphic on the following pages suggests a map to help visualize how a model of care for an Aboriginal Health Practitioner may work. The map is not comprehensive and is for illustrative purposes only.

7.6.2 Model of Care Map

Aboriginal Health Practitioner - Model of Care - Development Map



7.7 Award and Payment

7.7.1 Rate of Pay

Many people interviewed believe that because the rate of pay is no more significant than the rate that is paid to an AHW that there is no incentive to change into those roles.
There was an argument that there was a greater responsibility for patient's wellbeing when conducting assessments and clinical observations and also, there would likely be a higher demand on AHPs from their local communities for clinical care. Therefore, this responsibility should be rewarded.
When you consider the first part of the argument that there is greater clinical responsibility, this argument is difficult to support when you consider that an Enrolled Nurse has an almost equal clinical responsibility, but when you consider the known preference for Aboriginal people to be treated and cared for by 'their mob', we must consider this additional demand on the positions.

Suggested Action: Consider making an application at the next NSW Health Service Aboriginal Health Workers' (State) Award and Public Hospitals (Professional & Associated Staff) Conditions of Employment (State) Award, review for allowances for AHPs working in isolation and regional communities.

7.7.2 Additional Cost of Professional Registration

Aboriginal Health Practitioners were aware of the additional cost of annual registration and the cost of mandatory continuous professional development required to maintain AHPRA Registration.

Suggested Action: Consider making an application at the next NSW Health Service Aboriginal Health Workers' (State) Award and Public Hospitals (Professional & Associated Staff) Conditions of Employment (State) Award, review for the addition of allowances for registration continuous professional development expenses.

7.7.3 Shift work

Workers noted that they were limited by the award conditions to work in a clinical environment and be able to obtain out of hours shift penalties should they be in an environment where an AHP was able to work in a team such as a hospital or Multi-Purpose Service.

Suggested Action: Consider making an application at the next NSW Health Service Aboriginal Health Workers' (State) Award and Public Hospitals (Professional & Associated Staff) Conditions of Employment (State) Award, review for the addition of a provision to work shift work with associated penalty rates.

7.8 Access to training hours

LHDs that have supported AHWs to make the transition have been able to support the AHPs with clinical training hours and access to CPD hours. However, an unsupported individual wishing to complete the clinical hours required to register may find it hard to complete the unpaid clinical training hours without incurring a high cost to themselves and their families. AHWs undertaking the Certificate IV in Clinical Practice noted that it was limiting not being able to access funding to release them from their current role to participate in the hours required for clinical training. In consultation, it was noted, however that some of the hours might be able to be conducted in a current workplace.

Besides the handful of AHWs who were able to be released from work, most found it challenging to access placements to obtain the necessary hours of clinical experience. They suggested that they also are given access to clinical placements the same way that training nurses use ClinConnect to access placement hours.

Suggested Action: NSW Health consider funding for work release hours for Aboriginal Health Workers currently employed to undertake clinical training hours where they have an identified AHP role on completion.

Suggested Action: Explore the ability of Aboriginal Health Workers employed by NSW Health to access clinical placement through ClinConnect.

7.9 Registration

Training is being conducted in high numbers in Western NSW and Port Macquarie at a rate of approximately 40 people annually.

7.9.1 Numbers of AHPs being trained

Many people noted that the Certificate VI training courses for the AHPs were not always eligible when completed because the mandatory requirements of the Aboriginal and Torres Strait Islander Health Practice Board of Australia registration were not being met. This appears to have been resolved now with Compliant provider's listed on the Aboriginal and Torres Strait Islander Health Practice Board of Australia website.

7.9.2 Delays in Registration

While there are only still small numbers of practitioners progressing to registration at the moment, people who had completed their training and their clinical hours were experiencing delays of one to three months in registration completion with AHPRA. It was unclear to them or anyone in consultation why this was taking so long. Phone calls to AHPRA resulted in merely an explanation that if they had not heard anything then everything was fine.
This delay may discourage people from completing their registration and being available as Aboriginal Health Practitioners.

Suggested Action: seek the support of Aboriginal and Torres Strait Islander Health Practice Board to map the process of registration and identify the delays in registration and determine what can be improved.

It was recommended through the consultations that there be support provided at TAFE to guide the AHP through the process that they would need to undertake to obtain Aboriginal and Torres Strait Islander Health Practice Board registration.

Suggested Action: seek the support of TAFE providers of the Certificate VI to add information that will assist Aboriginal Health Practitioners to register on completion

8. References

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9. Appendix A: Reference Group

Name and position
Richard Griffiths (Chair) Executive Director WP&TD
Charles Davison Manager AWU, WP&TD, MoH
Wendy Bryan-Clothier Senior Project Officer AWU, WP&TD, MoH
Jade Gow Assistant Project Officer AWU, WP&TD, MoH
Megan Campbell Medical Advisor CAH, MoH
Gay Foster Principal Advisor, CAH, MoH
Elizabeth Best Manager Aboriginal Maternal Child & Family Health MoH
David Follent Senior Project Officer, Aboriginal Chronic Care, ACI
Julie Smith Manager Diversity, HNELHD
Kim Nguyen Executive Director Workforce & Allied Health, HNELHD
Clare Daley Allied Health Manager, District Service, HNELHD
Jill Humphreys Executive Officer, ATSIHPBA
Sandra Duff Executive Director, Workforce & Culture, WNSWLHD
Carolyn Murray NSW STI Programs Unit, SESLHD
Sally Laugesen HR Director, SCHN
Brian Shimadry Director Workforce Planning & Performance, WP&TD, MoH
Julia Meredith Aboriginal Health College
Paul Preobrajensky PMP Health
Donna Cruickshank Director Aboriginal Health and Planning, FWLHD
Matthew Trindall Director Aboriginal Strategy & Culture, J&FMHN
Jacqueline Ballard Principal Advisor, NaMO, MoH (Proxy)
Elise McCarthy-McPhann Aboriginal Nursing Cadetship Coordinator, NaMO, MoH
Leona McGrath Aboriginal Nursing Cadetship Coordinator, NaMO, MoH
Gay Foster Senior Project Officer, AWU

10. Appendix B: Workshop feedback

Aboriginal Health Practitioners – Workshop Findings

Why are Aboriginal Health Practitioner positions not being taken up at a higher rate in NSW Health?

1. Purpose

The purpose of this document is to provide a summary of the findings of the workshop on the barriers and solutions to increasing the numbers of Aboriginal Health Practitioners (AHP) in NSW Health Services.

The feedback on this document will be used to further inform the consultation with Aboriginal managers, health workers and practitioners across NSW. The ongoing consultations will aim to build a framework for supporting the increase in numbers of AHP in NSW Health workforce by identifying solutions that lie within:

- Effective models of care
- Position and role descriptions
- Processes for position establishment
- Models for clinical supervision
- Models of High-Performance work systems.

2. Introduction

The workshop was undertaken on the 11th of July at the annual 'Stepping Up' Forum sponsored by the NSW Health Workforce Planning and Talent Development Branch.

The objective of the workshop was to;

1. Gain access to a large group of Aboriginal and non-Aboriginal health workers who would be confident in providing an opinion on-
    a. Why AHP positions are not being taken up at a higher rate in NSW Health?
    b. What are there barriers to establishing AHP positions?
2. What can you, your health service, or the workforce branch can do to increase the number of Aboriginal Health Practitioners?

As there was a very active and lively discussion on question one of the barriers, question two discussion was incomplete and has been held over to the consultation with individual managers, workers and practitioners.

The barriers listed in this document were not prioritised by the workshop group. The structure of this document is to group the barriers identified in themed areas.

3. Summary of Workshop Findings

Financial Barriers

1. **Lack of payment incentive**

For many Aboriginal Health Workers who are on higher years of service on Aboriginal Health Worker award payment, there is no incentive of an increase in pay for taking on the additional clinical role, in fact, there can be a decrease in pay for a senior Aboriginal health worker.

2. **The additional cost of APHRA registration**

The additional cost of payment of the registration fee acts as a disincentive to registration before the individual actually has successfully attained a position as an Aboriginal Health Practitioner.

3. **Cost of ongoing Professional Development**

The workshop identified that the cost for ongoing professional development was a barrier to taking up registration under AHPRA.

4. **Development budget**

The workshop stated that there had not been any budget to support the development of role definitions or models of care.

5. **Enhancement budget**

The workshop stated that there had not been any budget to support additional Aboriginal Health Practitioner roles in the workforce.

Understanding of Role

6. **NSW Health promotion of the role**

There was a strong view in the room that the NSW Health central agencies including the pillars, has not at this time made adequate investment in ensuring all managers and directors across the system had knowledge of the roles that Aboriginal Health Practitioners could undertake.

7. **NSW Health implementing the role**

There was a strong view in the room that the NSW Health central agencies including the pillars, has not used its existing functions to collaborate with health agencies to build models and care and roles for Aboriginal Health Practitioners.

8. No clearly communicated rationale for the role

There was a strong view in the room that the NSW Health central agency had not provided a clear rationale for why the Aboriginal Health Practitioners were required in the NSW Health clinical workforce.

Aboriginal Knowledge

9. Inadequate usage of Aboriginal knowledge

Where models of care have been developed that include an Aboriginal Health Practitioner, there has not been an appropriate level of Aboriginal knowledge and intellect used in the role and model definition.

10. Recognition of the importance of Aboriginal Health professionals

The workshop identified that there is still a lack of recognition of how significant the roles of Aboriginal Health Workers and Aboriginal Health Practitioners are to provide a connection to the Aboriginal community and improve access to safe and culturally appropriate health care access.

Uncertainty of role

11. Career progression

There was a view that the role is new, and there is no certainty of the long term commitment and ongoing use of these positions.

12. Community pressure

The workshop identified that there might be in some instances reluctance of individuals to take on the Aboriginal Health Practitioner in their local community because they will be expected to practice outside of their scope of clinical practice.

13. Cultural supervision

The workshop identified that there might be in some instances reluctance of individuals to take on the Aboriginal Health Practitioner if they are not assured of access to culturally appropriate supervision.

14. Availability of mentoring

The workshop identified that there might be in some instances reluctance of individuals of mentoring from a practicing Aboriginal Health Practitioner.

Models of Care

15. Design of Roles

The group identified that NSW Health central agencies and pillars had not been actively engaged in assisting the health services in designing the models of care for Aboriginal Health Practitioner roles.

16. Sharing of Models

The group identified that there had not been broad sharing of the models of care that have been implemented and are effective locally and interstate.

Training

17. The perceived value of training differentiation to Aboriginal Health Worker

There was a view presented that as the Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Aboriginal Health Worker) and the Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Aboriginal Health Practitioner) only differ in terms of 2 subjects. One an extension on the health assessment of physical wellbeing and second Administer medications, there is little difference in the roles that each will be undertaking (See medication administration).

18. **Access to Training**

It was agreed that the required travel for training in Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Aboriginal Health Practitioner) was a barrier to entry.

19. Training Providers

It was identified in consultation that there has been are third party trainers in the market that have provided the Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Aboriginal Health Practitioner) but have not provided all units required to register under AHPRA, this has caused a loss of some trust in this training in one area of NSW.

20. Time and space to train

Many Aboriginal health workers would consider training as an Aboriginal Health Practitioners if they were able to afford the time away from work or were able to train with their workplaces support.

21. No provision of transitioning roles

The group identified that there were not any positions advertised that explicitly state that that the organisation will support an Aboriginal Health Worker transitioning to an Aboriginal Health Practitioner role within their organisations.

Legislative barriers

22. Medications Administration

It was pointed out that in NSW under the *Poisons and Therapeutic Goods Act (NSW) (1966[32])* there is no provision for the Aboriginal Health Practitioner to administer medication as they are trained to do in the Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice (Aboriginal Health Practitioner) and as they are able to do so in the other Australian States.

NSW Health Workforce Culture

23. Local Health District buy-in

The workshop identified some Local Health Districts have not been active in recognising where AHP roles can be developed in their local workforce.

24. NSW Nurses

The workshop identified that NSW Health nurses might perceive that the Aboriginal Health Practitioners as competing for positions that are being held by nurses currently.

Conclusion

The workshop was able to identify many areas that may be a barrier to the motivation of a workforce of Aboriginal Health Practitioners. There is a mix of occupational hygiene[33] factors, particularly remuneration and training issues, but there are also motivational factors such as

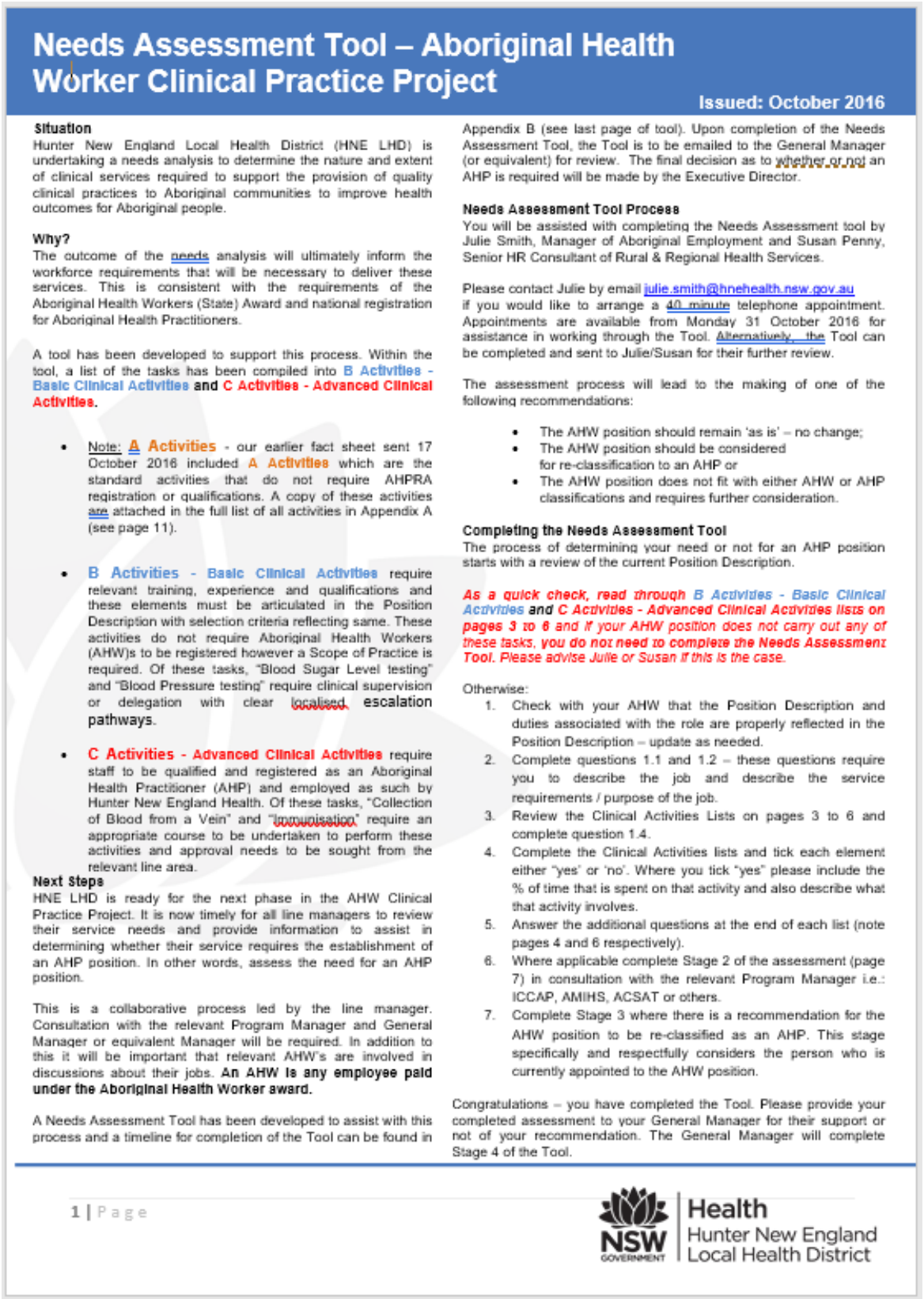
[32] NSW under the *Poisons and Therapeutic Goods Act (NSW) (1966[32])* https://www.legislation.nsw.gov.au/#/view/act/1966/31/full

[33] Herzberg, F., Mausner, B. and Snyderman, B. [1959] The Motivation to Work. New York: Wiley.

dissatisfaction with role limitations, inadequate role development of cultural and community connections, and limitations on autonomy of practice in medication administration.
Continued consultations with the Aboriginal workforce will be required to identify a suitable way forward to build a framework for engaging additional Aboriginal Health Practitioners in NSW Health Services.

11. Appendix C: Needs assessment and planning tool (HNE)

Nb. This is an extract only and should be read with the Hunter New England Local Health District (2016) AHW Assessment Tool. And Hunter New England Local Health District (2017) Aboriginal Health Workers and Aboriginal Health Practitioners Framework v2.



Needs Assessment Tool – Aboriginal Health Worker Clinical Practice Project

Issued: October 2016

Situation
Hunter New England Local Health District (HNE LHD) is undertaking a needs analysis to determine the nature and extent of clinical services required to support the provision of quality clinical practices to Aboriginal communities to improve health outcomes for Aboriginal people.

Why?
The outcome of the needs analysis will ultimately inform the workforce requirements that will be necessary to deliver these services. This is consistent with the requirements of the Aboriginal Health Workers (State) Award and national registration for Aboriginal Health Practitioners.

A tool has been developed to support this process. Within the tool, a list of the tasks has been compiled into **B Activities - Basic Clinical Activities** and **C Activities - Advanced Clinical Activities**.

- Note: **A Activities** - our earlier fact sheet sent 17 October 2016 included **A Activities** which are the standard activities that do not require AHPRA registration or qualifications. A copy of these activities are attached in the full list of all activities in Appendix A (see page 11).

- **B Activities - Basic Clinical Activities** require relevant training, experience and qualifications and these elements must be articulated in the Position Description with selection criteria reflecting same. These activities do not require Aboriginal Health Workers (AHW)s to be registered however a Scope of Practice is required. Of these tasks, "Blood Sugar Level testing" and "Blood Pressure testing" require clinical supervision or delegation with clear localised escalation pathways.

- **C Activities - Advanced Clinical Activities** require staff to be qualified and registered as an Aboriginal Health Practitioner (AHP) and employed as such by Hunter New England Health. Of these tasks, "Collection of Blood from a Vein" and "Immunisation" require an appropriate course to be undertaken to perform these activities and approval needs to be sought from the relevant line area.

Next Steps
HNE LHD is ready for the next phase in the AHW Clinical Practice Project. It is now timely for all line managers to review their service needs and provide information to assist in determining whether their service requires the establishment of an AHP position. In other words, assess the need for an AHP position.

This is a collaborative process led by the line manager. Consultation with the relevant Program Manager and General Manager or equivalent Manager will be required. In addition to this it will be important that relevant AHW's are involved in discussions about their jobs. **An AHW is any employee paid under the Aboriginal Health Worker award.**

A Needs Assessment Tool has been developed to assist with this process and a timeline for completion of the Tool can be found in Appendix B (see last page of tool). Upon completion of the Needs Assessment Tool, the Tool is to be emailed to the General Manager (or equivalent) for review. The final decision as to whether or not an AHP is required will be made by the Executive Director.

Needs Assessment Tool Process
You will be assisted with completing the Needs Assessment tool by Julie Smith, Manager of Aboriginal Employment and Susan Penny, Senior HR Consultant of Rural & Regional Health Services.

Please contact Julie by email julie.smith@hnehealth.nsw.gov.au if you would like to arrange a 40 minute telephone appointment. Appointments are available from Monday 31 October 2016 for assistance in working through the Tool. Alternatively, the Tool can be completed and sent to Julie/Susan for their further review.

The assessment process will lead to the making of one of the following recommendations:

- The AHW position should remain 'as is' – no change;
- The AHW position should be considered for re-classification to an AHP or
- The AHW position does not fit with either AHW or AHP classifications and requires further consideration.

Completing the Needs Assessment Tool
The process of determining your need or not for an AHP position starts with a review of the current Position Description.

As a quick check, read through B Activities - Basic Clinical Activities and C Activities - Advanced Clinical Activities lists on pages 3 to 6 and if your AHW position does not carry out any of these tasks, you do not need to complete the Needs Assessment Tool. Please advise Julie or Susan if this is the case.

Otherwise:

1. Check with your AHW that the Position Description and duties associated with the role are properly reflected in the Position Description – update as needed.
2. Complete questions 1.1 and 1.2 – these questions require you to describe the job and describe the service requirements / purpose of the job.
3. Review the Clinical Activities Lists on pages 3 to 6 and complete question 1.4.
4. Complete the Clinical Activities lists and tick each element either "yes' or 'no'. Where you tick "yes" please include the % of time that is spent on that activity and also describe what that activity involves.
5. Answer the additional questions at the end of each list (note pages 4 and 6 respectively).
6. Where applicable complete Stage 2 of the assessment (page 7) in consultation with the relevant Program Manager i.e.: ICCAP, AMIHS, ACSAT or others.
7. Complete Stage 3 where there is a recommendation for the AHW position to be re-classified as an AHP. This stage specifically and respectfully considers the person who is currently appointed to the AHW position.

Congratulations – you have completed the Tool. Please provide your completed assessment to your General Manager for their support or not of your recommendation. The General Manager will complete Stage 4 of the Tool.

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NSW GOVERNMENT Health
Hunter New England Local Health District

12. Appendix D: Consultations Offered

Nb. Only 50 of 75 individuals accepted the offer of the opportunity to be consulted

Indivduals Offered consultation	Organisation
Charles Davison	MoH
Gay Foster	MoH
Wendy Bryan-Clothier	MoH
Jade Gow	MoH
Brian Shimadry	MoH
Karl Briscoe	NATSIWA
David Follent	ACI
Anna McGowan	MoH
Kevin Omalley	HNE
Louise Maye	HNE
Nathan White	HNE
Peter Reay	HNE
Susan Penny	HNE
Angela Bryant	HNE
Delicity Crocket	HNE
Jessica Clark	HNE
Julie Smith	HNE
Kim Nguyen	HNE
Fred Maher	HNE
Julie Smith	HNE
Tony Martin	HNE
Susan Molick	HNE
Michelle Campbell	HNE
Amy Smith	HNE
Candice	HNE
Sharyn	HNE
Lucy	HNE
Sharyn Tyter	HNE
June Mccauley	HNE
Nicol Connor	HNE
Annette Slater	HNE
Bruce Cohen	HNE
Melissa Harrison	HNE
Louise Morris	HNE
Mandy	HNE
Bruce Cohen	HNE
June Mccauley	HNE
Gwen McKenzie	HNE
Mandy de Roover	HNE
Kenneth Allen	HNE
Louise Maye	HNE
Patricia Blackman	HNE
Pauline Blim	HNE

Carol Anderson	HNE
Tony Martin	HNE
Umer Qureshi	FWLHD
Dale Sutton	FWLHD
Donna Cruikshank	FWLHD
Stephen Ella	CCLHD
Shanell Bacon	CCLHD
Jennifer Smith	NCLHD
Jayde Fuller	AHPRA
Clare Daley	HNE
Lynette Lackay	HNE
Rachel	NBMLHD
Amy Wells	NBMLHD
Sharon Williams	NBMLHD
Bronwyn Culbert	SLHD
George Long	SLHD
Anna McGowan	SLHD
Timothy O'Neill	FWLHD
Barbara Turner	FWLHD
Geraldine Rolton	FWLHD
Dimity Kelly	FWLHD
Britny Coff	FWLHD
Sandra	WNSWLHD
Brendan	WNSWLHD
Helene Jones	MNCLHD
Donna	MNCLHD
Directors Aboriginal Workforce	NSW Health
Sally Laugesen	SCHN
Josh Brown	Dept. Education
John Murn	Dept. Education
Jane Conway	UNE