'Knowledge is power': Aboriginal Healthworkers' perspectives on their practice, education and communities.

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature: Miranda Rose

Date:

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List of Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AH&MRC of NSW	Aboriginal Health & Medical Research Council of NSW
AHCSA	Aboriginal Health Council of South Australia
AHEO	Aboriginal Health Education Officer
AHLO	Aboriginal hospital Liaison Officer
AHMAC	Aboriginal Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIH&W	Australian Institute of Health & Welfare
AIHWJ	Aboriginal and Islander Health Worker Journal
AIN	Assistant in Nursing
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
AQF	Australian Qualifications Framework
ATSIHRTONN	Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network
ATSIHWA	*Aboriginal and Torres Strait Islander Health Worker Association*
ATSIPB	*Aboriginal and Torres Strait Islander* Health Practice Board
ATSIPHC	Aboriginal and Torres Strait Islander Primary Health Care
CS&HISC	Community Services and Health Industry Council
CSU	Charles Sturt University
DEEWR	Department of Education, Employment & Workplace Relations
DoHA	Department of Health and Ageing
ECG	Electrocardiography
EN	Enrolled Nurses
ENTS	Ear Nose and Throat Specialists
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GDIHP	Graduate Diploma in Indigenous Health Promotion
GDIHSU	Graduate Diploma in Indigenous Health-Substance Use

GP	General Practitioner
HREO	Human Rights and Equal Opportunity
HWA	Health Workforce Australia
MIHSU	Master in Indigenous Health-Substance Use
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHC	National Aboriginal Torres Strait Islander Health Council
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NH&MRC	National Health and Medical Research Council
NHMRC	National Health and Medical Research Council
NRHA	National Rural Health Alliance
OH&S	Occupational Health and Safety
OTEN	Open Training Education Network
RFDS	Royal Flying Doctor Service
RPL	Recognition of Prior Learning
RTO	Registered Training Organisations
SCRGSP	Steering Committee for the Review of Government Service Provision
StEPS	Statewide Eyesight Preschool Screening
TAFE	Technical and Further Education
UOW	University of Wollongong
UTS	University of Technology, Sydney
VET	Vocational Education and Training
WHO	World Health Organisation

Abstract

This study explores Aboriginal Healthworkers' workplace roles and practice, their education and training, community experience and their discourse about these topics. Aboriginal Healthworkers fulfil a wide variety of roles in Aboriginal community and mainstream health services. Their scope of practice has expanded and diversified in recent years, and the education programs they undertake have evolved in tandem. Moreover, their community experience is crucial in terms of their contributions to the treatment of health issues in Aboriginal communities.

The study is based on in-depth interviews with nine Healthworkers in NSW, with varied workplace roles, education, and community backgrounds. Analysis, and interpretation follow three steps. Firstly, transcripts from Healthworkers' spoken interviews are recontextualised as biographies, to display the complexity and diversity of their personal and professional lives, and to provide a context for the more analytical aspects of the study. Selected extracts from the original transcripts are then analysed in detail, drawing on discourse analytic methods to identify ways in which each Healthworker presents and evaluates their roles, education, and connections with their familes and communities. Thirdly, patterns emerging in analyses of each Healthworker's presentation and evaluation are compared, discussed and interpreted.

The analyses reveal three general types of Healthworker roles that overlap with three general types of education. Roles are described most generally as clinical, community care, and program management. The study found that Healthworkers who studied at vocational Certificate III or sometimes at the Certificate IV level, tend to list and recount their workplace practice and education; those with multiple qualifications tend to generalise and argue for the contributions of their roles and education; and those with a university degree or a mainstream Certificate IV tend to generalise, reflect, and systematically link their education and work roles. Common amongst all the Healthworkers is an educational pathway that began with vocational study and workplace practice, and a recognition of the value of university qualifications for their profession, which is the ideal goal for all. With regard to family and community, all

Healthworkers were also motivated by their families, and shared experiences with their communities that gave them a unique set of skills and knowledge in their practice, and underpinned their dedication to improving Aboriginal health.

The study contributes useful new knowledge to the field, in the analyses that are applied to the data, and in the findings that emerge from these analyses. In regard to the first stage of the analyses, the recontextulisation of interviews as biographies gives each Healthworker an explicit life story, including their family/community experiences, the phases in their working careers, and the educational pathways they have taken. In the second stage , the detailed analysis of interviews using discourse analytic techniques forms a coherent, objective basis for identifying common patterns between them, and interpreting these patterns. Critically, these analyses draw on the voices of Healthworkers themselves to provide information about the parameters of what it is to be a Healthworker, and the experiences and education that shape it.

Findings reveal the diversity and complexity of Healthworker' practice, that is not recognised in current role definitions or Healthworkers' vocational training; the knowledge, skills and values that Healthworkers bring to their practice from their families and community that requires systematic description; the educational pathways that Healthworkers have forged for themselves; the power that a university education gives Healthworkers, to reflect on and explain their practice; and that Healthworkers' identities as Aboriginal community members remain strong, no matter what their educational achievements.

Chapter 1: Background and rationale

1.0 Introduction

This study is concerned with Aboriginal Healthworkers'[1] perspectives about three domains, that is: i) their workplace roles and practice, ii) their education and training, and iii) their connections to their families and communities. A particular focus of the study is the relation between Healthworkers' education and their discourse about each of these three domains.

This chapter presents a broad outline of the context of the research and research problematic. This is followed by an overview of the research approach including the research questions, research design and participants. The chapter concludes with an outline of the content and purpose of each chapter, followed by a summary of the study's structure.

1.1 Aim of the study

The aim of this study is to analyze Healthworkers' discourse about their experiences of their roles and practice, education and training as well as their family and community connections, to gain a better understanding of their perspectives about these domains and the relations between them.

My interest in this field developed from my own twenty years experience working in Aboriginal health. This experience has been as a non-Aboriginal woman in various health care settings, and in Aboriginal Healthworker education in the community, vocational and university sectors. From 1993, I worked with Healthworkers in remote communities in central Australia as a Healthworker educator and community health nurse. From 1996 to 2000, I taught and then managed the South Australian

[1] The term 'Aboriginal Healthworker' is inclusive of all Aboriginal and Torres Strait Islander Healthworkers (http://www.naccho.org.au/aboriginal-health/definitions/). In this study all Aboriginal Healthworkers are hereafter referred to as Healthworkers.

Healthworker education program for the Aboriginal Health Council of South Australia (AHCSA) and TAFE SA (Technical and Further Education South Australia). I subsequently taught Healthworkers at Yooroang Garang School of Indigenous Health Studies at the University of Sydney. This was followed by my participation in a range of Aboriginal health research projects, including the statewide Aboriginal Smokecheck Health promotion and education program with the School of Public Health at the University of Sydney. My work in the field has been built on my long-term experience in community health and raising a family in remote Aboriginal communities through the 1980s and 90s.

These experiences have amplified my awareness and understanding of disparities between the health status, education and career opportunities of Aboriginal and non-Aboriginal people. As a non-Aboriginal woman I have had far more opportunities than the Aboriginal women with whom I have lived and shared periods of my life. My familiarity with this injustice, particularly that experienced by Healthworkers in remote and rural Aboriginal communities has been a powerful motivator that continues to drive my contributions in this field.

1.2 Context of the study

The following brief overview contextualises the study. It draws on two seminal reports about Healthworker training (Curtin Indigenous Research Centre 2000) and the Healthworker workforce (Health Workforce Australia Final Report 2011, p. 1). Additional literature that informs the study is discussed in Chapter 2.

The first national review of Healthworker training conducted over a decade ago (Curtin Indigenous Research Centre 2000) and a recent comprehensive national project exploring the Healthworker workforce (Health Workforce Australia Final Report 2011, p. 1) make comparable findings about the Healthworker field. A key finding is that Healthworkers make important contributions to the health care of Aboriginal people, yet their roles and practice are not well understood or professionally recognised (Curtin Indigenous Research Centre 2000, Health Workforce Australia Environmental Scan, Interim Report and Final Report 2011). Both reports identify a number of factors that contribute to this problem, including for example: in the diversity of Healthworkers'

roles, variations in definitions of their practice, scopes of practice and education standards, as well as limited research in the field (Health Workforce Australia Final Report 2011). Each report also notes that these factors might be limiting the development of Healthworkers' career pathways, and weakening the potential of the Healthworker workforce to contribute to Aboriginal health outcomes (Curtin Indigenous Research Centre 2000, Health Workforce Australia 2011). Furthermore, although not specified in either report, it is possible that these factors maybe inhibiting the participation of Healthworkers themselves in the development and professionalisation of their roles and practice.

Definitions of Healthworkers' roles have varied over time and across states, territories and organisations. In part, this is because Healthworkers perform different roles and scopes of practice in varied contexts. For example, in regards to roles, Healthworkers might be broadly classified as either generalists or specialists. Generalist roles commonly include Aboriginal Hospital Officers (AHLO), Aboriginal Health Education Officers (AHEO), and Aboriginal Health Workers (AHW). These roles are performed in a range of settings such as hospitals and mainstream and Aboriginal controlled community health centres. Healthworkers' scope of practice in these roles is likely to entail a broad range of activities such as advocating for community members' health needs, the provision of basic health care, social and emotional support and health information and education. In contrast, specialist Healthworker roles are commonly found in fields such as mental health, drug and alcohol treatment and rehabilitation, maternal and infant health and women or men's health. Specialist roles may also refer to Aboriginal program managers, health service managers, policy officers and researchers in a wide range of contexts such as government health departments, research units and specialist health organisations such as drug rehabilitation units. Within these specialist roles Healthworkers are also likely to perform a more narrowly focused range of activities than generalist Healthworkers.

In an effort to clarify Healthworkers' roles and scope of practice, Health Workforce Australia presented the first 'nationally agreed definition' (Health Workforce Australia Final Report 2011, p. 23) of a Healthworker as someone who:

'a) identifies as an Aboriginal and/or Torres Strait Islander and is recognised by their community as such, AND
b) is the holder of a minimum (or higher qualification in Aboriginal and Torres Strait Islander primary health care AND
c) has a culturally safe and holistic approach to health care' (Health Workforce Australia Final Report 2011, p. 23).

This is a broad definition that specifies Aboriginal identity as an essential feature of Healthworkers' roles. Aboriginal identity is also recognised in other statutory definitions of Healthworkers' roles (Aboriginal and Torres Strait Islander Health Board 2013, National Aboriginal and Torres Strait Islander Health Worker Association 2012). The definition also acknowledges the need for a minimum health qualification and specifies the two key concepts that underpin Healthworkers' roles and practice (Health Workforce Australia Final Report 2011, p. 23). The first concept, 'cultural safety' refers to the ways in which Healthworkers acknowledge, respect and nurture their clients' unique cultural identity to maximise feelings of safety and meet their 'needs, expectations and rights ' (Wood, Schwass 1993 p. 6). The second concept, an 'holistic approach', describes health care that considers peoples' physical, social, emotional and cultural wellbeing at the level of the individual and the community (National Aboriginal Health Strategy 1989). As such, the approach is closely aligned to comprehensive primary health care, which focuses on addressing the social determinants of health such as: poverty, education, social exclusion, unemployment. Comprehensive primary health care activities include those that promote health, prevent illness, and provide treatment, rehabilitation, community development and advocacy (Wilkinson & Marmot 2003). Although comprehensive primary health care is not explicit in the Health Workforce definition of Healthworkers, it is widely acknowledged as an integral component of their roles and practice (Health Workforce Australia Final Report 2011).

The capacity of Healthworkers to provide culturally safe and holistic healthcare is likely to be enhanced by their connections to their communities and consequent understanding of community health issues. Champion, Franks and Taylor (2008, p. 300) report that Aboriginal people 'understood better than anyone' the links between the health issues they experience. Healthworkers' understanding of their communities' issues are manifest in their first hand experience of their communities' histories, concerns and

concepts of health. The National Aboriginal and Community Controlled Health Organisation (NACCHO 2006) defines this concept of health as

> *'not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each Individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their Community. It's a whole of life view and includes the cyclical concept of life-death-life (NACCHO 2006)*

A key aspect of Healthworkers' roles is that they vary across contexts. The National Review of Aboriginal and Torres Strait Islander Health Worker Training (Curtin Indigenous Research Centre 2000) clarified that Healthworker roles and practice are 'often contingent upon the cultural, social, political and economic context in which individual Aboriginal Health Workers are situated' (Curtin Indigenous Research Centre 2000, p. 15). The recent review of the Healthworker workforce, also notes that Healthworkers roles and practice are characterised by diversity (Health Workforce Australia Final Report 2011). For example, the review found that in the Northern Territory Healthworkers' roles had 'an emphasis on clinical, complex and acute care' (Health Workforce Australia Final Report 2011, p. 11) whereas in New South Wales mainstream health services, their roles focussed more on 'health promotion programs and cultural brokerage' (Health Workforce Australia Final Report 2011, p. 11). There are numerous other dimensions to the diversity of contexts that may impact on Healthworkers' roles and practice. For example, the remoteness of the communities where they work, their community's demographic characteristics, and health care needs, whether they are employed in the Aboriginal community controlled health sector, their qualifications, and their experience. These contexts are discussed further in Chapter 2.

Like their roles and practice, Healthworkers' education also varies, with courses including non-accredited on the job training, nationally accredited Healthworker Certificates to Advanced Diplomas in the Vocational and Education Training (VET) sector and some self-accrediting university programs. These education options may provide Healthworkers and organisations with choices and some flexibility, although there has been 'no evaluation of whether the number and type of educational opportunities for Healthworkers are sufficient to meet future workforce demands'

(Health Workforce Australia Environmental Scan 2011, p. 6). Neither does there appear to have been any evaluation of whether current Healthworker education is providing Healthworkers with the requisite skills and knowledge to address current Aboriginal community healthcare needs. However, there are reports that some health services find it difficult to recruit 'appropriately trained Healthworkers' (Interim Report HWA 2011, p. 20), and others that Healthworkers do not always have the full range of skills and knowledge they need for their roles (Curtin Indigenous Research Centre 2000, Clapham and Gosden 2001, Genat 2006, Mitchell and Hussey 2006).

Examples of other issues reportedly associated with Healthworker education are: inconsistencies in course entry level requirements, unevenly distributed vocational education opportunities which tend to be at lower certificate levels, variation in education standards and limited opportunities for university study at either undergraduate or graduate levels as well as blurred education pathways (Health Workforce Australia Environmental Scan 2011, Health Workforce Australia Final Report 2011, Murray & Wronski 2006). Literacy and numeracy difficulties and the lack of available positions in Healthworker education courses are also thought to preclude prospective Healthworkers from entering the workforce (Health Workforce Australia Interim Report 2011, p. 192). Many of these issues impact negatively on the Healthworker workforce by constraining Healthworkers' career pathways and professional recognition, limiting their access to related health education programs such as nursing or social work and contributing to wage disparities (Curtin Indigenous Research Centre 2000, Health Workforce Australia 2011). A more detailed overview of these issues and those associated with Healthworkers' roles and practice in the context of the literature is presented in Chapter 2.

In sum, there are considerable variations within and between the three domains that are the focus of this study, that is Healthworkers' roles, practice, education pathways and their connections to the Aboriginal communities they assist. These variations are multifaceted and occurring in a rapidly changing field. Furthermore, the complex of relations between each of the domains gives rise to issues that may limit Healthworkers' career opportunities and the development and professional recognition of the Healthworker workforce. In turn this may impact on the contributions Healthworkers

make to the health care of Aboriginal people. The complexity of the relations between these domains and Healthworkers' perspectives of them constituted the focus of this study.

1.3 The problematic

The problematic addressed by this study is the relations between Healthworkers' varied healthcare roles and scopes of practice in their communities, the types of education programs they undertake, and the skills and knowledge they acquire from these programs. These relations have been discussed in a few reports and studies. For example a national review of Healthworker training (Curtin Indigenous Research Centre 2000) described the relationship between Healthworkers' roles and education as a 'paradox', since 'the role of Aboriginal Health Workers is described as unique and essential to health care in Aboriginal communities but at the same time they are undervalued and often lack the educational preparation needed to confidently and effectively perform this role (Curtin Indigenous Research Centre 2000, p. 17). The review also found that Healthworkers themselves 'were concerned about the quality of some of the training offered, and questioned the relevance of training programs in relation to their actual roles' (Curtin Indigenous Research Centre 2000, p. xv)

Murray and Wronski (2006, p. 37) also note that although some Healthworkers have 'expanded clinical care' roles, their skills and knowledge are not always acquired through formal education but rather 'informally developed while working alongside doctors'. Genat (2006, p. 195) also notes in a study of Western Australian Family Healthworkers, that in terms of their holistic practice, some Healthworkers 'appear less than adequately trained to skillfully handle the complexity of this work'. An evaluation of a Queensland Healthworker training program identified that there was 'a need to strengthen the education and training program for Aboriginal Health Workers working in primary health care settings' (James Cook University 2001). At the national level, there are similar reports. For example, Health Workforce Australia (Final Report 2011, p. xii) highlights that although the Healthworker workforce is becoming 'increasingly qualified', there are still discrepancies in education standards that leave some Healthworkers 'not adequately prepared when they enter the workforce (Health Workforce Australia Final Report 2011, p. 12).

Much of the research into Healthworkers' roles and education has tended to treat them as separate domains of enquiry. Although this has resulted in the clarification of specific issues it has left a gap in terms of explicating the relations between the two domains. In particular there has been no research into how current Healthworker education, contributes to Healthworkers' career pathways, or to the development of the Healthworker workforce. Nor has there been any published research exploring the skill and knowledge base that Healthworkers may need to achieve professional recognition comparable to that afforded other health practitioners such as nurses or allied health professionals. Furthermore to date there is almost no evidence to indicate the level of Healthworker demand for university level qualifications (Health Workforce Australia 2011 Final Report). A related issue for which there is evidence is the lack of articulated education pathways between vocational and higher education and the limited availability of Healthworker specific degree programs (Health Workforce Australia 2011). Another issue, for which there appears to be little evidence, is Healthworkers' level of awareness about the potential benefits of a university qualification to them as individuals and to the overall development of the Healthworker workforce.

These gaps in the research suggest there are a number of issues worthy of exploration. Firstly, for example, how might different types of education and training prepare Healthworkers for their various roles and scopes of practice in different contexts. Secondly, what type and level of skills Healthworkers need to effectively perform their various roles and scopes of practice in different contexts. Thirdly, what are Healthworkers' views about what type and level of education do they consider necessary for professional recognition?

1.4 Research approach

This section includes a brief discussion of the research questions, method and setting.

1.4.1 Research questions and their significance

The primary research question that underpins this study asks:

> *What is the relationship between Healthworkers' workplace roles, their education, their families and communities and their discourse about these domains?*

The use of the term 'discourse' here refers to the actual text produced by Healthworkers. This usage is associated with Halliday's functional model of language as text in social context (Halliday 1978, Martin & Rose 2007), discussed in more detail in Chapter 3.

This question gives rise to two areas of enquiry. The first area focuses on the issues in, and relations between Healthworkers' workplace roles, their education and their families and communities. The second area focuses on Healthworkers' discourse about these three domains of interest.

In the first area of enquiry, the research asks:

- *What roles and scopes of practice do Healthworkers perform?*
- *What types of education and training do Healthworkers undertake and what skills and knowledge do they acquire in order to perform those roles in their scopes of practice?*
- *What interconnections are there between Healthworkers' families and communities, their roles and the skills and knowledge they bring to their roles?*

These questions arise from recent recommendations to strengthen the Healthworker workforce through actions such as establishing the parameters of the profession, workforce planning and research and improving the quality and accessibility of education (Health Workforce Final Report 2011, p. ix). The questions sought to enquire

about the characteristics and issues associated with each topic and secondly the relations between the domains of interest.

Firstly, in regards to characteristics and issues associated with each of the three domains it was anticipated that questions related to Healthworkers' roles and practice might elucidate information about: formal definitions, scopes and contexts of practice, community healthcare needs, registration and accreditation. Similarly, questions about Healthworkers' education and training might provide insights into issues such as education pathways, education standards, qualifications, course access, flexibility, accreditation, and articulation. In addition, questions about Healthworkers' connections to their families and communities might elicit information about issues such as their professional/ community relationships.

Secondly, it was anticipated that the investigation of the characteristics and issues in each domain would support the clarification of relations between them. For example, elucidating the scopes and contexts of Healthworkers' practice might clarify what education pathways and types and levels of skills and knowledge they need for effective performance. Conversely, understanding Healthworkers' different education pathways and the connections they have with their families and communities, may help to explain what skills and knowledge they derive from them and how they might inform their roles and practice.

Questions in the second area of enquiry ask:

- *What are Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities?*
- *How do they evaluate each of these topics?*
- *How do they present their perspectives and evaluations in their discourse about each of these topics?*

These questions arise from Halliday's (1978) trifunctional model of discourse in context as enacting participants' social relations, (e.g. through their evaluations), construing

their experience (i.e. their perspectives on the topics) and presenting[2] their perspectives and evaluations as discourse that is meaningful in context. Halliday refers to these as the interpersonal, ideational and textual metafunctions of language.

The questions call for a close analysis of Healthworkers' discourse. To this end a number of Healthworkers with varying backgrounds in education, health practice, and families and communities were interviewed. Interviews were analysed from three functional angles, to ascertain: i) Healthworkers' perspectives on the three topics, ii) their evaluations and iii) how they presented them. It was anticipated that the analyses would provide insights into the commonalities and differences between Healthworkers' in regards to their discourse in the three topics and be a basis for discussion, interpretation and drawing implications for Healthworkers' education and practice as well as further research in this field.

1.4.2 Research design

The study adopts a qualitative approach, using in-depth, semi-structured interviews with nine Healthworkers in diverse roles and settings, that are analysed, discussed and interpreted. Open-ended descriptive interview questions aim to elicit descriptive and explanatory responses about Healthworkers' professional and personal experiences of their healthcare roles, education and family and community connections. Interviews were recorded, transcribed and analysed.

There are three phases of analysis that lead to findings. First, the nine interview transcripts are recontextualised as biographies that briefly recount each Healthworker's life history, in order to contextualise the discussion in Healthworkers' lived experience. Secondly, segments of interview transcripts are analysed using discourse analytic methods, to explore the ways in which each Healthworker presents[3] and evaluates their roles, education and family and community connections. Thirdly, patterns emerging across the analyses, in commonalities and differences between Healthworkers, are

[2] The term 'representation' is avoided because it implies a pre-existent reality that language merely 'represents' (Halliday 1978).

discussed and interpreted. This approach and methodology provide a foundational structuring for the study and an opportunity to access detailed objective insights into Healthworkers' perspectives on their practice, education and connections to their families and communities.

1.4.3 Research participants

The nine Healthworkers in this study were located in a variety of communities in New South Wales, including rural, regional and metropolitan centres. They performed roles in a range of healthcare settings, and had various educational experiences. Their roles were in generalist and specialist healthcare positions in Aboriginal community controlled and mainstream health services, including an Aboriginal Medical Service (AMS), community health services, a population health unit, and hospitals. Healthworkers' education included vocational training in TAFE colleges and other Registered Training Organisations (RTO), and higher education institutions, including metropolitan and regional universities.

The selection of Healthworkers' in New South Wales from varied community, workplace and educational backgrounds as well as their varied roles and scopes of practice sought to capture as much of the diversity of the Healthworker field as possible. Healthworkers in NSW comprise an average proportion of the total national Healthworker workforce (Health Workforce Australia Environmental Scan 2011), and are therefore likely to deal with a fair proportion of workforce related issues. NSW has also been at the forefront of the development of Healthworker roles in many ways. Examples include the first AMS at Redfern, establishment of the Aboriginal and Islander Health Worker Journal, the NSW Aboriginal Health Worker Forum, and the first dedicated Aboriginal Health Training College. These factors make the group of Healthworkers selected for this study a reasonable sample that accords to some extent with the range of experiences across the profession.

Nevertheless it is important to acknowledge that the size of the group prevents it from being a representative sample of all Healthworkers. Despite this, the groups' diversity still provides a detailed snapshot of the Healthworker field that allows at least some of

the findings to be extrapolated to Healthworkers with similar roles, scopes of practice and educational backgrounds in comparable workplaces and communities.

1.5 Overview of the study

This introductory chapter has outlined the context of the study, the problematic and research approach to provide a framework for considering the two areas of enquiry encapsulated in the research questions (1.4.1 above). Chapters 2 to 7 address the literature, research design, analyses, findings and discussion.

Chapter 2 reviews relevant literature in the fields of Aboriginal health, Healthworker education, and the history of Aboriginal healthwork, including reports, reviews and research papers. The available literature on Healthworkers' practice and education is relatively limited to date, but portrays a distinct domain characterised by Healthworkers' diverse roles, varied and complex scopes of practice, and an uncompromising commitment to their communities. The literature also addresses issues that constrain Healthworkers' potential to participate at all levels of the health care system to meet Aboriginal communities' healthcare needs.

Chapter 3 outlines the study design and research method. The method is a qualitative research approach using analyses of interviews to interpret Healthworkers' discourse about their roles, education, and family and community connections. The chapter includes a detailed discussion of analyses procedures, including the recontextualising of interviews as biographies, the application of discourse analysis to interview extracts, and examples of analyses and their functions to enable variations in the discourse of each Healthworker to be identified and compared.

Chapter 4 presents Healthworkers' interview transcripts recontextualised as brief biographies. The purpose is to explicitly portray each Healthworker's life story, providing a holistic point of reference for the analyses, and offering readers an accessible overview to appreciate Healthworkers' individual and collective experiences. The recontextualising process also helped frame the exploration of relations between Healthworkers' roles, education, and family/community connections, and the questions about these relationships.

Chapter 5 presents the second phase of analysis and initial findings related to the nine individual Healthworkers. This phase applies discourse analytic methods to extracts of interviews, to systematically and objectively explore the ways in which each Healthworker presents and evaluates their roles, education and family and community connections. Analysis is from three perspectives. Firstly, each Healthworkers' presentation of their roles and education is analysed to present findings about both the information they present about these topics, and how they organise this information. These analyses reveal patterns of commonalities and differences between Healthworkers, that are related to their types of roles and types of education. Secondly, each interview is analysed for the lexical content that Healthworkers present, including levels of everyday, specialised, technical and abstract terms. These analyses show commonalities and differences in Healthworkers' perspectives on their fields of practice, education and communities, that are again related to their types of roles and education. Thirdly, interview extracts are analysed to show how Healthworkers evaluate their roles, education and family/community connections.

Chapter 6 presents the third phase of the analysis and findings related to Healthworkers as a whole group. This phase presents the patterns of similarity and difference that were identified in the three topic areas, across the nine Healthworkers' interviews, in terms of the information they discuss, how it is presented and how it is evaluated. These patterns form the bases for grouping Healthworkers together and distinguishing them from each other, in terms of their types of roles and education. Patterns emerge in response to questions about Healthworkers types and levels of education, the programs and activities they perform in their scope of practice, the relationships between their education and practice, and relationships between their practice and family and community experience. The analyses show consistent but variable relations between three types of Healthworker roles: clinical, community care, and program management; and three general types of education experience: basic vocational, higher vocational, and university. On the other hand, Healthworkers' evaluations of their family/community connections show consistent patterns across all types of roles and education.

Chapter 7 draws together the analyses of the interviews and information in Chapters 2, 4, 5 and 6 to present the study's findings in relation to the research questions. It also considers these findings in terms of their implications for Healthworkers' roles, practice and education. It concludes with suggestions for strengthening the professional recognition of Healthworkers, for education pathways and focused research.

The structure of the study is thus designed as a sequence of contextualisation, analysis, discussion, interpretation, findings and implications. Chapter 2 provides the context of the Aboriginal healthwork field as discussed in the literature. Chapter 4 provides the context of each Healthworker's life story. Chapter 5 analyses and presents findings in terms of each Healthworker's discourse, specifically their perspectives, evaluations and how they present their roles, practice, education and family/community connections. Chapter 6 discusses patterns across the analyses of each topic, and interprets their significance as findings. Chapter 7 draws on the analyses to interpret the findings and suggest implications for policy and further research.

Chapter 2: Literature Review

2.0 Introduction

This chapter presents literature that constitutes a background to the Healthworker field and the three domains of interest in this study, that is, Healthworkers' healthcare roles and scopes of practice, their education, and their families and communities. It includes research in Aboriginal health, in Healthworker education, and in ethnography and the history of Aboriginal health work. For Healthworkers' roles and practice, literature includes reports, reviews and research tracing the development of Healthworkers' roles and current workforce issues. For education and training it includes reviews, course descriptors and published studies in vocational and higher education and Healthworker roles. Literature in ethnography and history includes ethnographic descriptions of Aboriginal women's traditional roles maintaining the wellbeing of their families and communities, and Aboriginal health and healthcare in the colonial period.

The chapter begins by considering Healthworkers' roles in the context of Aboriginal cultural traditions and proposes that they are linked to the current roles of Healthworkers. In this section there is a focus on ethnographic descriptions of Aboriginal women's traditional roles prior to colonisation and the features of these roles such as care giving and the maintenance of family and community wellbeing. The traditional healthcare roles of Aboriginal men are also briefly described and differentiated from those of women. Literature tracking the emergence of Healthworkers' formal institutional roles and their development over the last two decades in different community and organisational contexts is also reviewed.

The second section of the chapter examines the current Healthworker field. It refers to key national and state reviews of the Healthworker workforce and research into issues such as the diversity and lack of clarity in roles, varied scopes of practice, stakeholder expectations and professional recognition. A number of policy documents that inform the discussion of the Healthworker field are also identified.

The chapter's third section considers literature about Healthworker education at vocational and university levels. It refers to reports and reviews of issues impacting on Healthworkers' roles such as access to education, the alignment of qualifications and roles, course content variations and the quality of training. In addition this section considers the Aboriginal and Torres Strait Islander Primary Health Care Training Packages, including the bench-mark qualifications for practice, and descriptions of undergraduate and postgraduate Healthworker courses. Sourcing detailed Healthworker education literature for this study was a challenge. This was a consequence of i) limited research particularly in regards to Healthworkers' experiences of their education, ii) the national review of Health Training Packages (HLT07), and ii) the Aboriginal and Torres Strait Islander Health Worker Project (Health Workforce Australia 2011).which were both in progress while this thesis was being written. Limited access to detailed curriculum was primarily via the web as repeated requests to education providers for curricula were largely unsuccessful.

2.1 Historical and cultural contexts

This section considers the traditional roles of Aboriginal women as the historical context in which Healthworkers' contemporary roles may have evolved. It draws on ethnographic and historical literature describing the roles of Aboriginal women as care givers with a key responsibility for the general wellbeing of their families in traditional and colonial environments. The section also acknowledges and differentiates the traditional roles of men in healthcare. However, in view of the current predominance of women in the Healthworker workforce, women's traditional roles are considered in more detail.

2.1.1 Traditional roles of Aboriginal women

The roles of women in traditional Aboriginal societies have tended to be marginalised by mainstream ethnography. According to Behrendt (1993, p. 28) 'Aboriginal women enjoyed a position in society which has been ignored by many anthropologists'. Bell (1993, p.235) suggests this disinterest was a consequence of the 'preponderance of male researchers which prevented women from speaking; it was also the orientation of the discipline'. In addition, early anthropology was more interested in the 'exotic' roles of

traditional healers who were mostly men, whereas the everyday responsibilities of women to protect the health of their families and communities were mostly overlooked (Bell 1982, p. 198).

Those studies that do provide descriptions of Aboriginal women's' lives before colonisation (e.g. Kaberry 1939, Behrendt 1993, Bell 1993, Gale 1972, Berndt 1974), show they had a distinct role as caregivers, mediators, key providers of food and bush medicine as well as overseers of women's laws and their related ceremonial rituals. Kaberry's (1939) study of the 'sacred and profane' roles of Aboriginal women in north western Australia reports that women provided the bulk of the staple diet, maintained a primary role instructing and caring for young children, attended to older relatives, and were 'keepers of the hearth' (Kaberry 1939, p. 58-141). Other responsibilities included the ceremonial and practical management of childbirth and death (Kaberry 1939, p. 246). Fifty years later, Bell (1993) described the similarly pivotal roles of central Australian Aboriginal women as caregivers and community mediators:

> *...women emphasise their role as nurturers of people, land and relationships. Through their yawulyu (land based ceremonies) they nurture land; through their health and curing rituals they resolve conflict and restore social harmony, and through yilpinji (love rituals) they manage emotions. Thus…their major responsibilities in the areas of love, land and health fuse in the nurturance motif with its twin themes of the 'growing up' of people and land and the maintenance of harmonious relations between people and country' (Bell 1993, p. 21).*

In a comprehensive study of Ngarrindjeri women in southern Australian, Bell (1998, p. 341) documented the extensive knowledge and skills of older female 'doctors' in traditionally oriented communities, including their involvement in women and children's wellbeing, knowledge of bush medicines, religious rituals and the efficacy of numerous traditional treatments.

These portrayals of women's traditional healthcare roles show they were clearly oriented towards promoting 'the general health and wellbeing of their whole family'(Clarke 2008, p. 10), and that some also had exclusive roles as healers (Maher

1999). Although these roles were specific to their historical times and contexts, their focus appears to have links to Healthworkers' current roles providing holistic healthcare care to individuals, families and the community.

2.1.2 Traditional roles of Aboriginal men in health

Some men also had designated healthcare roles as traditional healers with a primary responsibility for 'treating sick individuals' (Maher 1999, Clarke 2008, p. 9). Maher (1999, p. 232) notes traditional healers were highly regarded and had 'exceptional knowledge and powers…to remove the influence of sorcery and evil spirits and to restore the wellbeing of the soul or spirit'. In addition, Clarke (2008, p. 12) reports the role of traditional healer was not inherited but rather, bestowed on young men with 'an aptitude for learning', who were trained 'into the methodology and rituals related to discerning causes of illness'.

Further discussion of the traditional roles of Aboriginal men as healers is outside the scope of this literature review. However it is important to acknowledge that 30% of the Healthworker workforce now comprises men (Health Workforce Australia Environmental Scan 2011, p. 71). Male Healthworkers emerged during the 1950s approximately two decades after women began work as nursing assistants in the missions and later as hospital assistants (Abbott and Elliot 2007). It is probable that their roles were modeled on those of their female colleagues. In their current roles, male Healthworkers perform activities comparable to their female counterparts, but many are likely to perform a scope of practice specifically related to men's health.

2.1.3 Roles of Aboriginal women in the colonial period

As described above, the descriptions of traditional Aboriginal women's roles in promoting the general health and wellbeing of their families suggests continuities with the roles of contemporary Healthworkers, particularly in regards to activities such as advocacy, cultural brokerage and the provision of comprehensive primary health care. This suggestion is given weight by historical records documenting Aboriginal women's care giving and advocacy roles in colonial contexts, in voluntary and involuntary capacities. For example, Berndt (1974, p. 71-2) notes that during the protectionist and assimilationist periods Aboriginal women 'came to serve as hinges or pivots occupying

a crucial position between the newcomers and their men folk - as intermediaries'. Reynolds (1995, p. 143) also suggests 'that women had a customary role in diplomacy and intertribal negotiation' and played a key mediation role with mission administrators. Gale (1972) reports that missionaries and government administrators found it more convenient to deal with Aboriginal women, as men were often employed in rural industries and absent from their families for extended periods. Berndt (1974) argues that this convenience was because women were regarded by the colonists as 'more biddable, more submissive and easier to keep under control' (Berndt 1974, p. 71). Irrespective of their foundations, these interactions, may have played a part in strengthening the roles of Aboriginal women in their communities (Berndt 1974, p. 71).

2.1.4 Segregation of Aboriginal healthcare

During the nineteenth and early twentieth centuries, segregation policies restricted Aboriginal people's access to healthcare. Saggers & Gray (1991, p. 386) describe healthcare in this period as 'crude or non-existent'. Furthermore conditions in the missions and reserves meant that women and their families lived with few services, minimal fresh water and sanitation, overcrowded housing and endemic health problems. In Queensland for example, Maryborough Hospital refused to admit Aboriginal patients because there was a 'lack of separate accommodation…and the absolute dislike - we might almost say refusal of the servants to attend upon them' (Franklin & White 1991, p. 386). In cases where treatment was provided, it was not because of the shattering effects contagious diseases were having on Aboriginal people who had little or no resistance but rather because the white population was deemed to be at risk, although it was Europeans who had introduced these diseases in the first place.

In Western Australia, fears about the spread of venereal disease resulted in the establishment of 'lock' hospitals on uninhabited islands where many Aboriginal people were taken in chains and left without effective treatment to die (Saggers & Gray 1991, p. 123). It was not until the 1930s that Aboriginal people were admitted to public hospitals, but only in separate accommodation where care could be refused or left to other Aboriginal patients to provide (Saggers & Gray 1991, p. 124).

Segregation remained a common feature of Aboriginal health care into the 1960s. According to Abbott and Elliot's (2007) historical timeline of Aboriginal Healthwork, many missions in the Northern Territory employed Aboriginal nursing assistants between 1930 and the 1960s. In general however Aboriginal people were excluded from the 'decision making processes and delivery of health care' (Franklin &White 1991, p. 27). This was in contrast to international settings such as in Africa, India and China where Indigenous primary Healthworkers had a principal role to 'dispense Western healing concepts and practices across the cultural divide' (Genat 2006, p. 4).

In sum, the depiction of Aboriginal women as nurturers of family and community health and wellbeing in the literature, suggestsa link to the development of female Healthworkers' contemporary roles. These links are apparent in the strong parallels between women's' traditional roles in diplomacy, negotiation and cultural brokerage and Healthworkers' contemporary roles as community advocates, liaison workers and providers of holistic culturally safe healthcare. They are also apparent in the association between the health promotion activities performed by women in their traditional roles as 'keepers of the hearth' and the comprehensive primary health care provided by contemporary Healthworkers in their current roles (Kaberry 1939, p. 58-141).

The suggestion of a link between women's traditional roles and those of contemporary Healthworkers does not preclude the recognition of current male Healthworkers. According to Abbott and Elliot (2007) it was the 1950s before 'health inspectors proposed training men as council employed hygiene workers' whereas Aboriginal women's healthcare roles as nursing assistants in the missions and as hospital assistants was established during the 1930s and 40s. It is therefore likely that women's traditional roles lay the foundations for all current Healthworker roles, regardless of their performance by women or men.

2.1.5 The development of Healthworkers' contemporary roles

The literature reports that Healthworkers' roles were first formally recognised when Aboriginal women and some men were employed in isolated leprosariums during the 1950s in the Northern Territory and Western Australia (Curtin Indigenous Research Centre 2000, Health Workforce Australia 2011). Saggers & Gray (1991, p.161) note

that during the 1960s, Northern Territory Healthworkers had roles as 'medical assistants'. Genat (2006) also reports that in Western Australian the health department employed a limited number of Healthworkers at this time. However, in NSW it was not until the 1970s that Healthworkers were accepted in government health positions (Saggers & Gray 1991, p.161).

International and national health care reforms in the 1970s, provided further impetus for the development of the Healthworker workforce in Australia. For example, the Report of the International Conference on Primary Health Care (World Health Organisation 1978) expressed strong endorsement for community healthworkers who were described as being 'the first level of contact between individuals and the health care system' (World Health Organisation 1978, p. 62). Although Healthworkers' roles in Australia at this time were still evolving, they were comparable to community healthworkers as described by the WHO, in that they often performed as community advocates who could bridge the divide between the mainstream health system and Aboriginal communities. The development of Healthworkers' roles was also supported by Aboriginal community controlled health organisations which were also emerging at this time in response to the healthcare needs of Aboriginal communities. Larkin et al (2006) contends that these organisations have made a critical contribution to strengthening Healthworker's efforts to improve Aboriginal people's access to health care over the years.

Since its inception the Aboriginal and Islander Health Worker Journal (A&IHWJ) has provided a forum for discussing and tracking the development of Healthworker's roles. For example, in 1977, the first edition of the journal defined Healthworkers roles as:

> *'...those people responsible for primary medical care, and for the prevention of sickness in Aboriginal communities. "Primary care" is care for sickness that can be diagnosed and treated at home – 99%. "Referral care" is for those diseases requiring admission to hospital – 1%'. (Aboriginal and Islander Health Worker Journal, 1977).*

The same issue also identified activities that Healthworkers provide assistance with including to:

- *'diagnose and treat sick individuals;*
- *interpret sickness, its causes and its prevention, to the local community;*
- *educate the Australian public, since many decisions affecting Aboriginal health do not rest with health workers' (Aboriginal and Islander Health Worker Journal 1977).*

These early definitions indicate that even from the initial stages of their development, Healthworkers' roles and practice entailed a comprehensive range of activities covering clinical care, health promotion, illness prevention and the education of non-Aboriginal people about Aboriginal healthcare needs. However, the use of the word 'assist' also indicates that Healthworkers were not autonomous practitioners and may have lacked the professional status that might otherwise be considered to be associated with performing such roles and activities. Consequently, developments in Healthworkers' roles and practice during this time were quite limited.

In a later edition of the AIHWJ, Kamien (1982) describes that Healthworkers had roles in early disease detection, health education, cultural interpreting, and providing cultural insights to non-Aboriginal healthcare staff. However, not everyone agreed. For example, in the same issue, Hicks (1982, p. 9) a senior medical officer indicated wrote, 'some people think that they [Healthworkers] should do all the things a doctor can do. Others think that they should just be there to fetch and carry and not really have any say at all. The truth lies somewhere between'. These debates have contiued to perpetuate confusion about Healthworkers' various roles and the scope of their practice in different settings. It is only in the last 15 years that there have been efforts to clarify the difficulties this confusion has caused.

2.2 The current Healthworker field

The lack of clarity about Healthworkers' roles and the divergence in their varied scopes of practice presented in the literature above, is still apparent today. Genat (2006) for example, reports there is a level of confusion in some services about the exact role of Healthworkers, particularly amongst other health professionals such as nurses and doctors. This may be a consequence not just of the lack of understanding about Healthworkers' roles, but also the development and complexity of the Healthworker

field. Some of this complexity is reflected in the range of policies that have influenced the development of the field. Most of these have arisen through the federal and state government, non-government and the Aboriginal community controlled sectors. They include recommendations that are specific to the development of Aboriginal health workforce and those that refer to Healthworkers as component of a wider policy to improve Aboriginal health.

The current key policy document that specifically addresses Healthworkers' current roles is the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework 2011-2015 (Australian Health Ministers Advisory Council 2011). This document recommends the development of a national Healthworker 'scope of practice', the registration and accreditation of Healthworkers as 'practitioners', and the revision of Health Training packages related to Aboriginal health (Australian Health Ministers Advisory Council 2011, p.7). These recommendations are also addressed by organisations, including the National Aboriginal and Community Controlled Health Organisation (NACCHO 2008) the Aboriginal and Torres Strait Islander Health Worker Association (ATSIHWA 2013), Aboriginal and Torres Strait Islander Registered Training Organisation Network (ATSIRTONN 2011), Aboriginal and Torres Strait Islander Health Practice Board (ATSIPB 2012), Aboriginal and Torres Strait Islander Health Workforce Working Group (AHMAC 2011) Community Services and Health Industry Council (CS&HISC) and Health Workforce Australia (HWA 2011).

A major document that refers to Healthworkers as a component of a wider policy to improve Aboriginal health is the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013. The Framework makes a number of recommendations in regards to Healthworkers as part of 'a competent workforce', including national qualifications, the support and development of an Aboriginal Registered Training Organisation Network and a national Aboriginal and Torres Strait Islander Healthworker Association (2007, p. 21). Other key documents that acknowledge Healthworkers' roles and support their development include the Australian Medical Association's Indigenous Health Report Card Healing Hands (2004), Human Rights and Equal Opportunity Commission's Social Justice Report (2005), and Close the Gap initiative (2008).

The number of organisations that contribute to policies impacting on Healthworkers' roles and practice is extraordinary. It indicates a level of commitment but also illustrates the complexity of the policy environment of the Healthworker field. A challenge is to ensure that this does not create a bureaucratic quagmire that further complicates Healthworkers' struggle to articulate their field and in particular to ensure their roles and scopes of practice are valued and formally recognised.

To comprehend the complexity of the Healthworker field I suggest it might be considered in terms of three domains. These domains frame the context of this study. The first domain is Healthworkers' **roles and practice**. At the forefront of this domain is Aboriginal people's **health status,** which indicates the type, extent and severity of health issues that Healthworkers confront in their roles and practice. The domain also includes the various contexts in which Healthworkers practice, the various definitions for Healthworkers, issues in the field, including those associated with the development of the Healthworker workforce and the policies that inform it. The second domain is Healthworkers' **education and training** including for example: vocational and university course types, participation levels and issues such as academic literacy. The third domain is Healthworkers' **connections to their families and communities** and the potential influence these connections have on the skills and knowledge Healthworkers bring to their practice. The literature associated with each domain is considered in the following sections.

2.3 Healthworkers' roles and practice

The literature describes that Healthworkers make important contributions to tackling the acute and chronic health conditions prevalent in Aboriginal communities. (Genat 2006, King et al 2007, Mitchell & Hussey 2006, Townsend 2008, Health Workforce Australia 2011, Watson et al 2012,). These conditions result in Aboriginal people having the worst health status of any group in Australia, as is apparent in their higher rates of morbidity and mortality, hospital admission rates, disability and injury and data (Australian Institute of Health & Welfare 2011, Department of Families, Housing, Community Services and Indigenous Affairs 2012).

Measures of the health status of Aboriginal Australians, including mortality, morbidity, birth-weight, immunization rates, hospital separations and health service access show minimal improvements over recent decades (Ring & Brown 2002). In terms of mortality, national data indicates that Aboriginal men are likely to live an average 11.5 less years, and women 9.7 less years, than their non-Aboriginal counterparts (Australian Bureau of Statistics 2010). More stark is evidence showing that 33% of Aboriginal males aged 15 will have died before age 60, compared with 8% in the Australian male population. Primary causes include ischaemic heart disease, Type 2 diabetes and suicide (Vos, et al 2007). Morbidity data also shows that in comparison to the total population, Aboriginal people in every age group experience illness and disease at higher rates, and are more likely to die from illness (Vos et al 2007). In terms of social and emotional wellbeing the data also indicates that Aboriginal Australians are twice as likely as non-Aboriginal Australians to report 'high or very high levels of psychological distress (Australian Institute of Health & Welfare 2011).

The Aboriginal health data also shows there are significant disparities between Aboriginal and non Aboriginal populations in Australia in terms of the socioeconomic health determinants such as income and education (Aboriginal Health Ministers' Advisory Council 2006, Banks 2007, Steering Committee for the Review of Government Service provision 2009). Moreover, research indicates there is an association between income, education and health. For example, when high household income is combined with the completion of a Year 12 education and employment, 'the proportions of Indigenous people between 15-34 years of age who reported they had excellent or very good health also increased' (Australian Bureau of Statistics 2011). The Australian Institute of Health Welfare (AIHW) and Australian Bureau of Statistics (ABS) explain that this is because higher levels of educational attainment advance employment opportunities, which in turn, affects income level, standard of housing and health care access (Australian Bureau of Statistics and Australian Institute of Health Welfare 2005).

Income data shows that overall median weekly wages for Aboriginal people aged over 15 years were an estimated $278 compared to $473 for non Indigenous people (Steering Committee for the Review of Government Service Provision, 2009, p. 4.99). Education

data shows that despite some improvements, Aboriginal children in every state and territory 'have lower school enrolment and attendance rates than non-Aboriginal children' (Steering Committee for the Review of Government Service Provision, 2009, p. 6.3). Retention rate data also shows differences. For example 48.7% of Aboriginal students were still at school in Year 12 compared to 80.7% of non-Aboriginal students (Australian Bureau of Statistics 2011). In NSW only 37 % of Indigenous compared to 73 % of non-Indigenous students complete Yr 12 or an equivalent vocational Certificate II (Australian Bureau of Statistics 2010). Furthermore Aboriginal people 'are less likely to participate in [or] …be admitted to university on the basis of their prior educational attainment compared to non-Indigenous people' (Behrendt et al 2012, p. 7).

Disparities in health and health determinants have their origins in historical and contemporary social factors, from colonisation through generations of discriminatory treatment, to Aboriginal peoples ongoing experience of racism, discrimination and social marginalisation (Gracey & King 2009). Mackean et al (2008) notes such disparities are exacerbated by structural factors such as inadequate infrastructure, funding constraints, and complex bureaucratic systems. Another factor maybe the shortfalls in the health workforce, particularly in rural and regional areas where the overall supply and distribution of health professionals to population is low (Department of Health and Ageing 2008). Although an audit of these regions was unable estimate the supply of Healthworkers due to the lack of national data, it claimed their numbers were also 'relatively small' (Department of Health and Ageing 2008, p.4).

The enormity of health issues and disparities experienced by Aboriginal people are the focus of the National Partnership Agreement on Closing the Gap. This Agreement aims to address reduce inequalities to achieve health parity between Aboriginal and non Aboriginal people within twenty five years. (Department of Families, Housing, Community Services and Indigenous Affairs, 2012). Examples of action to achieve this include the development of a national network of teams to reduce risk factors for chronic disease such as smoking, improving chronic disease management and follow-up and expanding and supporting the primary health care workforce Department of Health 2013). Vos et al (2007) reports other measures such as the identification of opportunities for maximizing health gains, targeting the diseases and risk factors most

responsible for health disparities, appropriate and sustainable, health interventions and more equitable and efficient funding. Qualified Healthworkers with comprehensive primary health care skills and knowledge and an holistic and culturally safe approach to health care are a key resource that can contribute to the implementation of these measures (Health Workforce Australia Final Report 2011).

In terms of managing these health issues, all Healthworkers' roles and practice can be generally characterised in terms of **knowledge, skills and practice**. Firstly, roles are distinguished by a body of skills and knowledge that derive in part from Healthworkers' cultural backgrounds. Saggers & Gray (1991) point out that in many cases Healthworkers are members of the Aboriginal community in which they reside and work. This is likely to provide them with insider knowledge about the health of their communities. As the National Health and Medical Research Council (1997, p. 13), Healthworkers contributions 'lie not just in their roles as agents of Western medicine but in their being from and of the community, sharing its aspirations and burdens'. Mitchell and Hussey (2006, p. 529) also note that even when Healthworkers are not be from the community in which they work most develop 'ties' that provide them with 'a real sense what is going on and what is needed at a grassroots level'. Secondly, Healthworkers' roles and practice are informed by an Aboriginal holistic concept of health. The National Aboriginal Community Controlled Health Organisation (2009, p. 6) defines this as, 'not just the physical well-being of an individual but…the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being'. Thirdly, Healthworker's roles employ are generally underpinned by a comprehensive primary health care approach, defined by the World Health Organisation (1978) as,

> *…essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community can afford to maintain every stage of their development in the spirit of self reliance and self determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as*

close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The comprehensive primary health care approach is considered to be more effective in terms of achieving 'better health, less disease, greater equity, and vast improvements in the performance of health systems' (World Health Organisation 2008, p. 1). Larkin et al (2006) report that Healthworkers employed in Aboriginal health services that provide comprehensive primary health care make a difference by positively affecting client consultations, spending time with clients, and dealing with a range of issues. Similarly, Lloyd & Wise (2011, p. 4) suggest that Healthworkers are integral to the provision of primary health care programs that 'more precisely meet the health needs of Aboriginal people and communities'. Examples of common comprehensive primary health care activities performed by Healthworkers include clinical assessment, screening, monitoring and intervention, health promotion, illness prevention, and chronic disease management.

Although Healthworkers' roles exhibit these commonalities, they are also highly diverse in their types of specialisation, the extent to which they entail varied scopes of practice and in their locations and cultural and linguistic settings. In regards to the types of roles and practice that Healthworkers perform, they may be broadly classified as either generalists or specialists. Examples of generalist roles are Aboriginal Hospital Liaison Officers (AHLO), Aboriginal Health Education Officers (AHEO) and Aboriginal Health Workers (AHW). These roles, usually in hospitals and community health services, typically involve a scope of practice that generally entails activities such as providing basic health care and health assessments, health information and education, and social and emotional support, and advocating for community members' health needs. Specialist Healthworkers' roles are found in fields such as mental health, maternal and infant health, and women's or men's health. Examples of specialist roles also include Aboriginal program co-coordinators, health service managers, policy officers, and researchers. Within, these roles Healthworkers are likely to perform a narrower scope of practice than a generalist Healthworker that may include either clinical or non-clinical activities.

2.3.1 Contexts of Healthworkers' roles and practice

The National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989) emphasises that a key aspect of Healthworkers' diverse roles is their capacity to respond to the various contexts in which they live and work. For example in terms of the geographic context, Healthworkers' roles in isolated rural and remote areas are often constrained by limited health infrastructure, including restricted transport, skills shortages, recruitment and retention difficulties as well as the poorer health outcomes associated with living in these areas (Humphreys et al 2008, Humphreys & Wakerman 2008). In these contexts Healthworkers are more likely to have to provide a whole gamut of clinical and non-clinical services and are 'rarely off duty, [and] called upon outside the workplace to provide education and support' (Abbott et al 2008, p. 159).

In metropolitan areas, comparable issues affect Healthworkers' roles, but there are other issues specific to these contexts. For example, Scrimgeour & Scrimgeour (2008, p. 3) found that in urban areas Aboriginal population groups are 'heterogeneous…hidden and frequently mobile', which may make it difficult for Healthworkers to provide clients with effective and consistent follow-up care. Support for people requiring medical treatment who have to travel from rural to metropolitan locations where they have no family support or are unaware of the services available to them may also be a challenge for Healthworkers. Dwyer et al (2011, p. 1) observes that Aboriginal people from country areas who come to the city for treatment have 'complex patient journeys' that entail diverse needs, many of which are met by Healthworkers. One Healthworker describes an instance:

> *'I actually went to the [hospital] myself…on my own time and sat with her for the weekend and observed what they were actually doing for her, what benefit it was having for her health and her psychological and physical and spiritual, wellbeing, and acted as an advocate for her to the nurses. So I was sort of spending maybe 10 or 12 hours on the Saturday and Sunday' (in Dwyer 2011, p. 20).*

Organisational contexts is another aspect of Healthworkers' roles. This is principally in terms of and whether they are located in the Aboriginal community controlled or mainstream sector. The Aboriginal community health sector includes Aboriginal

community controlled health services and others that are controlled by state or territory health departments. Both types of service have a primary responsibility to deliver health treatment, and/or promotion and prevention programs to local Aboriginal communities. However, community controlled services differ in that they are initiated and operated by the communities through locally elected boards of management, to deliver holistic, comprehensive, and culturally appropriate health care to the community (National Aboriginal Community Controlled Health Organisation 2009). According to Scrimgeour & Scrimgeour (2008) a defining feature of services in the Aboriginal community controlled sector is their support for Aboriginal people's political struggle to gain control of their health. Fagan (1984) contends these services respond to community concerns and address health at both the individual and community level, thereby involving themselves in the wider concerns that impact on the community's health. Councillor (2003) notes they also provide access to culturally appropriate care and are a source of knowledge and expertise.

The first Aboriginal community controlled medical service was established in Redfern by a small group of activists in 1971 (Foley 1991). It was supported by volunteers and doctors with a shared understanding of Aboriginal community control, Aboriginal views of health, holistic health care, and provided access to affordable treatment in a culturally safe environment. The NACCHO (2011) reports there are now over 152 Aboriginal community-controlled health services in Australia, including forty two services across twelve rural and metropolitan regions in NSW based on a comprehensive primary health model of care. According to NACCHO (2009, p. 2) these services are the preferred model in the delivery of comprehensive primary health care to Aboriginal people across Australia. This is in contrast to services that provide selective primary health care or primary clinical care that is 'drawn from the biomedical model' and more likely to prioritise medical interventions and doctors for provision of and control of health services (Kelleher 2001, p. 57).

Aboriginal community controlled health services prioritise the employment of Aboriginal staff including Healthworkers as a key component of the healthcare team (Abbott et al 2008). Some Healthworkers in these services may perform a wide range of clinical procedures such as childhood vaccinations, Pap smears, venepuncture, and

health checks. The practice of others may entail activities such as drug and alcohol, family violence counselling or the implementation of health promotion activities such as quit smoking, healthy eating and exercise interventions.

Mainstream health services include hospitals, community health and other government and non-government health services, such as general practitioners, and specialist medical and health professional services. Services in this sector differ significantly from those in the Aboriginal community controlled sector. For example, they are not managed by the communities they service, they tend to prioritise biomedically based primary, secondary and tertiary medical treatment over holistic comprehensive primary healthcare and generally employ a lower proportion of Aboriginal staff (Murray et al 2003). Nevertheless, Australian Institute of Health and Welfare (2011) research shows that Aboriginal people receive the majority of their health care through this sector, in particular in public hospitals and community health services, but make comparatively low use of privately provided medical, pharmaceutical and dental services. Urbis Keys Young (2006) point out this pattern of use may not be by choice, but a consequence of limited alternatives. For example, in small communities with reduced health service infrastructure, Aboriginal people's only access to any kind of health care may be through the mainstream sector.

In the mainstream sector, Healthworkers are commonly employed in hospitals and community health centres in AHLO and AHEO roles where their practice often focuses on non-clinical activities such as advocacy, liaison, illness prevention, health promotion and interventions related to chronic conditions such as diabetes, and cardiovascular disease (Australian Institute of Health and Welfare 2010). Cunningham (2002) emphasises the importance of Healthworkers in the mainstream health sector and the key contributions they make to supporting Aboriginal patients some of whom experience higher rates of under-servicing than non-Indigenous patients with the same medical needs. However, as Taylor et al (2001, p. 127) reports these services tend to be dominated by non-Aboriginal bureaucrats and practitioners, and a 'Western management culture with its understandings of leadership, power, ways of communicating, planning and organising'. The Australian Health Ministers Advisory Council (2001, p. 3-5) also notes the power differentials between Aboriginal an non-

Aboriginal practitioners in mainstream services, and asserts that health services in Aboriginal communities are 'in danger of becoming racially segregated…where inevitably power is concentrated in the non-Aboriginal group of tertiary qualified health professionals'. According to Lloyd & Wise (2011), Healthworkers in some mainstream health services experience a lack of understanding, mistrust and restricted communication. In addition, Mitchell & Hussey (2006) note that in some of these services Healthworkers are not at the forefront of service delivery, but rather confined to performing semi-skilled activities such as client transport.

Fewer Healthworkers are employed in private medical services, although the Division of General Practice Program now includes Aboriginal 'Outreach Workers' in the national Close the Gap campaign to tackle chronic disease. These roles however are largely restricted to community liaison, administration, feedback and practical assistance to promote and support Indigenous people to access and attend health service appointments, rather than Healthworker roles (Department of Health and Ageing 2010).

The Australian Health Ministers' Advisory Council (2008), reports the underrepresentation of Aboriginal people in the health workforce may contribute to reduced health service access for Aboriginal people. The Australian Medical Association (2004), reiterates this claim and has predicted a shortfall of some 2000 Healthworkers. This poses a significant problem, particularly for Aboriginal people who may feel more confident disclosing information to Healthworkers, who they perceive as better placed to represent their interests than non-Aboriginal practitioners (Lowell 2001).

In an effort to 'strengthen access to culturally sensitive health care services' the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2007-2013, p. 7) proposes partnerships between mainstream and Aboriginal community controlled sector health services in many states and territories (National Strategic Framework for Aboriginal and Torres Strait Islander Health 2007-2013, p. 7). According to the Aboriginal Health & Medical Research Council of NSW (2012, p. 2) the partnership approach is based on the 'recognition of the unique role of the Aboriginal Community Controlled Health sector…as the foundation of achieving a

shared vision for Aboriginal health'. This stance is supported by the Victorian Aboriginal Community Controlled Health Organisation (Victorian Aboriginal Community Controlled Health Organisation 2013, p. 13), who specify that cross sectoral partnerships are essential 'for closing the gap in health equality and progressing reform'. They add, such partnerships can change cultural attitudes, improve communication, form strategic alliances and improve the engagement with mainstream services. The NSW Aboriginal Healthworker Project (NSW Ministry of Health 2012) highlights the key roles of Healthworkers in these partnerships, particularly in the provision of primary health care, and improvement of mainstream service provision to Aboriginal communities

2.3.2 Issues that impact on Healthworkers' roles and practice

Healthworkers' roles and practice are also impacted by a complex of issues. Various national reviews and reports have documented these (Curtin Indigenous Research Centre 2000, Aboriginal and Torres Strait Islander Health Workforce National Framework 2002, HWA Environmental Scan, Interim Report and Final Report 2011). Numerous smaller scale state based investigations also report on these issues (Tregenza & Abbott 1995, Clapham & Gosden 2001, Genat 2006, Townsend 2008, NSW Ministry of Health 2012, Hudson 2012). Two issues widely documented in the literature are divergent expectations of Healthworker roles and scope of practice, and variable levels of support (Jackson, Brady, Stein, 1999, Curtin Indigenous Research Centre 2000, Mitchell and Hussey 2007, Genat 2006, Hooper et al 2007, Health Workforce Australia Final Report 2011, Watson 2012). Curtin Indigenous Research Centre (2000) further identifies the lack of clarity regarding role definitions, unrealistic employer expectations, restricted involvement in policy and decision making, and inadequate preparation for roles. In addition to these, the Health Workforce Australia Final Report (2011) identifies that Healthworkers experience inconsistent respect and lack of recognition from other health practitioners and employers, variable education and training, and limited career pathways. Jackson et al (1999), and Mitchell & Hussey (2006) identified that in their experiences, blurred boundaries between professional roles and community affiliation were additional issues that had a negative impact on Healthworkers' roles. Finally the issues of racial discrimination, prejudice and stereotyping are discussed by a number of studies.

Lack of clarity

With regard to lack of clarity in roles, Genat (2006) reports that nurses and doctors often appear to have a limited understanding of Healthworker practice. Jackson et al (1999, p. 100) observe that 'many nurses have a lack of knowledge, in terms of understanding the roles and functions of Aboriginal Healthworkers', which lead to 'tensions' between Healthworkers and nurses. Mitchell and Hussey (2007, p. 529) also consider doctors and nurses are 'ignorant of the Aboriginal Health Workers' skills and abilities'. Genat (2006, p. 139) presents the perspectives of Family Care Healthworkers' who complained that 'their professional colleagues rarely grant them serious recognition as fellow professionals'. In this same study, Healthworkers also expressed annoyance that their colleagues perceived them as 'junior assistants' (Genat 2006, p. 25) and claimed that their practice is 'often contingent upon decisions of nurses and doctors' (Genat 2006, p. 139). Genat (2006, p. 142) cites a range of underlying reasons for this, including conflict between Healthworkers' broad client-centered holistic approach and the narrow medical model underpinning medical and nursing practice, and a general lack of understanding for Healthworkers' roles.

Autonomy

With regard to decision-making, Healthworkers complain about having only 'marginal input' while 'doctors and nurses plan and develop policy and programs without adequate understanding of either the community context or the Healthworker's role' (Genat 2006, p. 146). In the palliative care field, McGrath et al (2007, p. 434) also found Healthworkers 'were not valued', because 'the health system …is informed by a biomedical, clinical tradition [that] concentrated on nurses and doctors'. The National Rural Health Alliance (2006, p. 14) found that although Healthworkers are critical to healthcare provision, they 'faced a lack of integration and acceptance as essential members'. On the other hand, some Healthworkers do experience support from other health practitioners when the value of their roles is recognised. For example, Hooper et al (2007, p. 50) explored partnerships between occupational therapists and Healthworkers, and found that in some instances Healthworkers felt 'personally and professional valued [and] that professional partnerships, based on professional respect, are more common than they are reported in the literature'. Jackson et al (1999, p. 99) point out that some individual nurses and Healthworkers also have 'mutually respectful

relationships, but argue this is a consequence 'of the ethics and personalities of individuals rather than… sensitive and effective organisational or workplace policies'.

Expectations of others

With regard to expectations, Watson et al (2012) note that both services and communities may have unreasonable expectations of roles, with the result that Healthworkers' may experience inadequate support. Curtin Indigenous Research Centre (2000, p. 55) identifies differences in expectations of Healthworkers, with some expected to organise transport and accommodation, while others thought it 'detracted from their main role'.

With regard to preparation for their roles, Curtin Indigenous Research Centre (2000, p. 17) reports Healthworkers are sometimes 'expected to perform unrealistic tasks without the necessary education and resources'. The NSW Health Ministry (2012, p. 11) recognises the importance of education and training and suggests Healthworkers should be offered organisational support to undertake it. They also recognise that in mainstream services Healthworkers may need 'networking, coaching and mentoring' if they 'feel isolated from other Aboriginal Healthworkers', but propose that NATSIHWA and the Aboriginal Healthworker Forum are the appropriate organisations to provide it. However, an Aboriginal health workforce survey (Noetic 2012, p. 22) found that only '22% of respondents access a mentor in their workplace, but mostly informally'. In the NT, a review of Healthworker practice found that Healthworkers need organisational support to undertake training to avoid 'the lack of a structured professional development program [which] limits their career progression and can allow skills to become outdated and underutilised' (Ridoutt & Pilbeam 2010, p. 36). Townsend (2008) also highlights the role of ACCHSs in providing Healthworkers with support to complete the national training qualifications.

Recognition

Inadequate professional recognition is an issue with links to misunderstandings and variable levels of support, and is another 'continued source of stress' for Healthworkers (Mitchell & Hussey 2007, p. 529). The HWA Interim Report (2011, p. xviii) found that limited professional recognition for Healthworkers 'disempowers and demotivates…

thus limiting their potential'. The NRHA (National Rural Health Alliance 2006, p. 6) also suggests that inadequate recognition limits 'the development of nationally accepted standards of Healthworker practice'.

Hudson (2012) argued that Healthworkers in clinical roles should pursue nursing qualifications to achieve professional recognition. However this was strongly refuted by NACCHO (Media Release 30 March 2012) who argue that Healthworkers should be recognised for the 'significant role, value, expertise and contribution [they] make to their communities'. Felton-Busch et al (2009, p. 1) assessed the career aspirations of a small group of Healthworkers and found 'the majority indicated a preference for advancement to management or specialist areas as Aboriginal Health Workers', rather than to nursing or medicine.

The NRHA (National Rural Health Alliance 2006, p. 5) describes Healthworkers as a 'discrete health profession within the Australian health sector'. However, there is still some debate about whether Healthworkers' practice includes the elements commonly used to define a profession such as power, prestige, autonomy, self regulation and a high degree of systematic knowledge (Freidson 1983). Evatts (2003, p. 395), describes professions in more general terms as 'essentially the knowledge based category of occupations which usually follow a period of tertiary education and vocational training and experience'. Everingham and Irwin (2001, p. 212) propose that 'it is the emphasis on theory and its application that separates the professions from other skilled occupations' and that this is an issue which should 'be addressed in curriculum development and teaching'. Cusick (2001, p. 127) emphasises that 'mastery of a body of knowledge that is identified to be specialised in some way' is perhaps the most important of all the elements characterising a profession. She also argues that without this body of professional knowledge there can be 'no education program to prepare professionals, no unique practice, no special privilege, no community of colleagues who share similar approaches… no autonomy, as practitioners would have nothing on which to base day-to-day decisions about situations that confront them, other than their own common sense' (Cusick 2001, p. 127).

Genat (2006, p. 187) points out that Healthworkers lack professional recognition 'in most contexts' and cites literature linking the 'marginal status' of Healthworkers' practice to the variability of their education and training. The NT review considers Healthworker education and training 'is always likely to lag other professions in terms of prestige (if this is associated as it normally is, with length of training, type of qualification and type of academic setting)' (Ridoutt & Pilbeam 2010, p. 29). Making comments that are arguably as applicable today as they were a decade ago, Tsey (1996, p. 228) observes that although Healthworkers 'are increasingly expected to deal with complex and difficult problems, the rate at which they are acquiring professional skills as well as their levels of remuneration do not appear to be keeping pace with the rising expectation'. Health Workforce Australia (Health Workforce Australia Final Report 2011) acknowledges the lack of recognition for Healthworkers and the need to improve the quality and accessibility of education. It makes numerous recommendations including a review and update of ATSIPHC Training Packages, monitoring training providers, flexible training delivery and the promotion of traineeships and apprenticeships (Health Workforce Australia Final Report 2011).

One strategy to improve Healthworkers' professional recognition is the recent inclusion of those who are eligible, in the national registration and accreditation scheme for the health professions. Registration, which is governed by Health Practitioner Regulation National Law Act, is administered by the Australian Health Practitioner Regulation Agency (AHPRA) in partnership with the Aboriginal and Torres Strait Islander Health Practice Board (ATSIHPB).

Career structure

An ill-defined career structure is another issue linked to the professional recognition and education of Healthworkers. Curtin Indigenous Research Centre (2000, p. 142) reports that many Healthworkers had 'few options' or 'did not have access to relevant information and/or the necessary support to allow them to actively pursue any career possibilities'. The NSW Health Aboriginal Healthworker Project (NSW Ministry of Health 2012, p. 11) concurs there are 'restrictions for career progression and opportunities for further skills development'. Career advancement may be predicated on Healthworkers' undertaking a review to identify opportunities for skill and knowledge

devlopment. However, a NSW Aboriginal health workforce survey reported that in 2012 approximately only 49% of Healthworkers had participated in a performance development review. A proportion of these also considered such as review unhelpful for identifying and working towards their career goals (Noetic 2012, p. 17). Felton-Busch et al (2009, p 4-5) showed three barriers interfering with career progression: inadequate family and workplace support; limited infrastructure such as inadequate access to libraries and the internet, and the 'need to improve marketing, promotion and knowledge about opportunities for advancement'.

Role boundaries

Blurred boundaries between Healthworkers' professional roles and community affiliation are reflected in their 'complex lines of responsibility and different levels of accountability' (Jackson et al 1999, p. 100). One Healthworker sums this up as being 'answerable to the local people first, then family and also a Western health system' (Jackson et al 1999, p. 100). Blurred boundaries between professional and community responsibility may cause Healthworkers to experience a level of conflict that harms their 'sense of their own professionalism' (Mitchell & Hussey 2006, p. 530). Some Healthworkers describe experiences such as 'the load of community expectation [which] can be very tiring combined with the responsibilities of work and family', and not being able to 'go out after work and relax, as community members may want to unload their problems on us' (Mitchell & Hussey 2006, p. 530).

Another complicating factor is the tensions associated with managing close family connections that may spill over into the health service. Behrendt (2006) describes the strength of these connections and how they 'bind communities in a way that reinforces more traditional obligations but interweave more widely than they once did'. Mitchell and Hussey (2006) report these connections can sometimes can cause concerns about confidentiality and result in families discontinuing their use of health service. On the other hand, McGrath et al (2007, p. 435) points out that if mainstream workplaces do not understand Healthworkers' community connections and cultural obligations such as attending funerals, Healthworkers may 'end up pulling out of those jobs because it doesn't support that cultural side'.

Discrimination

Racial discrimination, prejudice and stereotyping experienced by Aboriginal people in education and workplaces is another critical issue likely to affect Healthworkers' practice. In education Plevitz (2007, p.68) argues that Aboriginal students experience the 'unintentional consequences of historical policies' resulting in indirect racial discrimination that affects their education. In their workplaces, an Australian Public Service Commission (2010, p. 40) employee survey found that in a 12 month period '27% and 17%' of Aboriginal people had respectively experienced bullying or harassment, and discrimination. This included 'humiliation, persistent or unjustified criticism, intimidating or aggressive body language, withholding information, threats, shouting and physical violence' (Australian Public Service Commission 2010, p. 42). Healthworkers identified similar experiences in their workplaces, including 'feelings of disempowerment, racial discrimination and exclusion' (Health Workforce Australia Interim Report 2011, p. 134). In her study of racism in the health workforce, Winsor-Dahlstrom (2000) also reported that Healthworkers experienced racism, negative stereotyping as well as horizontal and organisational violence from healthcare practitioner colleagues and others. Commneting on the nursing workforce, Jackson et al (1999, p. 98) state that there is 'a history of overt and covert racism in Australian nursing'. Gould (2001, p. 94), the first Aboriginal registered nurse in NSW, substantiates this, noting 'racism, prejudice, and discriminatory practices are alive and well in nursing and the health care system in general'. Healthworker participants in a study with Felton-Busch (2009, p. 4) agree, stating they would 'feel uncomfortable working in the hospital because of racism'. Moreover, a review of stress levels, wellbeing and burnout in the Aboriginal substance use workforce found that an absence of culturally appropriate support and racism were common experiences (Roche et al 2013). These are complex issues that cannot be overstated and should be explored. Parides et al (2008) are unequivocal about this stating further research is required to 'combat racism as a threat to Indigenous health in Australia'.

The literature in this section has reported a range of factors that may contribute to difficulties in Healthworkers' practice. A lack of clarity in Healthworkers' roles and scope of practice is linked to misunderstandings and divergent expectations by stakeholders, blurred community/professional boundaries, discrimination, and

inadequate recognition, remuneration and career pathways, all of which contribute to inadequate support in the workplace. Underpinning many of these factors is the issue of education pathways for Healthworkers, which may also offer a potential resolution for them. Central to this is a body of professional knowledge that defines Healthworker roles, on which education pathways and professional recognition can be built. Literature related to Healthworkers' education and training is discussed in section 2.5.

2.3.3 Defining Healthworkers' varied roles and scopes of practice

It is clear from the literature identified above that Healthworkers perform diverse roles and varied scopes of practice (Australian Institute of Health and Welfare 2010, Health Workforce Australia 2011, NSW Ministry of Health 2012, Victorian Aboriginal Community Controlled Health Organisation 2013). As Healthworkers' roles have expanded and diversified, the need to define them has grown. This section begins with literature that discusses this need. It includes recent Healthworker definitions, including the proposed national Healthworker definition (Health Workforce Australia 2011). Factors that complicate Healthworker role definitions are then surveyed, including a lack of clarity in Healthworker roles, great variety in Healthworker scopes of practice, and the need for a clear understanding of the terms 'role' and 'scope of practice'. Literature referring to a range of other issues that impact on Healthworkers roles is also reviewed. An alternative framework for defining Healthworkers' scope of practice is then proposed that will inform this study.

Since their inception, Healthworkers' roles and scopes of practice have been perceived as diverse. For example, twenty years ago, Saggers and Gray (1991, p. 406-408) reported 'variation in the role of Healthworkers, as well as an 'absence of a clearly defined career structure'. A decade later, the comprehensive national review of Healthworker training by Curtin Indigenous Research Centre (2000), noted that although Healthworker roles had changed and expanded, they were still 'diverse and complex' difficult to define and provided 'few options…in regards to pursuing career paths' (Curtin Indigenous Research Centre 2000, p. 141-142). Similar findings were reported by the recent Aboriginal and Torres Strait Islander Healthworker Project, completed by Health Workforce Australia (Health Workforce Australia Final Report 2011). Current definitions of Healthworkers' roles also show they are variously defined.

For example, the NATSIHWA (National Aboriginal Torres Strait Islander Health Worker Association 2012, p 6) constitution defines Healthworkers briefly in terms of their identity, qualifications and field of practice as:

> *'An Aboriginal and/or Torres Strait Islander person who is in possession of a minimum qualification within the fields of primary health care work or clinical practice'.*

In contrast, the NSW Ministry of Health (2005) defines Healthworkers in nominal terms and acknowledges that developing a definition 'has been the subject of long standing debate'. This definition which has not changed in nearly a decade states that an Aboriginal Healthworker is:

> *'An Aboriginal or Torres Strait Islander person, employed in an identified position in the NSW Public Health System and provides health services or health programs directly to Aboriginal people regardless of whether the person is employed in a generalist or specialist position. It encompasses all/any areas, irrespective of the award that covers employment of the worker'*

The Royal College of Nursing (2003) also recognises the difficulties associated with trying to define their profession, but notes that a definition is critical for naming, controlling, financing, researching, teaching and influencing public policy. Health Workforce Australia expresses a comparable view, stating that a consistent definition of Healthworkers will assist in clarifying Healthworkers' position titles, remuneration, training standards, qualifications and career pathways (Health Workforce Australia Final Report 2011). However it also warns that such a definition is likely to exclude those Healthworkers who cannot meet its criteria (Health Workforce Australia Environmental Scan 2011, Health Workforce Australia Final Report 2011).

Current definitions of Healthworkers are so broad as to only provide a vague, general and non definitive outline of their roles, without any indication of the specific types of activities included in their practice or what constitutes a minimum qualification. Moreover the definitions provide very little information regarding the diversity of Healthworkers roles or their varied scopes of practice. As the NSW Ministry of Health reports definitions which remain unclear, negatively affect Healthworkers' 'ability to

perform in their role and have an understanding of the purpose of their work' (NSW Ministry of Health 2012, p.10). The lack of clarity expressed by current Healthworker definitions is also likely to perpetuate the misunderstandings that many other health practitioners have about Healthworkers' roles.

2.3.4 Towards a national definition of Healthworkers

Health Workforce Australia (2011) conducted an in-depth project exploring the Healthworker workforce including Healthworkers' roles, scope of practice, education and the many associated issues identified above (Health Workforce Australia Final Report 2011). Amongst its goals the project sought to i) 'inform the development of policies and strategies which will greatly strengthen and sustain the Aboriginal and Torres Strait Islander Healthworker workforce into the future', and ii) 'inform the requirements for national registration and accreditation of Aboriginal and/or Torres Strait Islander Health practitioners' (Health Workforce Australia Environmental Scan 2011, p. 1).

Three key publications documenting the Health Workforce Australia project's activities include the Environmental Scan, Interim Report and Final Report. The Environmental Scan (Health Workforce Australia 2011) presents information and data about 'Healthworker specific issues including: definition, scope of practice and role' (Health Workforce Australia Environmental Scan 2011, p. 1). The Interim Report presents analyses of information from the Environmental Scan, while the Final Report synthesises findings and presents a series of recommendations. Together these publications make a seminal contribution to the literature about the definition of Healthworkers, their roles scope of practice and education.

The Environmental Scan (Health Workforce Australia 2011) reiterates Curtin Research Centre (2000) findings that Healthworkers are variously defined across different government departments, agencies and Healthworker associations. It also notes that within these jurisdictions, definitions are often dependent on 'the workplace and context in which Healthworkers provide services (Health Workforce Australia Environmental Scan 2011, p. 75). This may result in discrepancies in the way terms are applied. For example, in some jurisdictions different terms may be applied to Healthworkers

performing the same roles, whereas in others, the same term may be applied to Healthworkers in different roles. There are also discrepancies in regards to the education qualifications that are specified in definitions. For example the Northern Territory Department of Health definition specifies a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice), whereas Western Australia Health specifies a Certificate III Aboriginal and Torres Strait Islander Primary Health Care (ATSIPHC). A further discrepancy between NACCHO and Queensland Health definitions and those of other organisations is that the former specify the Cultural Respect Framework and primary health care as components of Healthworkers' roles (Health Workforce Australia Environmental Scan 2011, p. 76).

The absence of a national definition of Healthworkers led Health Workforce Australia to canvass the views of stakeholders (Health Workforce Australia Interim Report 2011, p. 15). The aim was to develop a 'working definition' which included three components: Aboriginal and or Torres Strait Islander identity, an Aboriginal and Torres Strait Islander primary health care qualification and a culturally safe and holistic approach to health care (Health Workforce Australia Interim Report 2011, p. 54). Further extensive consultation resulted in the 'first nationally agreed definition' of a Healthworker as a person who:

> *'a) identifies as an Aboriginal and/or Torres Strait Islander and are recognised by their community as such, AND*
> *b) is the holder of the minimum (or higher) qualification in Aboriginal and Torres Strait Islander primary health care AND*
> *c) has a culturally safe and holistic approach to health care'*
> *(Health Workforce Australia Final Report, 2011, p. 23).*

The Final Report (Health Workforce Australia 2011) notes this definition is deliberately broad to ensure its applicability to as many Healthworkers in the current workforce as possible. While the definition does not specify a minimum qualification, the NATSIHWA recommends a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (National Aboriginal and Torres Strait Islander Health Worker Association 2013). However, the Final Report also notes that qualifications must be responsive to 'changing education levels and qualification priorities for the workforce'

(Health Workforce Australia Final Report 2011, p. 24). Importantly, it acknowledges that Healthworkers perform in a dynamic policy context which may result in future changes to the definition (Health Workforce Australia Final Report 2011).

The development of a national definition of Healthworkers (Health Workforce Australia Final Report 2011) is an important achievement but still presents problems. For example, it does not specify the context dependent nature or diversity of work performed by Healthworkers. It also excludes Healthworkers without accredited qualifications, or qualifications less than the specified Certificate III Aboriginal and Torres Strait Islander Primary Health Care (ATSIPHC). Furthermore, the definition does not refer to registered Healthworkers who are formally titled 'Aboriginal Health Practitioners' (Aboriginal Health Workforce Development Unit 2012, p. 6). These problems may further exacerbate the confusion about the differences that exist between Healthworkers' roles and scopes of practice across contexts. In particular, the absence of references to the differences between Healthworkers and Aboriginal Health Practitioners could result in perceptions that unregistered Healthworkers may be less capable than their Practitioner colleagues.

Compared to the proposed 'nationally agreed definition' of Healthworkers, the definition of Aboriginal Health Practitioners is more detailed. For example, it specifies a higher level primary health care qualification in clinical practice, first aid, professional experience and recency of practice as requirements for registration. The Aboriginal and Torres Strait Islander Health Practice Board of Australia (2013, p 3) considers these extended criteria are a necessity, as registration is 'a way of ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered'. For the purpose of registration, the Practice Board (2012) therefore defines Aboriginal Health Practitioners as:

> *'being Aboriginal; identifying as an Aboriginal and accepted as an Aboriginal person in the community in which they live;*
> *having a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice);*
> *having a current first aid certificate that includes cardio pulmonary resuscitation;*

having practiced in their profession between July 2002 -30 June 2012, for a consecutive 5 years or an equivalent period of time;
having a minimum 500 hours of clinical practice in the profession'
(Aboriginal and Torres Strait Islander Health Practice Board of Australia 2012).

This definition includes more specific requirements, such as a first aid certificate and cardiopulmonary resuscitation, however it still avoids any mention of Healthworkers' diverse roles or varied scopes of practice. Moreover the definition is restricted to recognising Healthworkers who have a qualification with a clinical care focus but omits identifying those with the equivalent qualification in community care. Again this has the potential to result in an ongoing lack of clarity regarding the parameters of Healthworkers' roles.

2.3.5 Defining the terms 'role' and 'scope of practice

The lack of clarity regarding how Healthworkers' roles and practice are defined is well recorded (Curtin Indigenous Research Centre 2000). The literature variably applies the term 'role' to identify and/or describe a) the general characteristics of Healthworkers' positions, and b) the activities they perform (Curtin Indigenous Research Centre 2000, Health Workforce Australia Final Report 2011, National Aboriginal and Torres Strait Islander Health Worker Association 2013). In other literature the terms 'role' and 'scope of practice' are often used interchangeably. For example, The Environmental Scan and Interim and Final Reports (Health Workforce Australia 2011) the terms are sometimes used in the same sentence without being clearly distinguished. The Interim Report (Health Workforce Australia 2011, p. 51) asserts that 'elements of the Healthworker scope of practice that are performed most frequently across Australia are: culturally safe health care roles [and] prevention and health professional roles'. It also identifies 'key roles that contribute to the broader scope of practice'. These include: 'the level of complexity of clinical roles [and] areas of specific primary health care or clinical focus' (Health Workforce Australia 2011 Interim Report, p. 51. These same 'key roles' are also described as 'key elements of the Healthworker role that contribute to the definition of the scope of practice' (Health Workforce Australia Interim Report 2011, p. 53). The Final Report (Health Workforce Australia 2011, p. 11) differentiates

Healthworkers' roles as: 'clinical, complex and acute care roles…roles that focus mainly on health promotion programs and cultural brokerage activities [and] varying roles depending on the employer'. It then defines Healthworkers' scope of practice in terms of 'activities and tasks' (Health Workforce Australia Final Report 2011, p. 77). A comparable description by NATSIHWA (2013) focuses on key components of Healthworkers' roles, in terms of the activities they perform as:

> *'clinical and primary health care for individuals, families and community groups. They deal with patients, clients and visitors to hospitals and health clinics. They also assist in arranging, coordinating and providing health care in Aboriginal and Torres Strait Islander community health clinics'.*

This presentation of Healthworkers' roles and scopes of practice is unclear. Further exacerbating this lack of clarity is the varied use of the terms in other literature. For example, Curtin Indigenous Research Centre (2001), considers Healthworkers' roles in terms of key characteristics and activities. It describes role characteristics as: I) being at the forefront of service provision to Aboriginal people, ii) integrating 'Western and Indigenous ways of working to deliver culturally appropriate health care', and iii) work 'that is always driven by community needs' (Curtin Indigenous Research Centre 2000, p.14). Examples of specific activities are: 'clinical procedures…counselling, program development and health service management' (Curtin Indigenous Research Centre 2001, p.16). Clapham and Gosden report that in their research, Healthworkers themselves described their roles in terms of the activities they performed such as 'health promotion, education, translation, liaison, counselling advocacy, lobbying, transport' (Clapham & Gosden 2001, p. 17). Genat (2006, p. 10) on the other hand applies the term 'role' to refer more generally to Healthworkers' workplace positions, and the term 'practice' to the range of activities they perform.

The lack of clarity between the use of the terms 'roles' and 'scopes of practice' in the literature contributes to the confusion about the activities Healthworkers perform in varied contexts. If the use of terms was made more explicit it would clarify the boundaries between Healthworkers varied roles and those of other practitioners and support the articulation of the activities that Healthworkers are qualified to perform. Genat (2006) concurs that it would reduce the ambiguity and confusion that is often

associated with the Healthworker field. This is particularly important in view of the part that ambiguity may have in contributing to Healthworkers' stress, limiting their professional recognition, the development of their roles and their contributions to healthcare provision. The following section explains this study's application of the terms.

For the purposes of this study, the term 'role' is applied to Healthworkers' occupational titles, as well as the general categories of work they perform. Examples of Healthworker titles commonly used include Aboriginal Hospital Liaison Officers (AHLO), Aboriginal Health Education Officers (AHEO), Alcohol and Other Drug Workers, Aboriginal Health Practitioners and/or Program Managers. Examples of general work categories include Healthworkers as 'clinicians, family support workers, health promotion officers, cultural mentors, researchers and managers' (Abbott et al 2008, p. 159). This use of the term also draws on Biddle's (1986) concept of 'role' as encompassing the 'patterned and characteristic social behaviours, parts or identities that are assumed by social participants, and scripts or expectations for behaviours that are understood by all and adhered to by performers' (Biddle 1986, p. 68). From this perspective, individual Healthworkers may be differentiated from each other by their various roles in different organisational contexts, but they are also members of a group with a shared Aboriginal identity.

The HWA acknowledges that Healthworkers' consider their Aboriginal identity central to the effectiveness of their roles. This is reflected in the nationally agreed definition of a Healthworker, which states s/he 'identifies as an Aboriginal or Torres Strait Islander person as recognised by their community' (Health Workforce Australia Final Report, p. 23). Healthworkers' Aboriginal identities accord them the skills and knowledge that arise from a shared understanding of community members' culture, life histories, experiences, health and health outcomes. Giblin (1989) reports that in the United States Indigenous Healthworkers exemplify the social and environmental ethnic qualities of their communities. Moreover they share a 'verbal and non-verbal language, an understanding of their communities' health beliefs, barriers to health care services, and an enhanced empathy with, and responsibility toward a communities and its health service needs' (Giblin 1989, p. 361).

Townsend (2008, p.12) also notes that Aboriginal identity is central to Healthworkers' roles, 'working in a culturally safe manner, providing cultural respect and maintaining the traditional and contemporary protection of Aboriginal and Torres Strait Islander communities'. This focus is consistent with the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004 -2009 (Australian Health Ministers' Advisory Council 2004, p. 6), which highlights that 'culture and identity are central to Aboriginal perceptions of health and ill-health'. In a compelling address to the 1999 National Healthworkers' Conference, Marjorie Gilmour a Healthworker from the Northern Territory aptly describes the significance of Aboriginal identity to Healthworkers' roles, saying:

> *'… it is Aboriginality that links us all together. We are Aboriginal Healthworkers – not just Healthworkers…As Aboriginal health professionals we are part of the community, but as Aboriginals we are community…We see things and we know things are going on in our communities long before non-Aboriginal media, politicians, powerbrokers know. We should be able to bring that knowledge into our work scenario because we as health professionals within the local community have a sense of responsibility that is Aboriginal. If we don't then we fail as Aboriginal Healthworkers to put the stamp of Aboriginality upon our working responsibilities …it is our duty' (Gilmour 2000, p. 9)*

The term 'scope of practice' is commonly referred to in conjunction with Healthworker roles. However, whereas roles are Healthworkers' workplace positions, their scope of practice is the healthcare tasks and procedures they perform (Health Workforce Australia Final Report 2011). This definition draws on the Queensland Nursing Council definition of nurses scope of practice (Health Workforce Australia Final Report 2011, p. 76). According to the Council nurses 'scope of practice' is the activities that a healthcare practitioner is 'educated, competent and authorized to perform' (Queensland Council of Nursing 2008, p.3). The Council also notes that practitioners' scope of practice is influenced by the 'context in which they practice; clients' health needs; level of competence, education and qualifications…and service providers' policies' (Queensland Council of Nursing 2008, p.3).

This definition suggests that nurses' scope of practice is a technical term with legal implications to ensure practitioners only perform activities they are qualified and officially certified to undertake. In regards to Healthworkers the term may be interpreted more broadly and has no legal implications except in the Northern Territory, where the 'requirement is to be registered with the NT Aboriginal Health Worker Board' (Riddout & Pilbeam 2010, p. 25). The introduction of national registration in 2012 means the Aboriginal and Torres Strait Islander Health Practice Board has assumed responsibility for all Healthworker registrations. However, to date only small numbers of Healthworkers in other states (except in the NT where it remains mandatory for practice) are choosing this option (Aboriginal and Torres Strait Islander Health Practice Board Communiqué 2013, p. 3).

2.3.6 Mapping Healthworkers' scope of practice

As a component of the recent review of the Healthworker field, a broad 'conceptual map' representing a national Healthworker scope of practice was developed (Health Workforce Australia Interim Report 2011, p. 78). Based on stakeholders' feedback, this map, specifies three elements including: i) culturally safe healthcare, ii) primary health care, and iii) areas of specific focus. These are further separated into 'elements which group similar types of activities' (Health Workforce Australia Interim Report 2011, p. 78). The 'culturally safe health care domain' has three elements classified as 'client, community development and health services' (Health Workforce Australia Interim Report 2011, p. 80). The 'client' element includes specific activities related to 'patient advocacy, communication and support'. The 'health service element' includes activities that 'make health services culturally safe and aware (Health Workforce Australia Interim Report 2011, p. 290). The 'community development' element includes activities focused on 'community wellbeing and development affecting social determinants of health' (Health Workforce Australia Interim Report 2011, p. 290).

After its development, this 'conceptual map' was used to survey how frequently Healthworkers performed activities within each domain. Survey results shown in Figure 1 reveal variations represented by the diagram's different shades of blue. The darker the blue the more frequently Healthworkers performed those activities.

Figure 1 Map of Healthworkers' scopes of practice (Health Workforce Australia Interim Report 2011, p. 80)

As illustrated in Figure 1,the activities Healthworkers performed most frequently involved providing clients with 'direct cultural support' in the 'culturally safe health care domain' (Health Workforce Australia Interim Report 2011, p. 290). In contrast, activities associated with child and maternal, sexual, women's/men's health or acute and emergency management in the 'areas of specific focus domain' were performed least frequently of all.

The map provides a useful depiction of the frequency and complexity of activity elements in Healthworkers' practice. Its structure implies definable boundaries between domains and elements whereas other descriptions of Healthworker practice, particularly those in the Aboriginal Community controlled sector present Healthworkers practice as an integrated system. For example, Healthworkers Mitchell and Hussey (2006, p. 529) describe their Aboriginal Community Controlled Health Service (ACCHS) practice as holistic, and dynamic because it commonly entails having to juggle the multiple, social, emotional and medical needs of clients and communities and being 'everything to everyone'. Similarly Abbott et al (2008) describe their broad scopes of Healthworker practice as entailing clinical care, health education to support clients with chronic diseases, health promotion, leadership, advocacy and the cultural mentoring of non-Aboriginal health practitioners.

Genat's (2006, p. 14) study of Family Care Healthworkers in an urban ACCHS also describes Healthworker practice as 'myriad demands and pressures' from clients and other health practitioners and encompassing multifaceted activities. These include 'welfare services, clinical monitoring, making appointments, recording client statistics, counseling, organising social visits, personal care assistance, transport, advocacy, referral, rehabilitation support, paramedical assistance, hospital visits, palliative care, shopping and liaison with other sections of the Aboriginal Health Service and other service providers' (Genat 2006, p. 12).

The NATSIHWA's (2013) descriptions of Healthworkers' scope of practice reflect a similarly broad range of activities, which it lists as:

- *The treatment of disease or injuries; maintaining health records and statistics.*
- *Acting as communicator and interpreter on behalf of clients and other health workers*
- *Taking part in case management and follow up, either independently or with other health care providers.*
- *Providing health education to individual clients and health staff.*
- *Providing cultural education to people outside the cultural community.*
- *Providing life skills education, counselling and referral for crisis intervention in the community they serve.*
- *Providing input into the planning, development, implementation, monitoring and evaluation of all health programs in the community, and carrying out administrative duties including budgeting and correspondence.*

(National Aboriginal &Torres Strait Islander Health Worker Association 2013)

The elements of Healthworkers' practice depicted by NATSIHWA are in keeping with NACCHO's comprehensive primary health care framework (National Aboriginal Community Controlled Health Organisation 2011, p. 55). NACCHO describes this framework provides:

> *'the sound structure to address all aspects of health care arising from social, emotional and physical factors…In addition to the provision of medical care, with*

its clinical services treating diseases and its management of chronic illness, it includes such services as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary support services' (NACCHO Constitution 2011, p. 54).

The elements of NACCHO's framework are clearly aligned with Healthworkers' various comprehensive primary health care roles and scopes of practice. In clinical roles for example, Healthworkers' scope of practice generally entails clinical activities focussed on 'treating diseases and… management of chronic illness' such as diabetes and cardiovascular disease. By contrast in other community care type roles such as those performed by AHEOs, practice may entail activities such as 'counselling, preventive medicine, health education and promotion'.

In 2012 NATSIHWA and Health Workforce Australia published the Aboriginal and Torres Strait Islander Health Worker Professional Practice Framework (2012). The framework, which aims to provide Healthworkers with 'guidance on what is expected of them on a day to day basis in their role', refers to five domains of practice (Health Workforce Australia 2012, p. 3). These include: 'providing culturally safe health care, delivering health care in a holistic manner, caring for the community, leading and developing self and others and practicing in a professional and ethical way' (Health Workforce Australia 2012, p. 7). Like the framework from which it was derived, (see Figure 1) the Professional Practice Framework provides a comprehensive depiction of Healthworkers' scope of practice. However, because the framework was only published after I had completed the data analysis it has not been considered in any detail in this study.

2.4 Healthworkers' education and training

The second domain that I suggest is a component of the Healthworker field is Healthworkers' education and training. Healthworker education and training has developed in tandem with Healthworkers' expanding roles and scope of practice (Saggers & Gray 1991). Its development continues to be dynamic and subject to change. The literature discussed in this section is therefore a discrete snapshot that traces key

changes and the issues they raise. Four phases can be distinguished, starting with informal programs, basic nurse aide training, followed by accredited state based vocational Healthworker training, and national Healthworker competency standards. Despite these developments, problems with Healthworker education continue to be identified, alongside Indigenous education in general.

2.4.1 Development of Healthworker education

In its early stages firstly in the NT, Healthworker education primarily comprised a collection of informal, individualised programs ranging from 'on-the-job training to full-time year-long courses' (Saggers & Gray 1991, p. 163). Programs which were specifically for Healthworkers were unaccredited and usually designed and delivered in-house by health services according to their needs and those of Healthworkers and communities. An example of one program required Healthworkers to reside at a training centre and attend lessons for one week in every six. Instruction, provided by nurses and doctors was in English and included 'basic health, community nursing skills, literacy and numeracy' (Mosley & Turner 1979, p. 29). Healthworkers could also nominate topics such as diabetes, diarrhoea, dehydration, nutrition, respiratory problems, ear infections, accidents and injuries, dental health, skin infections, snake bites and pregnancy (Mosley & Turner 1979). Training included visits to the hospital, Royal Doctor Service (RFDS), aged care facilities and activities such as making posters, studying slides and films and learning how to 'read and write…tell the time,…count, add and subtract' (Mosley & Turner 1979, p. 31). In addition, trainees reciprocated by teaching their non-Aboriginal instructors about 'bush medicines and traditional methods, as in the use of native plants for inhalations for colds' (Mosley & Turner 1979, p. 30).

In contrast NSW offered Healthworkers a two-year 'basic nurse aide training' that enabled them to be 'enrolled as trained nurse aides and trained community health workers' (Nemarluk et al 1979, p. 27). The program which had no pre-requisites, avoided formal lectures but provided 'inservice numeracy and literacy…on-the-job training sessions…a learning by doing approach [and] clinical experience in a hospital approved by the Nurses Registration Board for approximately 26 weeks over the 2 year period' (Nemarluk et al 1979, p. 27).

Efforts to address these variations in Healthworker education resulted in various improvements. One significant improvement was the introduction of accredited state based vocational Healthworker training largely provided through the Technical and Further Education (TAFE) system. Examples of programs included, the Certificate in Aboriginal Studies in SA (Buckskin 1987), the NSW Drug and Alcohol Advanced Certificate (Dwyer 1989) and Queensland Health's Certificate in Aboriginal and Torres Strait Islander Primary Health Care (Smith 1992). The AIHWJ (Aboriginal & Islander Health Worker Journal 1990) also reports the development of an accredited Certificate in Health Science (Aboriginal Community Health) by the NT, Batchelor College. According to the Australian Skills Quality Authority (ASQA), accredited programs are those that can be formally recognised, meet established industry or community needs, provide competency outcomes and assessment guidelines and result in a qualification aligned to the Australian Qualifications Framework. Accredited Healthworker training programs formalise the level of skills and knowledge Healthworkers need to perform specific sets of healthcare activities in different settings. They also provide consistency of qualification standards and are a foundation for Healthworker career pathways.

Another improvement was the development and endorsement of national Healthworker competency standards, which became 'the basis for all accredited Healthworker training in the vocational education and training sector' and provided Healthworkers who completed them with a nationally recognised qualification (Aboriginal and Islander Health Worker Journal 1997, p. 22). The vocational education and training sector (VET) continues to provide most Aboriginal and Torres Strait Islander Primary Health Care programs and Healthworker qualifications (Health Workforce Australia Interim Report 2011, p116). Additional developments include an articulated vocational Healthworker qualification pathway, a limited number of specialist Healthworker university undergraduate and post graduate qualifications and short courses that focus on skills specific to a particular specialised aspect of Healthworkers practice. Short courses enable skills and knowledge to be updated and or extended, but are generally non-accredited and do not lead to a formal academic qualification. Examples of short courses in specialty areas include emotional and social wellbeing, diabetes, fetal alcohol syndrome, immunisation, sexual health and cardiovascular health (Healthinfonet 2013).

2.4.3 Vocational Healthworker education

Vocational Healthworker education has been formalised in a national qualification framework, consisting of Certificate and Diploma level qualifications. There a many benefits to formal vocational Healthworker education programs. These include the links such programs have with the healthcare industry, increasing access to courses, articulation between courses at different levels, staged course structure that enables Healthworkers to build their skills through the completion of core units of study followed by a suite of electives to suit their needs, flexible study options that may include online distance programs and specialised study support. However, vocational courses also present some drawbacks such as their limited availability, mismatches between entry requirements and course demands, and in some cases inadequate academic support and preparation of Healthworkers.

2.4.4 The Healthworker vocational qualification framework

The Healthworker vocational qualification framework was developed by the Community Services & Health Industry Council (CS&HISC), in accordance with the Australian Qualifications Framework (AQF), the 'national system of qualifications in Australia' (Australian Qualifications Framework Council 2013, p. 9). The framework includes Certificates I, II, III, IV, Diploma and Advanced Diploma in Aboriginal and Torres Strait Islander Primary Health Care. These qualifications constitute part of the national Health Training Package HLT07, illustrated in Figure 2 (Health Workforce Australia Final Report 2011, p. 113).

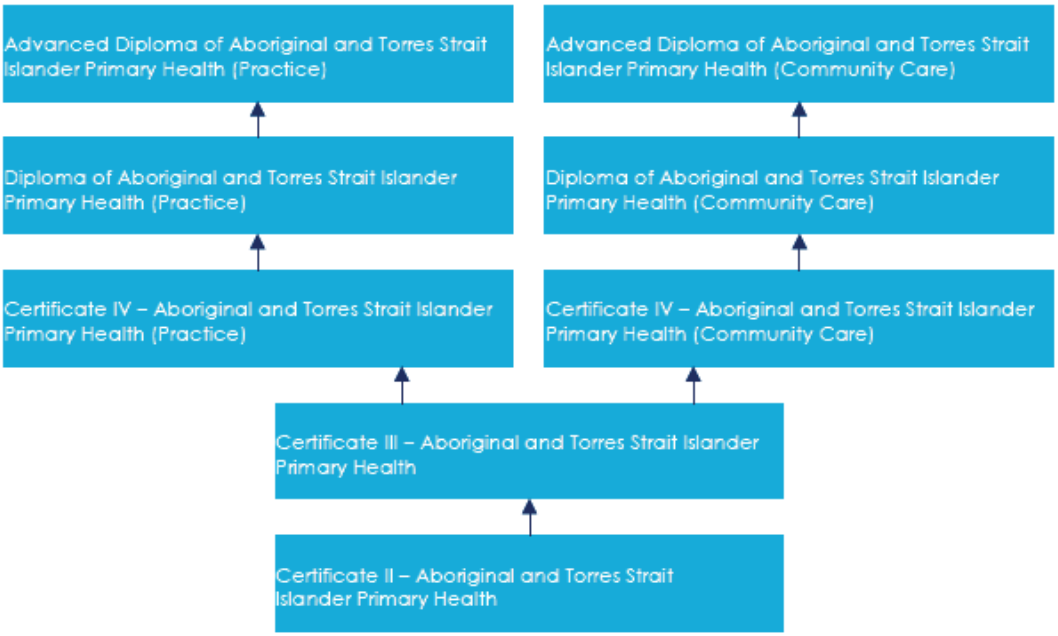

Figure 2: Current CS&HISC Healthworker qualifications framework (Health Workforce Australia Final Report, p. 113)

Each qualification is associated with an ATSIPHC Training Package, which is 'an accredited complete program of learning that leads to formal certification that a graduate has achieved learning outcomes as described in the AQF (Australian Qualifications Framework 2013, p. 92). The AQF specifies differences in the purpose, types of knowledge, skills, application and volume of learning required for individual qualifications at different levels (Australian Qualifications Framework 2013). Certificate II qualifies Healthworkers to 'undertake mainly routine work'. Certificate III qualifies Healthworkers 'who apply a broad range of knowledge and skills in varied contexts to undertake skilled work' (Australian Qualifications Framework 2013, p. 14). The Advanced Diploma qualifies Healthworkers 'who apply specialised knowledge in a range of contexts to undertake advanced skilled or paraprofessional work' (Australian Qualifications Framework 2013, p. 15).

The Health Training Package HLT07 guides the delivery of the ATSIPHC qualifications. It describes each qualification as a set of core and/or elective units of competency that Healthworkers need, to achieve that level of qualification. Units of competency include three components: elements, performance criteria and assessment criteria. Elements define the essential outcomes of a unit, while performance criteria specify the level of performance needed to demonstrate achievement of the element, and

assessment requirements outline the 'essential skills and knowledge and their level' that must be demonstrated to effectively show the task outlined in elements and performance criteria can be achieved (Community Services & Health Industry Skills Council, HLTAHW302B, p. 3-5). Education providers use these components to develop their own curriculum materials, pedagogy and assessment strategies which are not included in the health training package.

The ATSIPHC training packages at Certificate II and III levels include a set of core units. Certificate IV and Diploma levels include both core and elective units. Core units are mandatory and may be common to more than qualification. The ATSIPHC Certificate III (HLT33207) comprises 13 core units and one elective. Five of the core units are also core in the Certificate IV. The Certificate IV (HLT40213) and Diploma (HLT50213) in ATSIPHC Practice also include units that result in a qualification that has more of a clinical focus than either the Certificate IV ATSIPHC (HLT40113) or the Diploma in ATSIPHC (HLT50113).

There have been recent changes to this content in both streams. The ATSIPHC Practice Certificate IV, has increased from an overall total of 13 to 21 units. These include 14 core units such as 'administer medications, assess clients' physical wellbeing and deliver primary health care programs for Aboriginal and/or Torres Strait Islander communities' (Community Services & Health Industry Skills Council, 2013, HLT40213 p. 3). The ATSIPHC Community Care stream (HLT40113) has recently increased from an overall total of 14 to 21 units. This includes 14 core units such as 'plan, develop and evaluate health promotion and community development programs, assess and support social and emotional wellbeing and address social determinants of Aboriginal and/or Torres Strait Islander health' (Community Services & Health Industry Skills Council 2013, HLT40113 p. 3). Elective units at Certificate IV and Diploma levels enable course content to be tailored according to Healthworkers' and/or their employers' needs. Units that comprise a particular skill set needed to fulfil a specialist function may also be selected. Skill sets may build on qualifications but in themselves are not equivalent to a full qualification. Core units in the ATSIPHC Certificates III and ATSIPHC (Practice) and ATSIPHC Certificate IV are listed in the Appendix. While this provides Healthworkers with the option to pursue a clinical or

non-clinical pathway it may also present a potential dilemma in terms of their holistic practice, which can encompass both clinical an non-clinical activities. This is discussed further in Section 2.4.6 below.

Individual ATSIPHC qualifications are articulated so each is linked to that which precedes and follows it. Consequently, each additional level of qualification signals a corresponding expansion of skills and knowledge, autonomy and practice. According to the AQF this assists students to 'move easily and readily between different education and training sectors and between those sectors and the labour market and…gain recognition for their prior learning and experiences' (Australian Qualifications Framework 2012, p. 9). This may be an advantage for Healthworkers in terms of facilitating their access to education by providing optional commencement levels and a range of recognised education pathways.

Currently there are limited opportunities to enrol in ATSIPHC courses in NSW. The HWA Final Report (2011, p. 45) also reports 'a low ratio of qualified trainers for the number of students currently undertaking ATSIPHC courses'. At the time of writing only three of the eight courses are running at two of the 130 NSW TAFE campuses (Dubbo and Orange Campus, Western Institute TAFE). These include Certificates III and IV in ATSIPHC (Community Care), while Certificate II is available as a TAFE-delivered vocational education and training (TVET) program in some schools. A wider range of qualifications are offered at two Aboriginal RTOs, some by distance education (Australian Indigenous Healthinfonet 2013). A number of RTOs indicated that course availability is dependent on demand (Aboriginal Health & Medical Research Council 2012). For example, the Aboriginal Health College of NSW was delivering the Certificate III ATSIPHC, Certificate IV ATSIPHC Practice but no Certificate IV, Diploma or Advanced Diploma in either the Practice or Community Care streams at the time of writing (Aboriginal Health College of NSW 2011). According to the College, 70 students graduated in 2011 with Certificate III, IV, Diploma and Advanced Diploma qualifications but it did not specify which these specific courses were (Aboriginal Health & Medical Research Council of NSW 2012).

Nationally, there is also a considerable variation in the proportions of Healthworkers who hold healthcare qualifications. A survey by HWA reports that in a survey of 351 Healthworkers 60% had an ATSIPHC vocational qualification, 21% did not indicate any form of qualification, and 5% had 'another type of qualification such as nursing or social work' (Health Workforce Australia Interim Report 2011, p. 114). The proportion of ATSIPHC qualified NSW Healthworkers is considerably lower, with 44% reporting an ATSIPHC certificate level qualification, but no data specifying those with university degrees (Health Workforce Australia Interim Report 2011, p. 115). According to Noetic Solutions (2012, p. 3), only '23.7% of [NSW] Healthworkers have completed the Certificate IV ATSIPHC', which is the minimum mandatory qualification for formal registration.

2.4.5 Benefits of vocational education and training

The literature describes a number of benefits and drawbacks to vocational training (McInnis et al 2000, Beddie et al 2013). Benefits include the links between the vocational education and healthcare industry, the sector's capacity to provide practitioners with skills development, assist with access, course articulation, staged course structure, flexible study options, and specialised support for Aboriginal students.

Beddie et al (2013, p.12) reports that one benefit of vocational education and training is its links to industry. In the context of Healthworker training, these links are between CS&HISC, the body responsible for the development and review of ATSIPHC training packages, and organisations which represent Healthworkers and health services, such as NACCHO and the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN). The feedback and advice these industry stakeholders provide to CS&HISC is that ATSIPHC training packages provide Healthworkers with the skills and knowledge that need to effectively perform their roles. Such advice lead to a recent CS&HISC review of Certificates III and IV ATSIPHC (Practice and Community) and recommendations 'to ensure they target the objective, focus on industry and provider needs and are responsive to Commonwealth reforms' (National Aboriginal Community Controlled Health Organisation 2012, p. 40).

Another benefit is that the vocational sector directly provides skills development to practitioners. For Healthworkers at the front line of healthcare delivery in Aboriginal communities, skills development is likely to strengthen standards of practice and service provision, thereby contributing to Aboriginal health outcomes. The National Aboriginal and Torres Strait Islander Workforce Strategic Framework (2011-2015) endorses the revised Healthworker training packages. In addition it supports the 'national registration and accreditation of Aboriginal Health Practitioners and the development of a national Aboriginal Healthworker scope of practice' neither of which are possible without a ATSIPHC vocational Certificate IV qualification (Aboriginal Health Ministers' Advisory Council 2011, p. 7).

The accessibility of vocational education is a benefit for students seeking to study Healthworker courses, including its open entry conditions, affordability and articulation pathways. Access is facilitated by the absence of specified entry requirements and the lack of prohibitive fees such as those required for university. The Productivity Commission (2011, p. 87) finds that the 'affordability and accessibility of VET study are especially important to VET students from disadvantaged groups'. Access is also facilitated by the staging and articulation of qualifications, enabling Healthworkers to commence study at a level commensurate with their current skills and knowledge and to exit at a qualification level they choose. This stepping stone approach encourages the progressive development of skills, knowledge and self esteem. In addition, articulation between vocational and university courses may provide students with an incentive to progress to graduate qualifications and make the education system easier to navigate (Moodie 2012). This would also provide more flexibility so education could be matched to employment opportunities as they arose (Moodie & Curtin 2008).

Flexible course design, content and the study mode of some Healthworker vocational training has been found to result in positive outcomes for Aboriginal students (O'Callaghan 2005). McInnes et al (2000) reports that tailoring courses may make a difference as to whether students complete them. The Aboriginal Torres Strait Islander Health Registered Training Organisation National Network highlights the importance of flexible, accessible and culturally appropriate education opportunities and states that Aboriginal health RTOs are best at providing these (Aboriginal Torres Strait Islander

Health Registered Training Organisation National Network 2011). Flexible course design may enable Healthworkers who have experience but no qualifications to align their existing skills and knowledge with course units, and just complete those they need to gain the qualification. In addition, flexible content enables qualified Healthworkers who need additional skills specific to their scope of practice, to just complete the particular skill sets they require. Flexible study modes such as traineeships, full or part-time, block attendance, distance or on campus programs promote access and are particularly important as many Healthworker courses include mature aged students who also work and have family responsibilities.

Specialised study support, particularly for Aboriginal students, facilitates student wellbeing and outcomes. Study support includes dedicated Aboriginal study centres in mainstream RTOs, Aboriginal staff and tailored support programs such as academic skills workshops and tutorial assistance. McGlusky &Thaker (2006) report that where this type of support is provided, successful outcomes are achieved. Miller (2005, p. 8) also finds that Aboriginal ownership and involvement in training has been shown to be the single most important factor in achieving positive outcomes. This may be more easily achieved by Aboriginal controlled RTOs that have direct relationships with Aboriginal communities, respect for community control, cultural priorities and values, and an understanding of education and training needs (Aboriginal & Torres Strait Islander Health Registered Training Organisation National Network). According to ATSIHRTONN the understanding that Aboriginal RTOs have of the health, history and experiences of Aboriginal communities makes them particularly appropriate for providing Healthworker training programs that include:

- *the social determinants of health and effects of colonisation*
- *racism in the health system and its impact on Healthworkers and community members*
- *primary health care and Aboriginal views of health*
- *barriers to education*
- *strategies to provide Healthworkers with opportunities to 'update professional capabilities and…build sound career pathways' (Aboriginal & Torres Strait Islander Health Registered Training Organisation National Network 2012, p. 3).*

2.4.6 Drawbacks of vocational education and training

Despite the advantages of current vocational Healthworker courses they also present some drawbacks. These include the limited availability of courses, entry requirements that do not reflect course demands, inadequate academic support, and inadequate preparation for workplace demands.

The limited availability of Healthworker courses, outlined above, severely restricts access for people who do not live close to the RTOs that offer them. This is a particular obstacle for those seeking entry into the Healthworker workforce, and/or wanting to upgrade their skills and knowledge. Moreover it contravenes over a decade of national and state recommendations highlighting the importance of strengthening Healthworker education (Standing Committee on Aboriginal and Torres Strait Islander Health 2002, National Rural Health Alliance 2006, National Aboriginal & Torres Strait Islander Health Council 2008, Health Workforce Australia Final Report 2011). The extent of work that is still required in this area is reflected in a recent survey of 351 Healthworkers, which showed that '21% did not indicate they had any form of qualification (Health Workforce Australia Interim Report 2011, p. 114).

The minimal entry requirements of vocational courses is an advantage to some Healthworkers but can also present problems for students with inadequate preparation, such as confining them to lower levels of study. Research data shows that a high proportion of Aboriginal students (43.4%) enrol in AQF Certificate I and II level courses compared to non-Aboriginal students (25.3%) (Department of Education Employment and Workplace Relations 2008, p. 89. In addition, Aboriginal students are more likely to be mature aged compared to non-Aboriginal students (Behrendt et al 2012). In regards to tertiary education, data also shows that 19.5% of Aboriginal students compared to 8.8 % of all non-Aboriginal students had no educational attainment prior to commencement, placing them at particular disadvantage (Department of Education Employment and Workplace Relations 2008, p. 109). This suggests that literacy or numeracy skills are also likely to be inadequate for the independent learning that tertiary education usually demands. Admittance of students with limited literacy or numeracy skills to courses that do not provide academic support can be a barrier to 'positive outcomes' (O'Callaghan 2005). It may also may be a

contributing factor to VET completion rates, which are lower for Aboriginal students (Behrendt et al 2012, Department of Education Science & Training 2006).

Inadequate academic support, varied study loads and methods such as distance or block release may disadvantage Healthworker students, particularly if their prior academic preparation is limited. Moodie and Curtin (2008) note that subject completion rates differ according to a number of criteria such as students' prior educational attainment, socio economic status, the location and size of the RTO, study load (full time/ part time) and study method such as on campus, work based, distance education. This is pertinent for distance courses which are often selected by Healthworkers who juggle work, family and community commitments. For example, one distance Healthworker course is described by the organisation that offers it as based on 'a kind of Aboriginal learning style' and a view that 'Aboriginal people learn more from doing'. However the only academic support it provides is written feedback on assignments and a 1800 phone number for tutorial support (What Works, The Work Program 2013). While this might improve students' access to education and be adequate for those with the high levels of discipline and motivation needed for independent study, it may not be sufficient for students who have been inadequately prepared for this course delivery style.

Another issue is that vocational courses may not adequately prepare Healthworkers for their holistic roles across different contexts. The ATSIPHC Certificate IV and Diploma qualifications for example, do not include clinical units of study, yet Healthworkers with this qualification who have non-clinical roles may still have to provide clients with information regarding clinical aspects of their care. Taylor et al (2009, p. 553), reported that Healthworkers in a hospital cardiology ward felt 'undertrained' particularly in regards to 'the expectation of explaining complicated medical procedures to patients'. Genat (2006, p. 135) cites doctors and nurses who are critical of Healthworkers 'incomplete training', and who advocate 'a more systemic understanding of the body…to interpret clinical data…more practical training in a structured and supervised environment, and more exposure to the training of other professionals'. Moodie and Curtin (2008, p. 7) note more generally that vocational education 'has under-developed roles in preparing graduates for a career in their chosen occupation let alone for citizenship, and for further education'.

The quality and consistency of Healthworker vocational training has been an issue for some time (Curtin Indigenous Research Centre 2000, Health Workforce Australia Final Report 2011). Health Workforce Australia's Final Report (2011, p. 43) draws particular attention to the 'substantial variation in the quality of courses' and the 'fast tracking' of some students who may not complete all the units of study they need to fulfil their roles. While the introduction of training packages are designed to address this, there are still some concerns that courses are being tailored to suit the needs of employers rather than to meet qualification standards (Hudson 2012).

In sum, the literature shows that the Healthworker vocational qualification framework potentiates an explicit articulated pathway of qualifications at Certificates I, II, III, IV, Diploma and Advanced Diploma levels, although the variability in access remains an issue. The benefits of vocational courses include their links with the healthcare industry, their focus on skills development, course articulation, staged course structure, flexible study options, and specialised support. Drawbacks include limited availability of courses, mismatches between entry requirements and course demands, and inadequate academic support and preparation of Healthworkers. An understanding of these benefits and drawbacks can be applied to evaluating course content, structure, and delivery of vocational Healthworker courses, and to students' experiences. This study seeks to explore Healthworkers' views about their experiences of vocational education courses, what skills and knowledge they acquire, the extent to which they influence their capacity to effectively perform various roles and scope of practice and whether they consider a vocational pathway facilitates their engagement in further education.

2.4.7 University qualifications

University programs undertaken by Healthworkers include a limited range of undergraduate and postgraduate health degrees, certificates and diplomas that have been designed 'specifically to address the need for further and formal qualifications for Healthworkers' (Health Workforce Australia Interim Report 2011, p. 119). These programs are generally only available to Aboriginal students. Mainstream university programs such as nursing, medicine or allied health are also an option for Healthworkers. A review of the literature referring to Aboriginal students in mainstream university programs is beyond the scope of this study. However it is important to note

that such mainstream programs are not generally informed by Aboriginal comprehensive primary health care views of health and are not designed with Healthworker practice in mind. Furthermore Murray and Wronski (2006, p. 38) note 'the number of Indigenous students entering undergraduate health courses has been disappointing'

Health Workforce Australia (2012) reports Healthworkers are 'overwhelmingly positive' about 'improved access to further learning and development opportunities' (Health Workforce Australia Final Report 2012 p. 101), and consider 'a Certificate lV qualification as a minimum requirement' for their roles (Health Workforce Australia Final Report 2012, p. 101). But Health Workforce Australia also reports that in their survey of 351 Healthworkers, only 18% of the group intended to study at a diploma or undergraduate degree level and this was in another health professional stream such as nursing, social work or medicine. Moreover many were concerned about the lack of funding and organisational support to pursue training (Health Workforce Australia Final Report 2012, p. 102).

A significant barrier to Aboriginal Healthworkers achieving university level qualifications is the overall limited participation of Aboriginal students in higher education. Gray & Beresford (2008, p. 197) report that one issue associated with this is the lower levels of school achievement and academic literacy, both of which are a legacy of generations of discriminatory school education 'aimed variously at segregation and marginalisation'. Pechinkina, Kowal et al (2011) also note 'low levels of Indigenous students' academic readiness and aspirations'. According to Murray and Wronski (2006, p. 38) there are multiple factors that limit the involvement of Aboriginal people in university courses, such as 'educational disadvantage, poverty, remoteness and negative experiences at school'. They exemplify the consequences of these experiences, reporting for example that 40% of Aboriginal students compared to 12% of non-Aboriginal students did not reach the national reading benchmarks in 2001 (Murray and Wronski 2006). Other literature notes that a complex and interrelated range of broad historical and current policy and practice issues are associated with the continuing inequitable educational outcomes experienced by Aboriginal people (Mellor, Corrigan 2004, Gray & Beresford 2008). One solution to improving Aboriginal

students' participation in university has been the development of direct entry and tertiary preparation programs for mature age students. Although a number of Healthworker specific university courses are offered, the availability of these courses is currently extremely limited. The shortage of Healthworker specific university programs reflects the lack of clarity and recognition of Healthworkers as an autonomous profession with a defined knowledge base.

2.4.8 Participation in higher education

The literature provides incomplete statistical data about Healthworker participation in higher education making definitive descriptions of the field difficult. However, national data (Australia Bureau of Statistics 2011, p. 1) shows that in general Aboriginal people are under-represented in university courses, and that 'relatively few Aboriginal adults continued on to complete a Bachelor degree or above'. For example, 5% of Indigenous adults compared to 24% of non-Indigenous adults are likely to have attained a Bachelor degree or higher (Australia Bureau of Statistics 2011, p. 2). In addition, the Productivity Commission (2010) reports attendance rates for university and TAFE are lower for Aboriginal people than non-Aboriginal people. The ABS (Australia Bureau of Statistics 2010) reiterates this, noting that only 6% of Aboriginal people compared to 25% of non-Aboriginal people aged 18-24 years attend university, while attendance rates in the 25-34 age group are 3% and 7% respectively. Interestingly, attendance rates for people aged 35 years and over were similar for each group.

At a national level, Hossain et al (2008, p. 10) report that Aboriginal student university enrolments 'continue to decline', except in health fields where enrolments 'remained stable' (National Aboriginal Torres Strait Islander Health Council 2008, p. 23). In 2006, the proportion of Aboriginal students enrolled in university health programs represented 1.1% of all students in health, with many in nursing and public health (National Aboriginal Torres Strait Islander Health Council 2008, p. 34). However, completion rates for these courses were considerably lower for Aboriginal students compared to non-Aboriginal students (National Aboriginal Torres Strait Islander Health Council 2008 p. 25). James (2007, p. 5) notes that 'the retention of Aboriginal students in higher education, is particularly challenging as evident in the 'university completion rate [which] remains well below 50%'.

At a state level, these differences are evident in health workforce data. In NSW for example, a survey of the Aboriginal health workforce found that of 447 respondents, 29% had university qualifications, compared to 52% with a TAFE qualification (NSW Health Workforce Development 2008, p. 10-13). Although the survey included all Aboriginal health practitioners, the results still suggests the proportion of Healthworkers with university qualifications is likely to be low. This is despite recommendations that Healthworkers should have 'ongoing training and education and continual upgrading of clinical skills…and the same access…available to their non Indigenous colleagues' (Aboriginal & Islander Health Worker Journal 1997, p. 3).

2.4.9 Academic literacy

Literacy requirements for the successful completion of university programs are a particular issue. Behrendt et al (2012, p. 18) report 'a consistently wide gap in literacy and numeracy between Aboriginal and Torres Strait Islander and non-Indigenous students'. The impact of inadequate literacy skills on pathways to higher education is well documented. Thasker (2006, p. 12) for example reports that it 'is a significant barrier to Indigenous students accessing and successfully completing VET courses' and therefore even more likely to hinder their participation in higher education.

There is very limited literature about academic literacy in relation to Aboriginal students in Healthworker courses. In my experience in the vocational and university sectors I have come across two generally polarised views. One the one hand some argue that literacy should be explicitly taught as in integral component of curriculum and assessment procedures and that this should be at a level that prepares Healthworkers to function as equal members of professional healthcare teams. Others advocate that curriculum and assessment should be flexible and rely less on written tasks and more on oral and visual presentations to support Aboriginal students. These arguments are apparent in the broader literature about Aboriginal students in higher education. In suport of the latter view Biermann and Townsend-Cross (2008) advocate 'pedagogy embedded in Indigenous philosophy' which they suggest should include field trips, group based assessment, artwork and class discussion. Nakata et al (2008, p. 139) also cites a number of studies indicating a 'preference for hands on, practical learning over

theory based learning' in some Aboriginal specific university courses. By contrast and in support of the former view, Tsey (1996, p. 228) argues Aboriginal students training to be Healthworkers receive 'mixed messages' when they are lead to believe they can be competent health practitioners but not necessarily literate. Curtin Indigenous Research Centre (2000, p. 56) is also unequivocal about the importance of literacy to Healthworkers, stating that programs which 'do not emphasise literacy and numeracy skills' make 'access to higher education…more difficult'. This is supported by reports showing that many Aboriginal students who enter tertiary programs without literacy or academic discourses have difficulty participating effectively (Rose et al 2003, p. 42).

The literature notes that Aboriginal students need academic-literate discourses to provide them with access to vocational and professional training (DiGregorio et al 2000, Rose 1999, Rose et al 2003). Lester (2000, p. 22) describes literacy as 'a fundamental underpinning skill for effective participation …and a clear foundation for lifelong education training and subsequent employment'. According to Harris et al (2012, p. 129), many Aboriginal students find 'the current emphasis on written communication in undergraduate assessment, while perhaps necessary is not second nature'. This may pose a particular challenge in tertiary courses at higher AQF levels that are applicable to Healthworker' practice where proficiency in medical, science and humanities discourses is a requirement. King and Sinn (1999, p. 21) report that Healthworkers participating in a university diabetes health educator course found academic literacy was a specific problem, and in particular struggled with an 'unfamiliarity with medical terminology' and 'not knowing how to write an academic essay'. McGlusky et al (2006, p. 25) report that although Aboriginal students highly value literacy and numeracy skills the support they are given to acquire them in the vocational sector 'remains inadequate'.

Research into Aboriginal students' experiences of university and factors impacting on their participation and completion has identified a number of issues such as curriculum, pedagogy, institutional support structures and connections between the institution and students' communities (Farrington, DiGregorio, Page 1999, Malcolm & Rochecouste 2003, Howlett, Seini, Mathews, Dillon, Hauser 2008, Nakata 2008). Less attention appears to have been given to the association between Aboriginal students academic success and the disciplinary language and knowledge necessary for achieving at

university (Malcolm & Rochecouste 2003). This is despite research showing that skills including academic literacy are a contributing factor that affects Aboriginal students' participation, satisfaction and completion of university courses (Widin 2010). The issue of academic literacy must be addressed to ensure that Healthworkers are effectively supported to achieve a university level health care qualification if they so choose.

2.4.10 Direct entry and tertiary preparation

The development of direct entry programs and/or tertiary preparatory programs has been one strategy to provide Healthworkers with an alternative pathway into undergraduate mainstream health programs. For example, the *Yapug* program at the University of Newcastle is a 12-month full time 'tertiary preparation program' that supports Aboriginal students to qualify for entry into undergraduate degrees including health science, medicine, science and social sciences (University of Newcastle 2013). However no university, currently offers these programs as a direct pathway to Healthworker specific degrees. Direct entry programs are usually provided through universities with Aboriginal centres, which also provide services such as student support, tutorial assistance, scholarships and dedicated study spaces.

Some universities also collaborate with RTOs to develop formal pathways into undergraduate Aboriginal specific and mainstream programs. For example, students completing an Advanced Diploma at the NSW Aboriginal Health College may be eligible to enrol in the Bachelor of Health Science in Indigenous Health Studies at the University of Wollongong (UOW). Similarly, students may complete a Diploma of Community Welfare Work as a path into the Bachelor of Social Work at Charles Sturt University (CSU). Although these pathways provide access to university courses Healthworkers' participation in them is not well documented, largely due to the 'lack of a national data collection method' (Curtin Indigenous Research 2000, p. 22).

2.4.11 Healthworker specific courses

Currently in NSW only UOW and the University of Sydney deliver Healthworker specific graduate and post-graduate courses. At UOW, courses include the Bachelor of Health Science in Indigenous Health Studies, and the Graduate Certificate and Master of Indigenous Health. These courses are open to both Aboriginal and non-Aboriginal

students. The content of the courses is described as 'community health, community development, cultural issues, comparative Indigenous health issues and Indigenous health research' (University of Wollongong 2013). At the University of Sydney in the School of Public Health, courses include a Graduate Diploma in Indigenous Health Promotion (GDIHP) and Graduate Certificate (12 months), Graduate Diploma in Indigenous Health-Substance Use (GDIHSU) and Master in Indigenous Health-Substance Use (MIHSU). The GDIHP aims to teach students the skills and knowledge needed for 'identifying community needs and strengths, developing a plan of action, putting it into practice, and evaluating it to identify the extent to which positive changes have occurred' (University of Sydney, Graduate Diploma in Indigenous Health Promotion 2013). These courses are open to Aboriginal students. The Indigenous Health (Substance Use) degrees aim to 'build the clinical, public health and academic capacity of Indigenous health professionals to prevent and treat harm associated with alcohol, tobacco and other drugs in the Indigenous community' (University of Sydney, Indigenous Health -Substance Use 2013). Both the health promotion and substance use courses, entail a combination on-campus week long, intensive workshops supplemented by printed and online teaching materials and variable hours of home/work based learning tasks.

These courses have had positive outcomes with 75 Aboriginal graduates from the GDIHP, and 40 graduates from the GDIHSU and MIHSU, between 2008 -2012 (personal communication). A specialist post-graduate Aboriginal diabetes course at Flinders University also reports positive outcomes including that Healthworkers found it supported their competence as health professionals and benefitted their practice (King et al 2012). The benefits of these healthcare courses are multiple. Importantly, their focus on both theoretical knowledge and practical skills ensures that Aboriginal graduates are equipped for specialist scopes of practice that entail managing the complex health issues affecting their communities not just at the coal face but also at the level of policy development. Secondly, situating Aboriginal Healthwork in the higher education sector validates it as a defined field of professional practice informed by a distinct body of knowledge. This strengthens the fields' knowledge base and provides opportunities for further knowledge production dissemination and theory development. Thirdly, Healthworker courses that lead to a university qualification are accorded a level

of professional recognition and respect equivalent to other courses such as nursing or social work. Unsurprisingly, a number of Healthworkers who graduate from these courses, report that they experience a level of professional recognition and respect equivalent to other healthcare university graduates in their workplaces (personal communication).

2.4.12 Course availability

Despite the likelihood that higher education qualifications would provide Healthworkers with greater career and articulation options there appears to a limited availability in opportunities for advanced Healthworker university courses. Health Workforce Australia (Health Workforce Australia Interim Report 2011, p. 119) notes that only a 'small number of tertiary institutions provide higher education relating to the area of Aboriginal and Torres Strait Islander Healthworker practice'. In addition, there is a much wider range of advanced practice courses available to nurses and allied health practitioners, compared to courses for Healthworkers which are more narrowly focused on subjects such as substance use, mental health and health promotion. Furthermore there has been an overall decline in specific Healthworker courses. For example in NSW the University of Sydney has disbanded the former School of Indigenous Health Studies and discontinued its preparatory, undergraduate and post graduate Healthworkers courses in Health Science (Aboriginal Health & Community Development). At CSU, the Bachelor of Health Science (Mental Health) has shifted from a focus on preparing Aboriginal students to training non-Aboriginal students 'to work competently as a mental health worker within their own communities and mainstream mental health services' (Charles Sturt University Handbook 2013).

The limited availability of Healthworker courses may be an issue that hinders Healthworkers participation in higher education. Marginson and Considine (2000, p. 36) note universities are under increasing financial and governance pressures where 'economic choice is at the centre of decision making'. Consequently, some universities may consider the provision of higher levels of student support commonly required in Aboriginal specific programs too expensive, and that a more cost effective approach is to support enrolments into mainstream programs such as nursing or allied health. There may also be a view that Healthworker practice does not differ significantly enough from

nurses to require a dedicated university program. Hudson (2012, p. 23) argues the clinical components of Healthworker training match those in enrolled nursing, 'a broader and more widely recognised qualification…which could provide a clear pathway to further studies, such as a degree in nursing'. However nursing degrees are quite distinct in terms of their biomedical approach to healthcare and are not a surrogate pathway for Healthworkers whose practice is based on more holistic, comprehensive primary health care approaches. Furthermore, many Healthworkers when asked about study options are quite clear about a preference for their roles compared to those of nurses.

The limited availability of opportunities for advanced university education appears to contradict recommendations for strengthened Healthworker education pathways (National Aboriginal & Torres Strait Islander Health Council 2008), and dedicated degrees in key Aboriginal health priority areas (Council of Academic Public Health Institutions Australia 2012, Behrendt et al 2012).

2.4.13 Professional practice and higher education

An issue associated with limited course availability is the lack of clarity, understanding and recognition for Healthworkers' roles and practice. This lack of clarity and recognition in turn makes it difficult to ascertain what a university Healthworker curriculum might include and to argue for the development of such programs. Currently, it appears that Healthworker education is not informed by disciplinary knowledge boundaries that reinforce notions of professional autonomy as it is for most other health professions (McNair 2005 p. 456). Rather, the location of Healthworker education primarily in the vocational sector means that it leans towards a focus on the skills Healthworkers need to perform specific activities associated with their roles and varied scopes of practice. Flow-on effects are twofold. Firstly, without access to a university qualification to inform their practice, Healthworkers are denied opportunities to develop the disciplinary knowledge that would contribute to their professional recognition. Secondly, Healthworkers cannot engage in university-based research about their roles and practice, a process which would also contribute to their development as distinct professional practitioners.

In sum, many Healthworkers aspire to higher education qualifications, but low levels of participation of Aboriginal students in higher education, and associated issues of school achievement and academic literacy levels have been barriers to that ambition. Direct entry and tertiary preparation for mature age students have helped to alleviate these problems, alongside university courses specifically designed for Aboriginal Healthworkers. However availability of these courses is extremely limited, and has actually fallen, despite recommendations for increasing access. The growth of Healthworker specific university programs is important for the development of a defined knowledge base for Aboriginal Healthwork, which is linked to the recognition of Healthworkers as an autonomous profession.

2.4.14 Critiques of Healthworker education

Despite recent improvements in the educational outcomes of Aboriginal students evidence shows there are continuing disparities between Aboriginal and non-Aboriginal people across all education sectors (Department of Health and Ageing 2012, Department of Education, Employment & Workplace Relations 2008, Department of Families Housing, Community Services & Indigenous Affairs 2013, Biddle & Cameron 2012). Factors contributing to these disparities include the complex interplay of historical factors such as intergenerational and socio-economic disadvantage and the different forms of discrimination and/or racism that many Aboriginal students experience in education settings (Gray & Beresford 2008, Sonn et al 2000). For Healthworkers another factor may be the 'limited opportunities available in relation to entry-level or post-graduate univerity courses' which prevents their access or interfere with their progress and completion of courses (Health Workforce Australia Environment Scan 2011, p. 114). Other factors that may impact on Healthworkers'entry into and completion of a university education include: financial obstacles, geographic remoteness, family obligations, low literacy and mumeracy and course content and/or that is perceived to be culturally inappropriate (Health Workforce Australia Environment Scan 2011). In addition, Curtin Indigenous Research Centre (2000, p. 63) reports that in regards to Healthworkers, specific factors also include the perception amongst some, that higher level qualifications are not necessarily relevant to their roles, a lack of articulation between vocational and university courses and a need for 'consistency of award courses at higher education institutions'.

The national review of Healthworker training undertaken by Curtin Indigenous Research Centre (2000) criticised aspects of Healthworker training. It noted that adhoc planning, coordination and distribution of courses, training that varied from on the job training to formal vocational and university based courses and inconsistent training standards and curricula were all issues. The review recommended improvements to the planning, coordination, flexibility and quality of courses, and their contribution to Healthworkers' professional development. The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2002 also identified the need to 'improve vocational education and training sector support for training Aboriginal and Torres Strait Islander Healthworkers' (Standing Committee on Aboriginal and Torres Strait Islander Health 2002, p. 8). Health Workforce Australia (Health Workforce Australia Final Report 2011) notes that changes are needed to address the barriers that continue to hinder Healthworker education and training and thereby the Healthworker workforce. They also argue that clearer and improved Healthworker education standards and career pathways are essential for the development of the Healthworker workforce and strengthening its capacity to make a positive impact on Aboriginal health outcomes (Health Workforce Australia Final Report 2011). The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015 makes no recommendations specifying Healthworker education, although it does recommend 'support for national registration and accreditation' of Healthworkers which has a minimum education requirement for a vocational Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Australian Health Ministers' Advisory Council 2011, p. 7). Individual states also acknowledge that improving Healthworker education and training will strengthen the Aboriginal health workforce (Kalunga Research Network 2010, Queensland Health 2009). Health Workforce Australia (Health Workforce Australia Final Report 2012, p.42) reaffirms the need for improvements to Healthworker education and recommends a 'review and update [of] the competency standards and qualifications in the Health Training Package, to ensure Healthworkers are prepared to meet evolving community needs'.

In sum, Healthworker education has developed from informal, on the job, and basic clinical skills programs, to accredited vocational education supported by national

competency standards. However, as noted by both Curtin Indigenous Research Centre (2000) and Health Workforce Australia (2011), problems persist with access, relevance of content, consistency of standards and articulation between vocational and university level qualifications.

2.5 Connections to family and community

The third domain that I suggest is a key component of the Healthworker field is Healthworkers' connections to their families and communities. These connections, which arise from Healthworkers' experience as members of their families and communities, afford them a critical set of knowledge and skills that they bring to their roles. In addition, Healthworkers' Aboriginal identity is recognised as essential to their work by statutory definitions such as Health Workforce Australia (2011), the Aboriginal and Torres Strait Islander Health Practice Board (2013) and the National Aboriginal and Torres Strait Islander Health Worker Association (2012).

Healthworkers' experience as members of their communities gives them an in-depth knowledge of their communities' histories, membership, issues and concerns. This knowledge is a key factor in their deep understanding of their communities' health needs and social determinants of health. As a result they are often better placed than their non-Aboriginal colleagues to manage the health issues of Aboriginal communities and their members (Health Workforce Australia Interim Report 2011, p. 101).

Healthworkers' community experience also provides them with unique skills in communication, cultural brokerage, interpreting and advocacy, and a unique set of values to their professional roles, including a commitment to working for the well being of the community and for social justice. One Healthworker summed this up as 'we care. We are family. We want to make a difference' (Health Workforce Australia Interim Report 2011, p. 71). In most cases Healthworkers are also recognised by their communities as trustworthy, approachable and empathetic, as people they could disclose their problems to, and ease their access to the health system.

On the other hand, Healthworkers' close family and community connections also pose a challenge to their roles and practice. Their commitment and sometimes obligations to

their communities, and their communities' expectations of their roles, may make it difficult for Healthworkers to delineate the boundaries between their personal and professional lives. For example, in a situation where the community is dealing with the loss of a loved one, Healthworkers may well be expected to provide counselling and support at the same time as they must manage their own grief. Situations such as this often create physical and emotional stress for Healthworkers that they must manage as part of their practice. In addition, the knowledge and skills that derive from Healthworkers connections to their families and communities may also pose a problem in terms of being formally recognised. For example, Nakata (2008, p. 143) notes that Aboriginal students attending university bring their own knowledge and experiences but 'it is not well represented in the disciplinary knowledge base or course content'.

Despite evidence that 'Indigenous peoples are the most researched group in history' (Rigney 2001, p. 7), there is no literature exploring the contributions that Healthworkers' Aboriginal identities or family and community connections make to their healthcare roles and practice. However, an increasing number of Aboriginal scholars are debating topics such as Aboriginal identities, knowledges and philosophies and their contribution to the ' multi-layered problematic of knowledge production' (Rigney 2001, p. 9). These topics constitute a specialised disciplinary field in social science research, the exploration of which is beyond the scope of this study. Never-the-less, this study views Healthworkers' Aboriginal identities, community and family connections and the knowledge and skills that derive from them as integral to their roles and practice. This is in respect of the few descriptions of Healthworkers' roles published by Healthworkers themselves (Mitchell & Hussey 2006, Abbott et al 2008)

2.6 Conclusion

The literature reviewed in this chapter highlights the dynamic nature of Healthworkers' roles and scopes of practice, and their educational pathways in vocational and higher education. The review began with evidence that Healthworkers' roles may have links to women's healing and caring roles in traditional Aboriginal societies, as well as cultural brokerage roles in the colonial period, and assistant roles in the period of segregated Aboriginal healthcare. It surveyed the emergence of Healthworkers' roles in mainstream and community controlled health services, and the increasing diversity of these roles.

Literature describing the current Healthworker field was then reviewed. This included an outline of policies impacting on Healthworkers' roles and practice, followed by an in-depth examination of literature in four domains that I suggested could be applied to the description of the Healthworker field. This included: 1) Aboriginal health status, 2) Healthworkers roles and practice, 3) Healthworkers education and training and 4) Healthworkers' connections to their families and communities. A range of topics in each of these domains was reveiewed. In the first domain Aboriginal health status was compared to that of the non-Aboriginal population to show that Healthworkers are faced with providing care to communities where there are higher rates of morbidity and mortality. In the second domain, Healthworkers' varied roles and practice across a range contexts were described. The discussion covered the complex of issues including clarity of roles, involvement in decision making, expectations of health services and communities, preparation for roles, professional recognition, boundaries between professional and community roles, discrimination and stereotyping. This was followed by a discussion of struggles over definitions of Healthworkers' roles and scope of practice and the development of a national definition. The terms 'role' and 'scope of practice' were then reviewed and clearly defined. This section cloncluded with a map of Healthworker prcatice as proposed by Health Workforce Australia.

The literature in this domain set the context for reviewing literature on Aboriginal Healthworker education. This section began with the development of Healthworker education from informal programs, to accredited vocational and university education, followed by critiques of Healthworker education as it is currently provided. Vocational Healthworker education was then surveyed in detail, focusing on the current Healthworker vocational qualification framework, including Certificates III, IV and Diploma qualifications. Evaluations of benefits and drawbacks of vocational Healthworker education in the literature were then reviewed. Benefits included industry links, skills development, course articulation, staged course structures, flexible study options, and specialised support. Drawbacks were associated with availability of courses, entry requirements and course demands, academic support, and preparation of Healthworkers. University education for Healthworkers was then surveyed, beginning with the context of low participation rates of Aboriginal students in higher education, the problems of school achievement and academic literacy, and the responses of direct entry and tertiary preparation for mature age students. University courses designed for

Aboriginal Healthworkers were then reviewed, alongside the problem of limited availability for these courses. Finally, the critical role of Healthworker specific university programs in defining the body of knowledge that constitutes Aboriginal Healthworkers, and thus their identity as an autonomous profession, was briefly addressed.

The literature shows that Healthworkers fulfill diverse generalist and specialist roles in a wide variety of health care programs across a range of community and organisational contexts. Consequently, Healthworkers' roles and scope of practice which vary widely, but generally focus on the provision of comperhenisve primary health care that may include clinical, community and program management activities. Furthermore, Healthworkers experience significant obstacles that impact on their day-to-day practice and long term career advancement. However, despite these challenges and irrespective of differences between their individual roles, all Healthworker practice necessarily includes client-centered activities and cultural brokerage. These roles are founded on social justice and a culturally safe, secure and respectful health care approach (Curtin Indigenous Research Centre 2000, Murray et al 2003, Genat 2006, Health Workforce Australia 2011). Importantly, they are also often informed by Healthworkers' local understandings, cultural knowledge and experiences gained from their own families and communities (Health Workforce Australia Final Report 2011, The Royal Australian & New Zealand College of Psychiatrists 2012, NSW Health 2014).

However the literature also suggests that there may be gaps in our understanding of the intersection between Healthworkers roles, practice and the knowledge and skills they acquire through their education and that they bring from their connections to their communities and families. There is only limited literature exploring Healthworkers' views about their education and training experiences and how it equips them to perform their various roles or to approach the wide-ranging and complex issues that are associated with their practice. For example Genat's (2006) ethnographic study of Family Healthworkers in Western Australia provides a comprehensive picture of roles, but pays more attention to nurses' and doctors perceptions of Healthworkers' education and training than it does to the views of Healthworkers themselves. In addition literature, such as the Health Workforce reports (2011 Environmental Scan, Interim

Report, Final Report) that aim to clarify Healthworkers' roles and their education distinguishes some aspects of these topics, but does not offer an easily comprehended framework for understanding the intersection between them. Moreover, the national definition of Healthworkers proposed by Health Workforce Australia (Health Workforce Australia Final Report 2011) lacks specificity and contributes little to discussions about how the diversity and complexity of Healthworkers' roles and practice might be clarified.

Much of the other literature concerned with these topics in the Healthworker field is now also more than a decade old and therefore dated (Tregenza & Abbott 1994, Curtin Indigenous Research Centre 2000). Furthermore, to my knowledge there is no published research in regards to the extent of Healthworkers' local community based knowledge, skills and experiences and the contributions it makes to their healthcare roles or to healthcare outcomes.

While the literature reviewed in this chapter highlights gaps, it also provides a framework for analysing and interpreting what this study seeks to explore, that is what Healthworkers have to say about the relations between their roles and scope of practice, their education, and their family and community connections, in Chapters 4, 5 and 6 that follow.

Chapter 3: Study design and analysis method

3.0 Introduction

This chapter outlines the study design and analytical method used in this investigation of Aboriginal Healthworkers' perspectives on their roles, education, and family and community connections. The overall research approach was qualitative, using analyses of interviews to interpret Healthworkers' perspectives.

The chapter opens by reiterating the research questions, which are a point of reference throughout the chapter. The next section (3.2) describes the qualitative research approach, conceptual framework, study design and ethical considerations. The study design includes three key elements: research problem, method and analyses. Ethical considerations included the principles and values that apply to qualitative studies undertaken in Aboriginal health, focusing on their importance to the development of a culturally safe research framework. The following section (3.3) is a comprehensive discussion of interviews as the research method. The method included a set of activities that covered: choice of Healthworker interviewees; selection of interview type and settings; managing informed consent; question design and techniques; interviewer roles; voice recording; and transcription. The final section (3.4) constitutes a detailed discussion of the analysis procedures. These included 1) the recontextualising of Healthworkers' interview transcripts as a set of biographical recounts; 2) the application of discourse analysis to selected interview transcript extracts; and 3) examples of the analyses and their functions in identifying similarities and variations between Healthworkers.

3.1 The research questions

As outlined in Chapter 1, this study is concerned with Healthworkers' experiences, their discourse in three domains and the relationships between them: workplace roles and scopes of practice in different healthcare contexts; education and training; and connections to their communities and families. The overarching research question encapsulates these concerns:

What is the relationship between Healthworkers' workplace roles, their education, their families and communities and their discourse about these domains?

Chapter 1 also identified the two areas of enquiry that arise from this question. In the first area of enquiry the focus is on the relationships between Healthworkers' workplace roles, their education and their families and communities. The second area focuses on Healthworkers' discourse about these three domains. Both areas of enquiry generate a series of sub-questions. For the first area of enquiry, research questions are:

- *What roles and scopes of practice do Healthworkers perform?*
- *What types of education and training do Healthworkers undertake and what skills and knowledge do they acquire in order to perform those roles in their scopes of practice?*
- *What interconnections are there between Healthworkers' families and communities, their roles and the skills and knowledge they bring to their roles?*

For the second area of enquiry, research questions are:

- *What are Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities?*
- *How do they evaluate these topics?*
- *How do they present their perspectives and evaluations in their discourse about each of these topics?*

These questions emerged as the research evolved, becoming more distinct through the development of the study's conceptual framework and research design.

3.2 Approaching the study

This study adopted a qualitative research approach. Grbich (1999) notes there are diverse definitions for qualitative approaches and that such approaches are both complex and varied. However, in differentiating qualitative approaches from others, she specifies their capacity for allowing situations to be studied 'from a range of positions

and perspectives to find out how people interact in, experience and define contexts within cultures' (Grbich 1999, p. 8). In a comparison of various research approaches, Neuman (2003, p. 139) highlights the explanatory and descriptive characteristics of qualitative research, which include the 'detailed examinations of cases that arise in the natural flow of social life [and] authentic interpretations that are sensitive to specific social-historical contexts'. Miles and Huberman (1994, p. 6) emphasise the researcher's role in qualitative research is 'to capture data on the perceptions of local actors from the inside through a process of deep attentiveness, of empathetic understanding'. Like Grbich (1999), Denzin and Lincoln (2000, p. 6) note the intricacy associated with qualitative research and that not only is it 'difficult to define' but it also does not 'belong to a single discipline' or have a 'distinct set of methods or practices that are entirely its own'. Rather, it includes many methods and approaches that researchers may draw on to 'make sense of or interpret phenomena in terms of the meanings people bring to them' (Denzin & Lincoln 2000, p. 3). The description of qualitative research in these terms makes it clear that it is likely to be an effective approach for investigating Healthworkers' personal and professional experiences of their roles, education, and families and communities as well as their discourse about these experiences in each context.

Operationalising the qualitative research approach for this investigation required that careful consideration be given to key research processes. This included the development of the study's conceptual framework, design, and methods, including research ethics. The conceptual framework identifies the study's 'key factors, constructs or variables – and the presumed relationships among them' (Miles & Huberman 1994, p. 18). The study design is the 'strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes' (Crotty 1998, p. 3). Both processes are essential for refining, focusing and bounding the study parameters. The research method refers to the techniques applied to the collection, management and interpretation of the research data. This includes paying close attention to ethical factors, which are of particular importance in terms of the research method as well as every other aspect of the research process.

3.2.1 Conceptual framework

The conceptual framework specifies what may or may not be included in the study. It enables the study parameters to be defined and assists in the selection of participants, fields of investigation, relationships of importance, outcomes to be measured and analyses to be undertaken (Miles & Huberman 1994). Importantly, the conceptual framework developed for this study formed the basis for thinking further about how the investigation into Healthworkers' roles, education, and their family and community connections might proceed, but it was not so specific as to depict the precise research pathway. Rather it provided a visual representation of the context, and extent of the research and the constructs underpinning the research questions.

The conceptual framework is illustrated in Figure 3. It depicts Healthworker practice as the focus of the study, and Healthworkers as the principal research participants. It further illustrates the three topics that constitute the key domains of interest described in the introduction, those of Healthworker roles and scopes of practice, their education and training and family and community connections. The conceptual framework presents these domains as three interlocking spheres, highlighting interrelationships between them and Healthworker practice. It also depicts key components of the domains to be researched. These domains were included on the basis of my in-depth knowledge and experience of the field and are fundamental to the approach of the study. The framework also depicts the qualitative nature of the study through its non-linear representation of social processes in specific contexts and provides the foundation for the development of the study design.

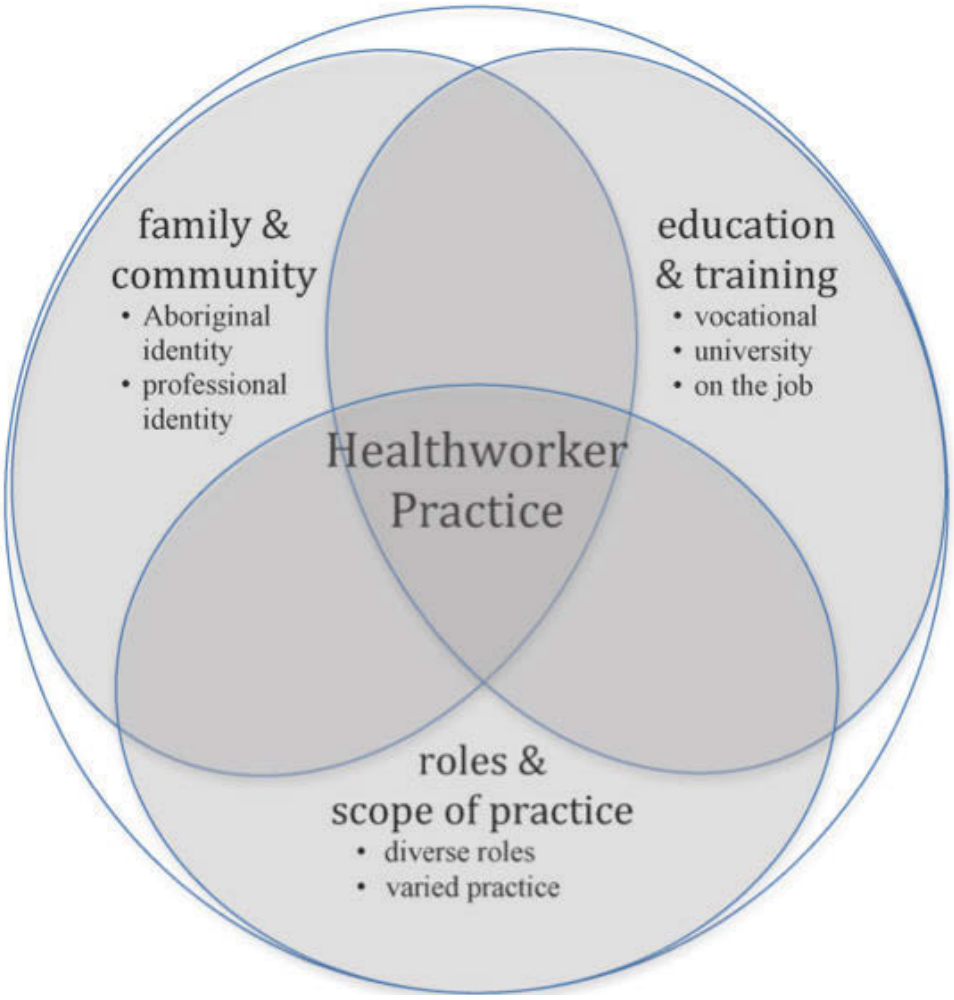

Figure 3: The study's conceptual framework

3.2.2 Study design

Drawing on the conceptual framework, the study design is a more specific delineated plan of activities. According to Denzin and Lincoln (2000, p. 25), a qualitative study design crucially 'involves a clear focus on the research question' and 'situates the researcher in the empirical world and connects her to specific sites, persons, groups, institutions and bodies of relevant interpretive material'. Neuman (2003) considers qualitative research to be characterised by a flexible style that combines available skills, knowledge and approaches to accomplish the research goals, which has been termed bricolage. Elements of qualitative study design include an emphasis on context together with empirical data that is commonly derived from one or a set of cases. Grbich (1999) suggests that qualitative study design should address issues such as the researcher's involvement, sampling techniques and research ethics. The study design underpinning this investigation included each of these elements and attempted to address such issues.

The design for this study included three elements. The first was the research problem: to investigate Healthworker practice in relation to the three domains of interest as depicted in the conceptual framework (Figure 3) and Healthworkers' representations of these, as has been articulated in the research questions. The second element was the use of Healthworkers' interviews as the primary method for collecting information to answer the research questions, particularly those that related to Healthworkers' discourse. The third element was the analysis, including recontextualising spoken interviews as written biographies, the application of discourse analysis to selected interview extracts, and the discussion of patterns that emerged in the analyses. These analyses identified ways in which each Healthworker represented and evaluated their roles, education, and family and community connections.

Elements of the study design included a range of activities. Activities associated with the research problem included the development of the conceptual framework and the research questions discussed above. Activities associated with interviews comprised the selection of Healthworker participants and the interview process. The interview process included: obtaining Healthworkers' informed consent; dealing with confidentiality; deciding on the interview type and interview setting; question design; conducting interviews using an audio recorder; and interview transcription. Activities associated with analysis included: recontextualising as biographies; selection of extracts for analysis; designing and applying discourse analytic methods; and interpretation of the analyses. Although the study began with an overall design, it evolved as the study progressed, as a recursive process of applying the design to the data, and refining it in response to the data analyses.

3.2.3 Ethical considerations

Researchers address ethical considerations using a range of standards and protocols commonly presented in institutional ethical guidelines or frameworks. Research in Aboriginal contexts requires specific guidelines to ensure that Aboriginal people are not positioned as research objects (National Health & Medical Research Council 2003; Tuhawai-Smith 1999). These guidelines are important in the development of culturally respectful and safe research frameworks that are founded on 'respect for Indigenous

peoples' inherent rights to self-determination, and to control and maintain their culture and heritage'(Australian Institute Aboriginal and Torres Strait Islander Studies 2009, p.8). Like culturally respectful and safe health care, these frameworks support non-Aboriginal researchers to recognise power differences in the research relationship and 'critically reflect on themselves as non-Aboriginal people and what is happening around them that would be different for Aboriginal people' (National Aboriginal Community Controlled Health Organisation 2011, p. 15). Culturally safe research frameworks are characterised by 'participatory, collaborative, partnership type modes, and … more inclusive approaches' (Australian Institute Aboriginal and Torres Strait Islander Studies 2009, p. 8). In addition, they may assist where there are differences in the social and cultural values of Aboriginal and non-Aboriginal research partners.

Two peak research institutions, including the NHMRC and the AIATSIS, have developed ethics guidelines specific to research undertaken in Aboriginal contexts. These guidelines were applied to this study. The NHMRC document, *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, describes six interrelated values specifically applicable to Aboriginal research. These include: spirit and integrity; reciprocity; respect; equality; survival; and protection and responsibility (National Health and Medical Research Council 2003, p. 13). In addition, two NHMRC companion documents outline priority Aboriginal research action areas and principles, highlighting the importance of community involvement, communication, ethical research of practical value and the development of the Aboriginal research workforce (National Health and Medical Research Council 2003; National Health and Medical Research Council 2010).

The Australian Institute of Aboriginal and Torres Strait Islander Studies Guidelines for Ethical Research in Australian Indigenous Studies (Australian Institute Aboriginal and Torres Strait Islander Studies 2011) specifies comparable research principles. It classifies these as: 'rights, respect and recognition; negotiation, consultation, agreement and mutual understanding; participation, collaboration and partnership; benefits, outcomes and giving back; managing research: use, storage and access; and reporting and compliance' (Australian Institute Aboriginal and Torres Strait Islander Studies 2011, p. 4).

Together, the NHMRC and AIATSIS guidelines assisted in this study's efforts to adopt a culturally aware, safe and secure approach to the research process. Coffin (2007) explains that these terms can be distinguished from each other, with cultural safety and awareness being the necessary precursors to cultural security. The Social Justice Report (Australian Human Rights Commission 2011) exemplifies and compares the terms. In regards to Aboriginal people and communities, the Report proposes that cultural awareness involves understanding cultural issues, whereas cultural safety entails working with people and taking actions and gestures not necessarily standardised as policy and procedure. On the other hand, cultural security entails a establishing clear connections between understandings and actions so that Aboriginal 'voices are heard and respected in relation to our community challenges, aspirations and identities'. (Australian Human Rights Commission 2011, p. 127).

In adopting a culturally secure framework, the study complied with the ethics policies and guidelines of the Jumbunna Indigenous House of Learning and the University of Technology Sydney Human Research Ethics Committee. Compliance was achieved by providing Jumbunna with a detailed report about the proposed research and meeting with their representative to discuss it. In addition other steps were taken to demonstrate my awareness of cultural issues and the need to establish a culturally secure framework. The initial step was to contact Healthworkers and discuss the research topic and the contributions they might make. These discussions provided an opportunity for Healthworkers and me to get to know each other. In particular I was anxious for Healthworkers to know about my motivation for the study and my personal and professional background and to also understand their views about the proposed study. The discussion process also enabled Healthworkers to ask questions about the research and its processes and to express concerns. The second step was to send Healthworkers a written description of the research and research documents including participant information and consent forms. This enabled them to give closer consideration to their participation in the research and to discuss it with others they felt may have had an interest. As this process was undertaken over a period of time I remained in close telephone and email contact to clarify queries. The third step entailed further meetings with each Healthworker on an individual basis once they had agreed to participate. This step required considerable consultation as it necessitated travelling to meet them at the

times and locations convenient for them. The aim of this was to demonstrate my respect for Healthworkers' willingness and commitment to participate in the research. In addition my view was that it was my responsibility not to disrupt or inconvenience Healthworkers who were accommodating my needs around their work and personal commitments. At each interview I sought to make the process informal and transparent and to consolidate the relationships Healthworkers and I had established. To this end, I spent time prior to the interview in informal conversation listening to Healthworkers and sharing some of my own personal and professional experiences living and working with Healthworkers in remote Aboriginal communities. These informal conversations enabled the aims of the research and research processes to be further clarified and additional queries to be addressed. This activity appeared to build a sense of camaraderie, ease, consideration and shared trust between Healthworkers and myself, to the extent that during interviews some Healthworkers revealed considerable personal information that was extraneous to the questions I asked. To ensure that only the interview information that Healthworkers wanted to be used, was used, I sent each Healthworker a copy of their interview transcript. They then verified, edited and provided final approval for this to be analysed. In addition, Healthworkers were asked for permission to conduct the first phase of the analysis. This entailed me writing a draft biography based on each Healthworkers' interview transcript and sending it to them for review, editing and final approval for inclusion in the thesis. This step required more discussion and ongoing email and telephone contact, which in turn, further consolidated the relationships between with Healthworkers and myself.

The close continual contact that I had with Healthworkers throughout these activities enabled me to demonstrate my responsibility for the study; my respect for them and their values, priorities and needs; and my respect for the information they shared. Overall, my capacity to establish a cultural secure research framework was largely due to Healthworkers themselves who showed me the 'fair, respectful and ethical way forward' (National Health & Medical Research Council 2003, p. 2).

3.3 Interviews as the research method

As already described, Healthworker interviews were the principal research method of this study and a key component of the research design. Research methods, sometimes referred to as instrumentation, are the 'concrete techniques or procedures' that researchers engage in to gather and analyse data (Crotty 1998, p. 6).

The choice of interviews as the most effective research method was based on the study as exploratory and largely descriptive, with an aim to gather as much information as possible about Healthworkers' experiences of topics in each of the three domains of interest. Moreover, interviewing was considered the best method for enabling the detailed analysis of the spoken discourse of individual Healthworkers. Although focus groups may have been an alternative method for gathering comparable data, they would have been harder to arrange and control and may have made it much more difficult to distinguish the views of individuals from those of the group (Gibbs 1997). In addition focus groups would not have permitted such a close analysis of the discourse of individual Healthworkers. Observation is another method that may have been used for recording Healthworker discourse. However it was not considered because it was considered likely to be time consuming and potentially more intrusive thereby resulting in possible unintended consequences for others who were not the focus of the study. Furthermore, the presence of others in either a focus group or observation setting could also potentially influence the discourse of individual Healthworkers and thereby impact on the findings of the study.

Interviews are a potential source of rich information, particularly if they are conducted in an atmosphere of mutual trust, respect and understanding between Healthworker and researcher. In addition, they are an ideal way to gain additional insight into the views of individual Healthworkers about issues at the heart of the study as well as those the researcher may otherwise have overlooked or not anticipated. Grbich (1999, p. 85) reiterates this, pointing out that interviews aim to 'gain information on the perspectives, understandings and meanings constructed by people regarding the events and experiences of their lives'.

The interview process comprised a number of planning and management activities, including the selection of Healthworker interviewees, interview type and settings,

obtaining informed consent, consideration of my role as interviewer, question design and techniques, the use of a voice recorder and ethical issues. More specific issues were associated with the management of interview transcriptions, the recontextualisation of interview transcripts as biographical recounts, and the selection of interview extracts for detailed analysis of Healthworkers' discourse.

3.3.1 Selection of Healthworker interviewees

The interview selection process began with an individual invitation to four Healthworkers for interviews. Each Healthworker in this initial group was purposely selected. This was on the basis that, although generally categorised as Aboriginal Healthworkers, they each performed a different healthcare role in a different context, had diverse educational qualifications and were therefore likely to have both common and uncommon experiences. Also, these Healthworkers were already known to me as they had all been students in an undergraduate Aboriginal Healthworker program in which I had taught. While my connection to the group may be interpreted as having the potential to interfere with the interview process, I considered the influence likely to be positive rather than negative. Particularly because each Healthworker had known me for a number of years and we had developed what I considered were relationships of reciprocal respect, empathy and trust. I had no reason to think otherwise because these Healthworkers had often come to me, casually and in an informal capacity, to openly share their personal and professional experiences. Building trust is a significant and complex research issue that is not just about observing rules and regulations but also 'small personal interactions … discretion and judgement' (National Health & Medical Research Council 2003, p. 3). I sought to achieve this throughout the research process by maintaining regular email and telephone contact with all Healthworkers and thereby demonstrate my commitment and express my gratitude and thanks to each Healthworker. Long after the interviews I also sought to meet with some of the Healthworkers, including those who had been students in my courses and who expressed an ongoing interest in the research. Importantly, in the 12-month period preceding the interviews I was no longer in a teacher–student relationship with any of the Healthworkers. In addition, I had moved to a position in a different university department located at another campus. During this time I had had only minimal informal contact with one of the Healthworkers. Consequently, I considered that the

Healthworkers I knew as students, were unlikely to have felt coerced or obligated to participate in the interview process. The relationship between students as the 'researched' and academics as the 'researcher' is a ethical issue, and more so when it involves Aboriginal students and a non-Aboriginal researcher. This is because in this context the researcher is likely to have more control and power than the participants. Karnieli-Miller et al (2009, p. 284) propose that although qualitative research methods are committed to redistributing power between researchers and participants, it is not easy to achieve in practice. They suggest the power relationship 'should be seen as a continuum', where at one end the relationship is 'a high level partnership', and at the other 'highly differentiated and asymmetric' (Karnieli-Miller et al 2009, p. 284). In terms of this study there was a partnership approach, although this was not 'high-level'. As a partners Healthworkers had full control of the type and extent of information they provided in their interviews, the transcript editorial process and were involved in approving the first phase of the analysis whereby individual transcripts were recontextualised as brief biographies. However, Healthworkers were not involved in the greater part of the analysis, principally because this required theoretical knowledge which I could not have been expected to pass on. Despite this, I endeavoured to ensure that Healthworkers were involved as far as possible in an as many stages of the research as possible and to make myself accessible, available and open to discussion and criticism in regards to the research processes. Most importantly I undertook to establish a culturally secure research framework as described in 3.2.3.

Using a snowball technique, the original four interviewees were asked to nominate other Healthworkers as potential interviewees. This resulted in an additional six Healthworkers, all unknown to me, volunteering to participate in interviews. Consequently, ten interviews were completed, but one interview was later excluded when I was unable to contact the Healthworker to corroborate the interview transcript (also discussed later in relation to ethics). This resulted in a total of nine interviews for this study. While this is a small number of interviews, it was considered adequate, as the proposed interviews were likely to be lengthy and to generate substantial data, the analysis of which had to be manageable.

3.3.2 Interview type and settings

The Healthworker interviews conducted for this study were guided or semi-structured. This interview type involves an interviewer and interviewee in direct communication with each other, rather than using the telephone or other medium. The advantage of this interviewing approach is that it seeks to offer the interviewee with a level of privacy to talk openly, which in turn may generate more information. It may also provide a better opportunity for building rapport and demonstrating trust and understanding between the interviewer and interviewee. The key features of guided interviews include broad ranging questions 'derived from theory/intuition or previous research' that are structured, phrased and sequenced 'at the interviewers discretion … to provide a minimally directive framework that enables both researcher and informant to access and identify key areas' (Grbich 1999, p. 93). In this study, questions were modestly directive and focused on the three domains of interest identified in the conceptual plan: the diversity of Healthworker roles and their varied scopes of practice; Healthworker education and training in vocational, university and on the job contexts; and the links between Healthworkers' and their families and communities. However, the sequence of questioning varied for each interview according to the direction individual Healthworkers chose to take it. This enabled Healthworkers to adjust the discussion of the topics as they judged pertinent and according to their expertise. Consequently, the structure and content of interviews varied, with each Healthworker offering more or less information than others about topics in each domain.

In addition, interviews were one-on-one, face-to-face and conducted in settings and at times determined by each Healthworker. The majority of interviews were conducted in the Healthworkers' workplaces or educational institutions where they felt comfortable. At the request of two of the Healthworkers, interviews took place in rooms hired specifically for the occasion. In total, eight interviews were conducted in regional or rural locations and one in Sydney. This ensured that Healthworkers directed, and were not inconvenienced by this component of the interview process.

Having established the interview type, careful consideration was then given to the interview process. This included Healthworker consent, my role as interviewer, question design and techniques, the use of a voice recorder and ethical issues.

3.3.3 Informed consent

Informed consent is a formal procedure that aims to ensure 'the ethical principles of respect for the dignity and worth of every human being and their right to self-determination' are honoured (Miller & Boulton 2007, p. 2199). To ensure consent is valid, three general elements are considered essential. These are that: participants have been provided and understand all information likely to be relevant to their decision about whether or not to participate; participation is voluntary; and consent can only be given by people who are competent to do so (Boulton & Parker 2007).

In regard to Healthworker consent for interviews, the procedure involved the development and submission of an interview consent form and a summary of the research to Jumbunna Indigenous House of Learning at the University of Technology, Sydney (UTS) and the University of Technology Sydney Human Research Ethics Committee. The consent form used plain language to clearly explain the purpose of the study, interview process, privacy, confidentiality and the meaning of voluntary participation. In addition, the researcher's contact details (telephone and email) were included on the form. Prior to, and at each interview, the form was verbally explained and queries invited and discussed. Voluntary participation was emphasised to ensure that Healthworkers knew they could withdraw from the study at any time.

This combination of strategies aimed to ensure that consent was informed. Two Healthworkers with roles in the Aboriginal Community Controlled Health sector consented to interviews but also obtained the prior consent of their health service. Healthworkers were provided with a duplicate of their signed hard copy consent form and the originals were kept in a secure filing cabinet according to accepted research protocols. Irrespective of these informed consent procedures, I was mindful that it is not necessarily a guarantee that research participants agree to every aspect of the research process. Miller and Boulton (2007, p. 2209) argue that 'experiences of agency, power and risk, all shape the qualitative research encounter in ways which cannot be anticipated by, or encapsulated in information sheets or signed consent forms'. For this reason, I also sought separate informal consent for aspects of the study as it evolved. For example, after interviews had been conducted, a separate request for consent to use interview transcripts was sought.

3.3.4 Interviewer role

The interviewer's role is critical to an effective and properly conducted interview. In this study, which used a guided or semi-structured style of interview, I considered my interviewer role was 'to facilitate and guide rather than dictate exactly what will happen in the encounter' (Smith and Osborne 2008, p. 63). My role therefore focused on ensuring that each interview was respectful, informal, open and friendly. Each interview was preceded by telephone conversations and email exchanges to allow for introductions and for the interview arrangements and process to be discussed. These initial exchanges assisted in the development of rapport, particularly with the Healthworkers I did not know. Similarly, the adoption of an easygoing manner, humour, my keen interest in Healthworkers' experiences and the disclosure of my own personal and professional knowledge and experiences all appeared to contribute to sense of reciprocity, inclusion and honesty. I cannot corroborate how my interview role was perceived by Healthworkers. However, their extraordinary generosity and willingness to share what I considered to be deeply personal information suggests that it was appropriately managed.

This role was unavoidably subjective because it was influenced by my twenty years of experience in Aboriginal health and Healthworker education, the high regard I have for Healthworkers and my prior professional and personal relationships with some of the Healthworker interviewees.

3.3.5 Question design and technique

Interview questions were open-ended, descriptive and probing, to draw out maximum detailed information. Open-ended descriptive questions aimed to elicit descriptive and explanatory responses about Healthworkers' professional and personal experiences of their healthcare roles, education and family and community connections. This type of question is exemplified in:

> What would you say are the key sets of skills and knowledge you need in your role?

On the other hand, probing questions aimed to gather additional information or to clarify issues and possible misunderstandings. An example of this type of questioning is:

> Interviewer: Of those healthcare positions, can you describe what the work has been about?
> Healthworker: Trying to get Indigenous people in contact with health services … All that sort of stuff
> Interviewer: Tell me more about it …
> Healthworker: Well … a normal day there would be …

Prompts were also sometimes used when Healthworkers expressed uncertainty about their responses. For example:

> Interviewer: When you say 'we go and do the screening', tell me what that involved?
> Healthworker: We look in the kids ears …
> Interviewer: Using a machine?
> Healthworker: Yeah, the … my mind's gone blank
> Interviewer: It's OK
> Healthworker: We put the …
> Interviewer: The probe?
> Healthworker: No, no
> Interviewer: The headphones?
> Healthworker: We put the headphones on them …

As stated earlier, the sequence of questioning varied for individual interviews. This was a consequence of the closeness of my relationship with each Healthworker and their individual responses. For example, there was a tendency for Healthworkers with whom I had a close relationship to be more relaxed and conversant whereas Healthworkers who did not know me as well were occasionally more diffident. Variations in the sequence of questions across interviews was also a response to individual Healthworkers and the way in which they adjusted to the discussion, broadening or narrowing its focus on topic areas they judged more or less pertinent. In contrast, the wording of questions was generally consistent across interviews and mostly relied on

non-technical language and everyday terms to make meaning as explicit as possible. Overall, interviews ranged in length from 5,000 to 10,000 words.

3.3.6 Voice recording

Healthworkers were asked for permission to record their interviews and the recording process was explained. Voice recording of interviews is a common and effective method for reviewing the interviewer and interviewees performances over the duration of the study. According to Halcomb and Davidson (2006, p. 41), it 'allows interviewers to reflect on the conversation to ensure that the meanings conveyed by participants are adequately represented'.

The use of a small digital voice recorder ensured that the recording process was unobtrusive and facilitated engagement between the interviewer and the interviewee. On completion of the interviews, recordings were downloaded, transcribed and sent to each Healthworker for verification, editing and comments. On their return, all identifying features of the transcripts, including the names of people, places and organisations, were either removed or substituted with codes or generalisations. For example, each Healthworker was identified by a code of two randomly selected letters, while places were described in general terms, such as rural, regional or metropolitan rather than explicitly named. Similarly, organisations were distinguished by their general characteristics using terms such as mainstream health service, Aboriginal community controlled organisation and non-government health service and mental health service. The return of individual interview transcripts to Healthworkers for review, editing and approval enabled them some control over the interview process including, for example, the option to exclude interview information or withdraw their interviews from the study.

3.3.7 Transcription

Voice recording was followed by verbatim transcription of the nine digitally recorded interviews. Poland (1995) describes transcription as the word-for-word duplication of verbal data, where the written words are an exact replication of the audio recorded words. I manually transcribed six of the interviews while three were professionally transcribed because of their extended length and time constraints. To test their accuracy, I crosschecked each of these three transcripts with their corresponding interview

recording and made minor corrections. Each Healthworker was then sent both their voice recording and their interview transcript for feedback including verification for accuracy and editing. The interview transcription process involved a high level of immersion in the Healthworkers' experiences. This provided a foundation for exploring the three sub-questions in first area of enquiry. This included: what roles and scopes of practice Healthworkers' performed; the types of education and training they undertook; their families and communities; and the relationships between them.

3.4 Analysis Procedures

The nine Healthworker interview transcripts resulted in an extensive data set. There were three phases to the exploration of this. In the first phase, each of the Healthworker interview transcripts was recontextualised as a written biography. In the second phase, short extracts that exemplified each of the three topic areas (roles, education, and family and community) were selected from each individual interview transcript for detailed analysis using discourse analytic methods. The focus of this phase was to ascertain: i) Healthworkers' perspectives on the topics, ii) their evaluations and iii) how they presented them. The third and final phase of analysis involved an exploration of the patterns in Healthworkers' discussions of topics in each domain, and how they were presented and evaluated. The analyses of patterns across interview extracts in this phase was applied consistently to two of the domains of interest, that is roles and education, whereas in regards to the family and community domain, analyses adopted a thematic approach.

Prior to the commencement of these phases of analysis, a preliminary framework was developed for articulating Healthworkers' roles and scope of practice. For this I drew on the NACCHO and NATSIHWA definitions and descriptions of comprehensive primary health care. This framework had three categories including: clinical care, community care, and program management. Each category encompasses both universal activities and specialist activities. Universal activities are those common to all Healthworkers irrespective of the category in which they practice, whereas specialist activities are specific to an individual category of practice, and perhaps more likely performed by Healthworkers at senior levels with specialist qualifications in specialised programs. Universal activities include advocacy, liaison, health education and culturally safe

healthcare, whereas specialist activities might include program planning, goal setting, budget management, and staff mentoring and training. The advantage of this practice framework is that it differentiates Healthworkers from each other, in terms of the types of activities they perform and helps to determine the skills and knowledge they need to perform them. Moreover, it distinguishes Healthworkers' clinical, community care and program management practice from other practitioners such as nurses and social workers.

The clinical care category in the proposed framework encompasses activities such as physical examinations, clinical tests, pathology collection, and in some roles 'vena puncture, internal and external examinations and suturing' (National Aboriginal Community Controlled Health Organisation 2008, p. 3). In some settings clinical practice may also entail specialist activities. For example in remote areas some argue that Healthworkers should have an expanded scope of practice and 'perform injections, undertake routine X-rays and conduct renal dialysis and midwifery functions (Productivity Commission 2005, p. xxx). This scope of practice includes activities frequently performed by vocationally qualified enrolled nurses or university registered nurses that enables them to document complex clinical actions and procedures, results and client information. Healthworkers who perform comparable clinical activities should therefore also hold equivalent qualifications.

The community care category includes activities such as cultural brokerage, advocacy, leadership, and education, which Nutbeam (1998, p. 30) describes as 'key health promotion actions'. McGrath et al (2007, p. 433-434) explain that Healthworkers performing these activities must be skilled in interpreting and translating between individuals, professional groups and cultures. As representatives with in-depth understanding and experience of their communities and community networks, Healthworkers in community care also have a primary responsibility to advocate for the individual and collective needs of community members. Rose & Jackson Pulver (2004) suggest that some Healthworkers might also be viewed as community leaders. Mackinolty (2013, p. 7) argues people with 'limited literacy and numeracy' are perhaps suited for performing healthcare activities such as 'community liaison, health promotion, cultural mentoring...that will all add to the capacity of the comprehensive

primary health care team'. However, while Healthworkers' community care scope of practice may include such activities, it also includes in-depth skills and knowledge comparable to welfare and social worker practitioners. Community care practice is therefore probably best performed by Healthworkers with a range of vocational and university qualifications.

The program management category commonly includes activities such as planning and evaluation, data collection, budget management, staff development and stakeholder coordination. These types of activities usually require extensive experience, skills, knowledge and higher-level qualifications. However, there are fewer Healthworkers in these roles and career opportunities are more limited (Community Services & Health Industry Skills Council 2010).

Research is an additional activity performed by some Healthworkers irrespective of their specific roles (Abbott et al 2008). Healthworkers' in-depth understanding and experience of community issues is often critical in the optimisation of research which should always be guided by Aboriginal people (Baum 2007). This is in keeping with the concept of Aboriginal community controlled health research, which is considered more responsive to community needs (Couzos et al 2005). The NHMRC (2010) also highlights the need to increase the participation of Aboriginal health researchers and provide employment and training opportunities in research. However Couzos et al (2005, p. 92) report that Aboriginal health research is infrequently 'initiated, driven and implemented by Aboriginal communities or representative agencies'. The reasons for this are unclear, although Humphery (2001, p. 201) argues that efforts to shift Aboriginal research away from 'the dominant, traditionally entrenched research bodies is..highly underdeveloped'. One aspect of this in regards to Healthworkers is the possible limited opportunities for acquiring the necessary research skills and knowledge. For example although the current Healthworker vocational Certificate IV courses offer units, which might be considered research, they are not core units. Furthermore they are classified as a 'community development' rather than research skill set (community Services and Health Industry Skills Council 2013). Hecker, however found that although the Healthworkers in her study had no formal research skills, the use of a participatory action research method 'was in itself empowering' and enabled

Healthworkers 'to present their concerns to the health service' and to make recommendations which were subsequently implemented (Hecker 1997, p. 787). While this suggests that some methods may be more favourable than others for facilitating the involvement of Healthworkers in research, it is still preferable that they should also have access to the same formal research skills and knowledge commonly held by non-Aboriginal researchers. This would undoubtedly support the development of the field in terms that were aligned with Healthworkers' views about their roles and scopes of practice.

3.4.1 Phase 1: Recontextualising Healthworker interviews as biographies

The first phase of analysis involved recontextualising the nine Healthworker interview transcripts as individual biographies that briefly recounted each Healthworker's life history. Recontextualising the interviews as biographies contributed to the exploration of the first area of enquiry, that is, the relationships between Healthworkers' roles, education, families and communities, and the questions about these relationships.

Recontextualisation is explained by Fairclough (2003, p. 32) as 'the appropriation of elements of one social practice within another, placing the former within the context of the latter and transforming it in particular ways in the process'. In this study, the recontextualising phase comprised the transformation of the Healthworkers' spoken discourses in the context of their interviews to written discourses in the context of their biographies.

The recontextualising process began with a close reading of each interview transcript. Key information was highlighted and organised chronologically. In addition, information relating to the three domains of interest was collated to provide a sense of the differences in the proportion of information about each domain. Nine draft biographies were written. The names of people and places were given an alphabetical code to ensure a level of anonymity while other features that may have identified Healthworkers were referred to in general terms. Each Healthworker was emailed a copy of their biography with a request for comments and editorial corrections. Two Healthworkers did not respond to this request. Approval for the inclusion of biographies

in the thesis was then sought from the seven Healthworkers who responded with comments. These Healthworker biographies are presented in Chapter 4.

Although the process largely resulted in a description of Healthworkers, it was considered to be a phase in the analysis of transcripts for three reasons. Firstly, it immersed me in the data, providing an overall sense of each of the nine lengthy interviews as a single data set. In turn, this provided a snapshot impression of each Healthworker's life history to reveal its complexity and diversity and to provide a context for the more analytical aspects of the study. Secondly, this immersion provided a global perspective of the nine interviews as a whole data set. This enabled me to identify thematic points and patterns of similarity and difference across the Healthworkers' life histories, particularly with respect to their roles, education and communities. Thirdly, it condensed an unwieldy quantity of complex information into a readable and more manageable format, providing an opportunity to establish an initial foothold in the data.

3.4.2 Phase 2: Discourse analysis

The second phase was the detailed analysis of interview transcripts drawing on discourse analytic methods to explore the second area of enquiry, that is, the ways in which each Healthworker presented and evaluated their roles, education and family and community connections. This phase began with the selection of three extracts exemplifying each of the domains of interest (role, education, and family and community) from each of the nine interviews. This resulted in a total of twenty-seven extracts for analysis. The selection of extracts was necessary, because most interviews were lengthy and a full discourse analysis of all nine was an unrealistic goal. Consequently extracts selected were restricted to a total word count of 1,000–1,500 words per interview. This word count was considered manageable for applying the highly technical discourse analytic methods. However, in analysing lexis (discussed further under 'fields of activity' on the following page) each Healthworkers' whole interview transcript was used rather than just the selected extracts. The rationale for this was that whole transcripts rather than short extracts, were considered more likely to provide a better representation of lexis.

Deciding which extracts to select for analyses was facilitated by the interview questions which broadly corresponded to the three domain areas. The selection process was also supported by my immersion in interviews, and the earlier phases of analysis (transcribing and biography writing). This meant that I had developed a deep familiarity with the variations in and between interviews and the extracts that were likely to be a reasonable source of data that could inform the investigation of topics in the three domains.

Despite the careful attention paid to the selection of extracts for analysis, it is vital to acknowledge that the extracts were only a snapshot and did not represent the entire perspectives of all Healthworkers. Although Healthworkers are not an homogeneous group the use of discourse analytic methods for this second phase of the analysis was considered reasonable and valid. Lincoln and Guba (1985), proposes four criteria for establishing the trustworthiness of qualitative research including: credibility, transferability, dependability and confirmability. They also describe a range of strategies that underpin each of these criteria (Lincoln and Guba 1985). The approach adopted by this study has employed a number of these. For example, strategies supporting the study's credibility' include: my extensive experience in the field, the use of open ended semi-structured interviews to elicit Healthworkers lived experiences, member checking to confirm the accuracy of interviews, along with my immersion in and the objective analysis of interviews using discourse analytic methods. Two strategies supported the 'dependability' of the study approach. Firstly, the in-depth interview process, which was repeated for each Healthworker, enabled the collection of comparable information from nine different sources. Secondly, the objective step-by-step discourse analysis technique was made explicit, comprehensible and applied consistently to all nine interview transcripts. In regards to the confirmability of the study, the discourse analytic methods were considered effective for providing a level of objectivity for the claims that have been made. In addition I have aimed to maintain a level of reflexivity to make myself aware of my possible influence on the data. Strategies supporting the study's' transferability' such as representative sample selection were considered less applicable. This was because, although the Healthworkers' were likely to exhibit commonalities in terms of their roles and scopes of practice, they also presented with unique unique life histories and experiences that

could not be generalised. It was therefore considered more important to provide rich contextual descriptions that drew as much information as possible from the interview data and thereby allow others to estimate the extent to which it might be transferable.

The detailed analysis of the three selected extracts from each Healthworker interview drew on discourse analytic methods. The technicality associated with these methods makes presentation of the analyses challenging, particularly for those outside the field. For this reason, the methods have been glossed but have been exemplified with text examples to make their application easier to comprehend. The primary reason for selecting this method of analysis was its objectivity and capacity to explore Healthworkers' first hand accounts of the issues and challenges associated with topics in each domain that were salient to them. In particular it was anticipated that the analyses would extend awareness Healthworkers' discourse and the meanings the discourse revealed in terms of the potential links between each of the domains, and more specifically between their roles, practice, and education.

The analyses focused on three dimensions of social contexts (following Halliday 1978; Martin & Rose 2007, 2008):

- the field of social activity that is represented in discourse
- the tenor of social relations that is enacted by speakers
- the mode of discourse in which activities and relations are represented and enacted.

These three dimensions of social context are known collectively as the register of discourse. In common sense terms: field is the subject matter or topic, what is going on, what people are talking about; tenor is concerned with who is involved, their relationships and evaluations; and mode is the role that language plays, how the discourse is organised and related to its social contexts.

Fields of activity was addressed by the selection of extracts focused on the three topic areas. Each extract was presented so that the reader can readily see what the Healthworker is talking about. For field, the whole of each interview (not just the selected extracts) was analysed to identify the lexical items with which each Healthworker construed their practice. Lexical items were then classified into the types of entities they construed, such as everyday, technical or institutional entities. This

enabled a broad comparison of how Healthworkers' construed their varying experiences.

The **tenor** of each interview is explored by analysing how Healthworkers evaluate their roles, education, and family and community connections. Analyses could then identify types of appraisal used by Healthworkers, including expressions of feelings, judgements of people, appreciations of things, grading of expressions, and sourcing of attitudes. These analyses can show potential differences and commonalities and possible patterns in how each Healthworker evaluated their various experiences, the different people they interacted with, and themselves. For example, what patterns of difference or similarity might there be in terms of how Healthworkers evaluate their healthcare colleagues and what might this tell us about their various roles and workplaces.

Mode was analysed by displaying the textual organisation of the interviews. Healthworkers' responses were first analysed into clauses, and these were grouped into phases clustered around particular topics. These analyses can show how each Healthworker organises the information they represent about each topic, and enable comparisons between Healthworkers' discourse.

To ensure general readers had maximum access to the analyses, interviews were treated individually and the analyses of their respective extracts are presented using the following subheadings:

- Presenting Practice: Textual Organisation
- Perspectives on Practice: Lexis
- Evaluating Practice: Appraisal

The first heading, 'Presenting Practice: Textual Organisation' refers to the analysis of mode, 'Perspectives on Practice: Lexis' to the analysis of field and 'Evaluating Practice: Appraisal to the analysis of tenor. This approach enabled variations in Healthworkers' discourse to be identified and compared. The analyses were presented in this order to provide the reader with a global view of the individual interview in regards to its overall textual organisation before the finer and more detailed analyses of field and tenor were presented.

These analyses are informed by two theoretical frameworks, including Bernstein's (1999) distinction between horizontal and vertical discourse, and a systemic functional linguistic (SFL) view of language as text in social context (Halliday 1978). Bernstein distinguishes between a vertical discourse and horizontal discourse that take 'forms of knowledge as criteria' (1999, p.158). He classifies common sense, everyday knowledge as horizontal discourse, that is 'likely to be oral, local, context dependent and specific, tacit, multi-layered, and contradictory across but not within contexts' (Bernstein 1999, p. 159). A critical feature of horizontal discourse is that it is 'segmented' by the specific sites or contexts in which it is realised, for example the home, work site, community or social club (Bernstein 1999, p. 159). Consequently, the knowledges of horizontal discourse cannot readily be transferred to other contexts, but remain meaningful largely within the context in which they are derived.

In contrast Bernstein describes vertical discourse as 'a coherent, explicit, systematically principled structure, hierarchically organised, as in the sciences, or…the form of a series of specialised languages with specialised modes of interrogation, specialised criteria for the production and circulation of texts as in the natural sciences and humanities' (1999, p. 159). A key differentiating feature of vertical discourse is that it is not segmentally organised and does not consist of 'culturally specialised segments' but rather of 'specialised symbolic structures of explicit knowledge' (1999, p. 161).

The second theoretical framework that broadly informed the analyses was the SFL view of language as a social semiotic, a resource people use to accomplish their purposes by expressing meanings in context. Martin and Rose (2007) specify that from this standpoint, language is used to achieve three social functions. These are to: 'i) enact our social relationships, ii) represent our experience to each other and iii) to organise our enactments and representations as meaningful text' (Martin and Rose 2007, p. 7). These three 'metafunctions' are interlinked, so their social function is achieved simultaneously (Rose and Martin 2007, p. 7). Furthermore, the social contexts of language can be viewed from three dimensions. Collectively termed 'register', these dimensions of social contexts (field, tenor and mode) were described earlier (page 109-10). Their application to the analysis of Healthworkers' interviews is described in more detail in the following section.

Bernstein's (1999) theory informed the analyses of Healthworkers interviews in terms of both mode (Presenting Practice: Textual Organisation) and field of social activity (Perspectives on Practice: Lexis). In regards to textual organisation, Healthworkers' discourse was considered in terms of whether it was more or less segmentally organised, context specific and dependent as for horizontal discourse, or was more likely to 'take the form of a coherent, explicit, systematically principled structure' as for vertical discourse (Bernstein 1999, p. 161). It was also considerd in terms of clauses, phases and genre. In regards to Healthworkers' perspectives on practice, interviews were analysed to determine potential differences in the proportions of everyday lexis characteristic of horizontal discourse, or the technical, specialised and other abstract lexis characteristic of vertical discourse. In regards to Evaluating Practice: Appraisal, Healthworkers' discourse was considered in terms of tenor, that is the types of appraisal they used.

3.4.3 Presenting Practice: Textual Organisation

The first question to be explored in the analysis was: how Healthworkers represent their roles, scopes of practice, education, and families and communities. This analysis focused on the textual organisation of Healthworkers' responses to interview questions. Extracts focusing on roles and education were analysed in order to explore relationships between Healthworkers' types of education, workplace roles and how they organise their discourse about these topics.

The first step in the analyses was to format the interview extracts into clauses and phases. Dividing the extracts into clauses enables the reader to see at a glance how each chunk of information is presented. Rose and Martin (2007) use the term phase to refer to the steps that a text goes through. Phases which may be a paragraph or a few sentences long are indicated by text boxes that show how the responses are organised into topics. Each phase was about a different topic. In the interviews, these phases often corresponded with responses to questions. This assists in revealing how speakers organise their responses into topics.

The aim of these analyses of the textual organisation was to identify patterns of commonalities and differences between interviews in regard to:

- genres used: recounts, anecdotes, explanations, descriptions, reflections, arguments
- the organisation of information
- how general or specific is the information presented
- whether it is presented explicitly or left for the listener to infer.

Genres are recognised by their purpose and pattern of meaning. For example, the purpose of a recount is to simply recount events. Its pattern of meaning is apparent in its structure, which includes an orientation and the record of events. On the other hand, an anecdote, which involves sharing an emotional reaction in a story, generally includes an orientation, complication and evaluation. In contrast an argument seeks to present two or more points of view and usually begins with the presentation of issues, followed by the various sides and a resolution. Based on these examples, it is clear that different genres require different sets of language resources.

The analysis of how Healthworkers organised information was in terms of their responses to interview questions and the extent to which they logically sequenced information or whether their presentation was more adhoc. Other considerations were whether information was more or less specific rather than generalised. Specifically relevant detailed information provided in response to questions may suggest a more in-depth understanding of the question and the type of response expected, whereas generalised information may indicate a limited understanding of the question or the topic referred to by the question. Responses that are logically sequenced and that include specific information relevant to the question are perhaps more likely to reflect the extent of Healthworkers' experience and the formal knowledge and skills they have acquired through education.

Another aspect of textual organisation that reveals how Healthworkers organise their responses is whether they present information explicitly or leave it up to the reader to infer. The analysis of textual organisation sought to show the extent to which Healthworkers' comprehended their various roles and scopes of practice, education and the relationship between their understanding and their education. It was directed to exploring the first sub question in the second area of enquiry, that is: What are

Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities?

The following extract illustrates responses to interview questions by two Healthworkers, presented in clauses and phases. The topic of each phase is marked in bold.

Extract 1: textual organisation

Just what do you do? What does it entail, as a job?

Well we go around and we, you know we **contact schools and that**.
They've actually changed how they wanted us to do, by only **referrals**, which we thought, well no that's not going to work because we don't get referrals now from teachers, Child and Family Health nurses things like that.
So we've, Sally and Mary just got together and put this **big portfolio thing** together and waiting to get that signed off by GWAHS.
But we've got a **new approach** now where we're just going to go out and do the kindergarten kids, Aboriginal kindergarten kids which is very similar to what it was, it was the nought to six year olds before. But they had to move the target group. so now we're going out and we're doing that. And what we' do, we'll also, is we'll tell them if there is any other Aboriginal students they have concerns with, we'll also see them.

So me and Mary at the moment, **Tuesdays are our days**
we ring the schools
and we go around.
We went out to Town X last week,
we're going to Town Y this week, um then Town Z the following week,
and then doing the public schools around here.
So each Tuesday
and then we have a day back in the office to do our paper work and that.

This presentation shows how the topic of each phase is announced in the first clause or two of the phase, such as *'contact schools, referrals, big portfolio, new approach'*. This Healthworker represents her role in everyday terms, recounting it as very general activities, people and places. With respect to the organisation of information, she digresses to various topics. She does not make explicit what she does when *'we ring the schools and we go around'*. This approach to analysis of the textual organisation of ideas provides one basis for comparison across the Healthworkers' presentations. This analysis of textual organisation in this excerpt suggests a very general rather than specific understanding of the role and practice being undertaken. Similarly, the use of recounts and the numerous digressions does not reveal a systematic coherent presentation about practice, but rather, a much more informal, unstructured and simplified view. This tends to suggest that, this Healthworker is perhaps new to this role, has minimal experience or perhaps little formal knowledge and skills for the practice that this role appears likely to entail.

3.4.4 Perspectives on Practice: Lexical Choices

The second question to be explored is Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities. This analysis focuses on comparing the lexical choices that Healthworkers used to represent their practice. The aim was to compare the kinds of lexical items that Healthworkers used, in order to gain an objective view of differences in their perspectives.

Following Martin and Rose (2007), lexical items were analysed into types of entities. These included concrete entities associated with everyday and specialised activities,

such as people, places and tools of the trade, and abstract entities associated with technical and institutional fields. Concrete entities can be directly observed with the senses, while abstract entities cannot.

In respect to the everyday world, for example, people may include *'girls, boys or families'* while examples of things are *'school, land, country, factories, shop'*. In the specialised field of healthcare, examples of specialised roles are *'Health Services Coordinator, general practitioners, senior clinical female Aboriginal Healthworker'*, while specialised things include *'antibiotics, thermometer, clinic'*, which can be observed directly with the senses. Examples of technical entities in healthcare include *'middle ear function, tympanometry, decibels, blood pressure, urinalysis'*, which can only be observed with technical equipment.

With respect to institutional entities, the analysis distinguishes those associated with Healthworkers roles, practice and education. Examples associated with roles and practice include *'referral, screening, cultural safety, occupational health and safety'*. Examples associated with education include *'knowledge, competency, clinical training, qualifications and academia'*. The classification of lexical entities as 'other abstract' refers to semiotic and metaphoric entities that are not classifiable in any of the other categories. Examples of such entities include *'experience, achievement, expectations, issues'*.

Martin and Rose (2007, p. 113) note that differences between concrete and abstract ways of meaning 'reflect the fundamental division in fields of activity in modern cultures, between the everyday activities of family and community and the uncommon sense fields of technical professions and social institutions such as law, medicine or education'. A significant difference between concrete and abstract ways of meaning is how they are learnt. Concrete ways of meaning, as expressed by everyday lexis, are typically learnt through observing and participating in the ordinary activities of daily living. Specialised ways of meaning are also concrete, but tend to be learnt through vocational or on-the-job training in specialised fields such as vocational trades. In contrast, abstract ways of meaning, as expressed by technical and institutional lexis, are primarily learnt through professional education, particularly at university. Specialised

fields can be learnt through demonstration and practice, whereas technical fields require academic study in addition to practice. This type of analysis was therefore designed to identify relations between Healthworkers' types of education and their perspectives on their practice.

Healthworker's lexical choices were analysed by identifying (and counting), contextualising and classifying lexical items in interview extracts focusing on roles, education and community. Lexical items are classified as everyday, specialised, technical, institutional: work, institutional: education and other abstract things. Table 1 illustrates examples of each category from one interview.

Table 1: Types of lexical entities

Everyday	**Specialised**	**Technical**	**Institutional: work**	**Institutional: education**	**Other abstract**
Nan	nurse	blood	health service	TAFE course	confidentiality
mum	teacher	pressures	AMS	Certificate 3	past
school	Healthworkers	diabetes	clinic	Assisting in	history
pop	doctor	hearing	appointments	Nursing course	chaos
grandfather	GP	tests	referrals	Year 7	situation
papers	specialist	pulse		uni	goal
brains	bloods	temperature		assignments	cultures
people	wounds	HBA1C			

It is not always easy to assign some entities to a specific category, and choices often depend on context. For example, *'school'* is an educational institution, but also a concrete place in children's everyday experience. Likewise, although an Aboriginal Medical Service is a health institution it is often thought of as a familiar place in Aboriginal people's everyday discourse.

Healthworkers' lexical choices are also represented graphically as pie charts and bar graphs. The aim of this is threefold: firstly to facilitate analysis of the proportion of lexical choices across all three topic areas in individual interviews; secondly to show variations between interviews, and between the three topic areas within interviews; and

thirdly to enable readers to easily see at a glance the lexical choices made by Healthworkers as well as any similarities and differences across all interviews.

The pie chart in Figure 4 illustrates the proportions of lexical choices made by Healthworkers across each of the six categories (everyday, specialised, technical, institutional: work, institutional: education, other abstract).

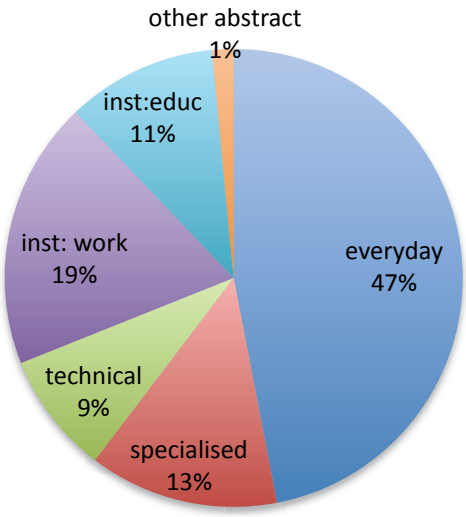

Figure 4: Proportions of total lexical choices across topic areas

Proportions of lexical entities in each category were also counted for each interview extract, and represented as column graphs and pie charts, to show variations between interviews, and between the three topic areas within interviews as shown in Figure 5. The category 'other abstract' was omitted from bar graphs because for each interview it was too insignificant to record.

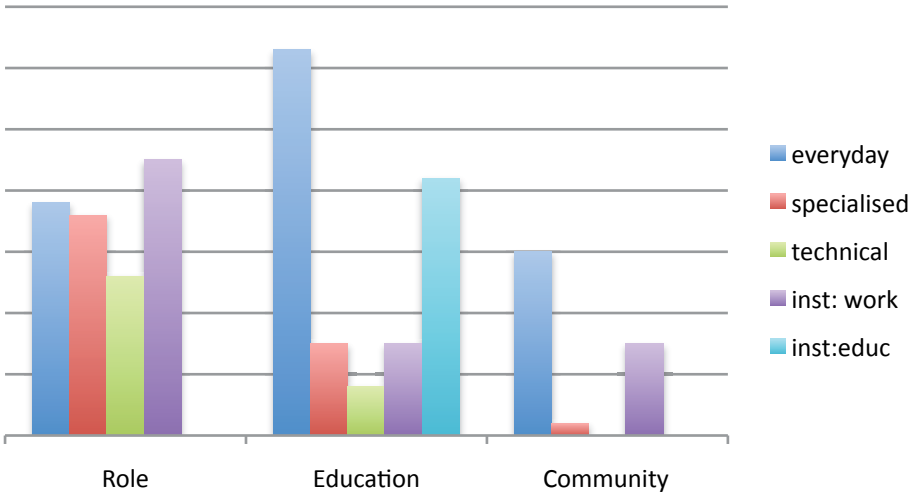

Figure 5: Proportions of lexical choices for each topic area

In this instance, proportions indicate this Healthworker's particular perspective on her work, education and community. In each of these fields, everyday people and things take precedence, particularly in relation to education and community.

In addition, lexical choices are summarised and presented in table format to illustrate the broad overall difference between each Healthworker to facilitate a comparisons at a glance. The table format also includes brief comments on each Healthworker's role, education and orientation to community (see Table 7, p. 219).

3.4.5 Evaluating Practice: Appraisal

The third question to be explored was how Healthworkers evaluate their roles, scopes of practice, education, and families and communities. This analysis focused on the types of appraisal they used.

Martin and Rose (2007, p. 25) define appraisal as the 'evaluative stance of the appraiser'. The appraiser in this case is each Healthworker. Appraisals include expressions of feelings (technically **affect**), **judgements** of people, and **appreciation** of things. These are referred to as types of **attitude**. Attitudes may be positive or negative, and may be stronger or weaker. The source of the attitude may be the speaker, *'I enjoyed it'*, or it may be sourced to others, *'my teacher kept saying, "look you've got the brains, you're real cluey, you can do it"'*. Technically, amplifying and diminishing the

strength of attitudes is known as **graduation**. Sourcing of attitudes is known as **engagement**. Engagement presents the voices of the speaker and others. Furthermore, appraisals may be stated explicitly, or implied. Explicit appraisals are said to be **inscribed** in the words. Implicit appraisals are **invoked**.

Martin and Rose (2007, p. 66) sub classify types of affect as:

- fear
- desire
- un/happiness
- in/security
- dis/satisfaction.

Judgements of people include:

- normality (how unusual someone is)
- capacity (how capable)
- tenacity (how resolute)
- veracity (how truthful)
- propriety (how ethical).

Appreciation of things includes:

- reaction (how interesting or appealing)
- composition (how balanced or complex)
- valuation (how worthwhile).

Graduation refers to 'how strongly they might feel about someone or something [by] turning the volume up or down' (Martin & Rose 2007, p. 42). It includes two variables, 'force' which intensifies attitudes, and 'focus' which sharpens or softens the boundaries between categories.

To illustrate for the reader how appraisal is analysed, a brief interview extract is presented below. The transcript is divided into clauses, which are numbered for ease of discussion. Inscribed appraisals are <u>underlined</u> and invoked appraisals are *italicised*.

1. I've always wanted to be a health, work in health,
2. my Nan was a health worker down at Eden,
3. she worked with Area Health down there,
4. my mum was a nurse
5. so I *decided to go and get it*
6. and did that
7. and straight after that course the teacher thought I was fine, I could handle it
8. so she put me *straight into* do the Assistant In Nursing course
9. so I did that.

   …

10. I *only went to Year 7*.
11. I'm the oldest of eight
12. so I helped,
13. I left school Year 7
14. and decided to help pop, my grandfather, look after the boys.

In line 1, the Healthworker makes her feelings explicit, she 'wanted' to be a health worker, and amplifies her desire with *'always'*, which is reiterated in line 5. Although she simply states, in lines 2–4, that her grandmother and mother were health professionals, this implies that they had a high capacity. These statements are analysed as **invoked positive capacity**. In line 7, her teacher explicitly judges her as having the capacity to *'handle'* another course, which is amplified with *'straight after'*. This capacity is invoked again in lines 8–9, and amplified with *'straight into'*.

The Healthworker's capacity to succeed in these courses contrasts with her truncated school education that she describes next. The word *'only'* in line 9 implies that leaving school in Year 7 was unusual, so this is analysed as **invoked negative normality**. On the other hand, deciding to help her grandfather look after her brothers, in lines 10–13, was an ethical decision, so this is analysed as **positive propriety**.

The **targets** of each of these appraisals are the speaker *'I'* in lines 1, 5–9 and 11–13, *'my Nan'* in lines 2–3, and 'my mum' in line 4. These are the people who are judged in each clause.

Appraisal is analysed by re-presenting interview extracts in table form. Columns are devoted to attitude and graduation, engagement, and the target of the appraisal. In addition, the type of attitude is labelled to the right of each line.

Extract 3: Appraisal analysis, CJ interview extract

	engagement	target	attitude and graduation	type
1.		I've	always wanted to be a health[worker], work in health,	desire
2.		my Nan	was a health worker down at Eden,	+capacity invoked
3.		she	worked with Area Health down there	
4.		my mum	was a nurse	+capacity invoked
5.	so	I	decided to go and get it	+capacity invoked
6.			and did that	"
7.	the teacher thought	I	was fine, I could handle it	+capacity
8.	so	me	she put me straight into do the Assistant In Nursing course	+capacity
9.	so	I	did that.	"
10.		I	only went to Year 7.	-normality invoked
11.		I'm	the oldest of eight	
12.	so	I	helped,	+propriety
13.		I	left school Year 7	
14.			and decided to help pop, my grandfather, look after the boys.	+propriety

The engagement column needs some explanation. As explained above, engagement introduces 'voices' into a text. An obvious example here is '*the teacher thought*', where it is the teacher who is judging the Healthworker's capacity, rather than the

Healthworker herself. However, there are several ways to suggest other voices than one's own. One way is to imply that an event is more or less expected by the listener. For example, conjunctions such as 'so, thus, therefore' imply that the listener expects one event to follow another. Conjunctions such as 'but, however, although' imply that an event is unexpected. Thus *'my Nan was a health worker, my mum was a nurse, so (as you would expect) I decided to go and get it'*. Similarly, '*I'm the oldest of eight, so (as you might expect) I helped'*. Expectations such as these are significant for understanding the evaluative stance of the speaker. In this example, the Healthworker considers it natural that she would study health like her mother and grandmother, and that, as the eldest girl in the family, she would help her grandfather.

In this component of the analysis, the extract is also divided into phases by outlines to explore how speakers organise their responses into topics. For example, here the first topic is about starting Healthworker training, and the second is about truncated schooling. The first evaluates her positive capacity to learn, and second evaluates her positive propriety in putting her family first.

The importance of the appraisal analyses is its capacity to reveal how Healthworkers evaluate the three topics that are the focus of this study. Appraisals concern with the kinds of attitudes being expressed, the strength of feelings and the 'ways in which values are sourced' provides important insights. For example it provides some indication of Healthworkers 'feelings and judgements about themselves and their various Aboriginal and non-Aboriginal colleagues including nurses and doctors across different workplaces, the professional and personal relationships they have with their communities and families as well as their appreciation of the demands they face in their roles and practice. These insights are important for developing a deeper understanding about Healthworkers and the issues they continue to deal with, such as role clarity, professional recognition, racism, identity, community connections and education pathways that prepare them for their roles.

Together the use of these discourse analytic methods to explore fields of activity, tenor and the textual organisation of each interview provided a way of objectively accessing and interpreting the patterns of meanings in Healthworkers' discourse. This provided

insights into the field of Healthwork, and in particular to the three domains that are the focus of this study, that is Healthworkers' roles and practice, their education pathways and their connections to their communities and families.

3.4.6 Phase 3: Comparing Healthworkers' discourse

The third phase of analysis was to identify the patterns that emerged in Healthworkers' whole interview transcripts. The analyses focuses on each of the nine Healthworkers as individuals in terms of the information they present, how it is represented and how it is evaluated in the three broad topic areas, that is Healthworkers' education, professional roles, and families and communities. These patterns group Healthworkers together while at the same time distinguishing individuals from each other.

This phase of analyses was organised into three sections that focussed on the patterns identified in each of the topic areas. These themes varied according to each of the topics. Firstly for example, education is analysed in terms of the patterns evident in: where and how Healthworkers learnt (institutions, program types and qualifications); what they learnt (range of subjects, skills and knowledge); and how they talked about their education (presentation and evaluation). Secondly, professional roles and practice are analysed in terms of the patterns evident in types of health services and Heathworkers' job titles. On the other hand, their practice is analysed in terms of specific program types and the corresponding activities they performed. Their representations and evaluations of their different roles are also compared to identify and interpret patterns of similarity and difference. The final section on family and community adopted a more thematic approach. It identifies themes that emerge in the interviews and analyses how Healthworkers represented and evaluated these themes.

3.5 Limitations of the methods

There were a number of limitations to the methods of this study. Firstly, the use of interviews on their own may be considered a limited source of data because interviews can only ever be a record of interviewees' perceptions and perspectives at that specific moment in time. Furthermore, interview responses may be subject to distortion for unanticipated reasons, such as how the interviewees were feeling at the time of the

interview and whether perhaps they were anxious, annoyed or perhaps stressed. The interview process itself may also give rise to feelings that could distort interviewee's responses. In addition, interviewees' responses may not be an expression of what they actually feel or think, but be provided to meet what the interviewee expects the interviewer requires. A second limitation is the study's focus on nine interviews, which may hinder the potential for the transfer of findings beyond this group.

The use of the discourse analytic method was considered less likely to present limitations. However, its high level of technicality meant that transcript extracts rather than whole transcripts were analysed. Although this may have constrained the extent to which Healthworkers' discourse was explored, the careful attention paid to the selection of extracts (in terms of their correspondence with the topics being investigated, the relevance of their themes and their language features) helped to limit this.

3.6 Conclusion

This chapter has presented the study design and analysis method applied to the investigation of Healthworkers' perspectives on their roles, education, and family and community connections. The chapter began with a reiteration of the research questions as they related to these three topic areas. Questions focused on two areas of enquiry: the relations between the three domains of interest and Healthworkers' discourse about these.

The chapter then described the study's qualitative approach. It was argued that a qualitative approach was appropriate for interpreting Healthworkers' perspectives on their practice. Key research processes used to operationalise the approach were also described. These included the conceptual framework, study design and ethical considerations.

The conceptual framework included three elements: Healthworker practice as the focus of the study, Healthworkers as contributing research participants, and the three key domains of interest. The three domains were presented as three interlocking spheres, highlighting the interrelationships between each one and Healthworkers' practice.

The study design also included three research elements: the research problem, the research method, and the analysis procedure. Each of these elements involved a specific set of activities. Activities associated with the research problem were the development of the research questions and conceptual framework. The research method was Healthworker interviews. Activities included: the selection of Healthworker interviewees; the most effective and appropriate interview type and settings; obtaining informed consent; considering my role as interviewer; question design and techniques; the use of a voice recorder and interview transcription in preparation for analysis. The analysis procedure included three phases of activities: recontextualising spoken interviews as written biographies; the application of discourse analysis to selected interview extracts; and discussion of patterns that emerged in the analyses. In the first phase, the nine spoken interviews were recontextualised as written biographies, to reveal Healthworkers' life histories and to provide a context for a more detailed analysis. In the second phase, short extracts exemplifying each of the three domains were selected from the interview transcript of each Healthworker for detailed analysis using discourse analytic methods. The third phase focused on the three broad domain areas and explored the patterns of discourse across the nine Healthworker interviews.

The chapter also discussed the ethical standards and protocols that informed the research approach and processes. It described the contribution of NHMRC and AIATSIS guidelines in the study's efforts to employ a culturally safe research framework to ensure Healthworkers' values and needs were recognised and respected. Guidelines were used to manage a range of ethical issues. These included: informed and voluntary consent; the evaluation and prevention of potential harm and risks to participants; the establishment of honesty; trust and integrity between interviewees and interviewer; protection of peoples' privacy; confidentiality and anonymity; and the maintenance of research integrity and quality. This framework provides the foundation for the following chapter which presents the first phase of the analysis, that is, the recontextualisation of Healthworker interviews as brief biographies.

Chapter 4: Aboriginal Healthworker Biographies

4.0 Introduction

As outlined in the preceding chapters of this thesis, the study is based on in-depth interviews with nine Aboriginal Healthworkers who talked at length about their diverse healthcare roles, educational experiences, and their community and family relationships. As explained and justified in Chapter 3, the first step in the analysis was to draw on the transcripts of the Healthworkers' spoken interviews to re-present them as brief written biographies. This step constitutes a description, rather than an analysis of Healthworkers interviews. However it is included as analysis because it provides readers with an impression of each Healthworker's life history, including their accomplishments and personal and professional challenges, as they were presented during their interviews. In addition it provides an overall perspective of the nine interviews and reveal thematic points and patterns of similarity and difference in respect to the three topic areas.

Importantly, as the initial step in the overall aims of this study, the biography writing process provided a starting point for considering the study's first set of sub-questions including:

- *What roles and scopes of practice do Healthworkers perform?*
- *What types of education and training do Healthworkers undertake and what skills and knowledge do they acquire in order to perform those roles in their scopes of practice?*
- *What interconnections are there between Healthworkers' families and communities, their roles and the skills and knowledge they bring to their roles?*

The biography writing process began with my immersion in Healthworkers' interview transcripts to gain an overall understanding of their content. Individual transcripts were then further explored and various elements identified, including the significant people and events in the Healthworkers' lives, their experiences and ideas, and issues arising from these. For each interview, these elements were compiled, organised and recontextualised as a series of life episodes in a general chronological sequence. As a result of this process, the content of each interview, which averaged 9000 words, was

reduced to approximately 1280 words per biography. This process enabled me to condense the extensive and complex interview data to provide a global perspective of the nine interviews as a whole data set. It also introduced consistency and coherence to the presentation of salient information in the biographies; information that was sometimes less explicit, more varied and dispersed in the interviews. In turn, this facilitated the identification of patterns of similarity and difference in the Healthworkers' experiences and life stories.

The biography writing process required several issues to be addressed. Firstly, to ensure that the identity of Healthworkers was protected and that people, places and organisations were de-identified. Secondly, to enable Healthworkers to authorise my rewriting of their interviews as biographies, they were emailed copies of both the interview transcript and biography for comments. Two Healthworkers, despite having previously viewed and approved the accuracy of their transcripts, did not respond with feedback regarding their biographies. The absence of authorisation from these Healthworkers regarding their biographies resulted in their exclusion from this chapter. The remaining seven Healthworkers responded, approving my interpretations of their interviews and the inclusion of the biographies in the thesis. Three Healthworkers provided minor editorial corrections that were subsequently made.

A particular issue in the biography writing process was managing my role as the writer of other people's experiences. This issue held even greater significance in light of my non-Indigenous identity and debates about Indigenous data being collected for the service of a non-Indigenous collaborator's theoretical or professional agenda. I approached this issue, by reflecting on my ethical responsibilities to report Healthworkers' life stories as they told them to me and trying to convey the stories at this point rather than to interpret them. While it would be naive to imagine that I could be completely objective in this task I never the less sought to at least achieve a level of 'empathic neutrality' (Patton 1990, p. 58). This meant that I sought to communicate interest and care towards the interviews that I was writing as biographies, and to simultaneously be nonjudgmental about their content so I could represent them truthfully without affecting their integrity.

The biographies I have presented in this chapter are more descriptive than interpretive. However I consider that the biography writing process constitutes a step in the analyses in that they provided me with an opportunity to familiarise myself with each Healthworkers' interview and with the themes that emerged in them.

4.1 JK

JK is the regional coordinator of a mainstream health promotion program in a government health department in a large regional city. The program focuses on screening Aboriginal children for ear disease and hearing loss. JK has been in this role for twelve months.

Although JK's story is the briefest of all those collected, it is a compelling account of professional and personal growth through study and work. As she related it, her story began when she left school after completing Year 12. At this time, she did not know what she wanted to do, so took a position as an administrative assistant in a family support unit, where a family member also worked. It was while working there that a promotional tour by visiting academics prompted her to consider enrolling in a two-year Diploma in Health Science (Aboriginal Health and Community Development). Finding that her studies complemented her work, JK was soon '*really enjoying myself and learning so much at the same time and able to use those new skills in the job and in everyday life really*'.

After completing the diploma, JK continued on to the bachelor's degree, while developing a greater interest in Aboriginal health and, in particular, the health of children. In her final year, and determined to focus solely on her studies, JK resigned from her job. This commitment was subsequently rewarded when she won a scholarship to complete an overseas study placement and was offered a university-based research position. She described this research investigating what health science students learn about Aboriginal health as interesting, but it was only a 12-month contract and she was soon applying for other positions as well as considering postgraduate study options.

As her story unfolded, JK recounted that she continued at university, firstly completing a Graduate Certificate and then a Masters in Aboriginal Health, while also working for a

short period in an Aboriginal vascular health program. Not content in this position, she applied for a clinical role in a regional health promotion program that entailed screening Aboriginal children for ear disease. Although the position required specialist skills and knowledge, JK was undeterred, committing to additional study in audiology and audiometry screening. At the time of this interview, JK had worked in this health promotion program for four years and had recently been promoted to the role of regional program coordinator. She described this new role as an upper-level position with extensive responsibilities that include management, strategic planning and clinical components.

Firstly, regarding her management and strategic planning roles, JK identified a range of activities and tasks. On the one hand, these include:

> *monitoring the budget … making sure the appropriate people are getting paid … trying to look for more enhancement funding to maintain current staffing levels, participation in area network meetings and advisory committees, ensuring the programs running properly, getting everything it needs as far as management and resources.*

On the other hand, she also described activities that required:

> *developing relationships, working with a whole range of professionals … audiologists and nurse audiometrists and department of Education and Hearing support teachers, [and] the Division of General Practitioners and doctors and Ear Nose and Throat specialists.*

Secondly, in regard to her clinical role, JK described her role in supervising Healthworkers to conduct audiometry procedures that involve checking children's ears for the presence of ear disease and hearing loss. JK explained that the focus of this role required her to:

> *coordinate screening, outreach screening clinics in schools and preschools to make sure that children experiencing OM and conductive hearing loss are accessing appropriate screening services and getting the proper follow up care.*

But it also entailed training Healthworkers to '*use the equipment … fill out reports … plot the graphs for middle ear function, and the hearing graphs*'.

Reflecting on how her university education has contributed to the skills and knowledge that she draws on in her current professional role, JK was unequivocal, relating specific units of study to her capacity for ' *monitoring a project, developing it, implementing it and … evaluating it*'. However, as JK explained, it has also taught her '*to be a critical thinker, analytical and how to communicate effectively through writing*'. In particular, she highlighted the direct link between her education and her written, verbal and non-verbal communication skills, and the difference these skills have made to her capacity ' *to communicate effectively with various groups of people, professionals, and community members, governments and non-government people*'.

In addition, JK pointed out that her education has also affected her personally, strengthening her confidence and enabling her to deal with people who '*automatically think they're your superiors and … know more than you and have more experience than you'.* As JK's story progressed, this confidence became palpable, particularly as she explained that, as an educated young Aboriginal woman, she is no longer intimidated by such people but is now:

> *up there with the best of them and can challenge people, and question people in order to do what's right for my program … and my staff and my community … to get what I want.*

As well as building her personal strength, JK noted that her education has also strengthened her identity as a Healthworker committed to improving the health of her community. She explains this in terms of her skills and knowledge enabling her to do:

something for the benefit of the Aboriginal community and … contributing … maybe better health outcomes for Aboriginal children, because Aboriginal children is you know my passion. … so I think that I'm, I'm happy with my contribution at the moment. Yes, because I'm coordinating an area otitis media program for Aboriginal children so that's a pretty big achievement I think.

JK also reflected on the contribution made by her:

experience in Aboriginal health and that strong education and that background and obviously being Aboriginal and being part of the Aboriginal community helps as well. To be able to understand the community and what the community needs and what the community wants.

Along with the other Healthworkers who shared their life histories with me in this research, JK's depiction of her journey – from being an uncertain young school leaver to becoming a confident health professional and proud Aboriginal woman – is both affecting and powerful. Her persistent but quiet commitment to her education, through the completion of a diploma, undergraduate and postgraduate qualifications, saw her acquire the skills and knowledge needed to fulfil a range of management-level positions and her passion for improving the health of Aboriginal children and communities. Perhaps more significantly, however, her story suggests that her educational achievements have strengthened her self-esteem and pride, enabling her to acknowledge her achievements and '*feel confident in my ability to be able to … expand my horizons*'.

4.2 CB

CB is a health promotion officer, but is classified an as Aboriginal Health Education Officer (AHEO). His role is in a mainstream population health program in a large regional town. He has been in this role for 12 months and is one of the two male Healthworkers interviewed for this study.

CB's role entails the delivery of population-based programs, including those targeting primary schools and pre-schools to address topics such as physical activity and smoking cessation. The team comprises 11 other people who are based in a number of towns

across an extensive geographical area. CB pointed out that the distribution of the team across towns is essential because services for Aboriginal people are still lacking in many places. Also, having staff in different locations provides them with the opportunity to understand the varying dynamics of individual communities. CB described that his interest in health was encouraged by his family who he considers to be '*hard workers*' and proud of his achievements. His siblings, who have vocational or university qualifications, have been his role models. CB has been in his role for approximately 12 months and was recently appointed on a permanent full-time basis. He is pleased about this because, as a father with young children, he says it will give him employment stability.

Before taking up his Healthworker role, CB first completed Year 12 and then a Business Administration traineeship and Certificates III and IV in Business Administration. He continued to study while working in health promotion, completing a Certificate IV traineeship in Aboriginal Primary Health Care (Practice Stream). He explained that he studied this at TAFE with support from an Aboriginal study unit, participating in week-long study blocks once a month for 18 months and undertaking concurrent healthcare work placements in community health, Aboriginal Medical Service (AMS) and hospital.

The community health placement required him to deliver programs such as a weekly men's group, an Elders clinic, and home visits to do wound dressings, measure blood sugar levels and conduct other tests. He also provided Aboriginal clients with transport to ensure they could access visiting specialist's clinics and other services. The purpose of the AMS placement was '*to get the experience working with Aboriginal people*'. While in the hospital, he learnt the basics of health, Aboriginal health, health history, anatomy and biology. It also required CB '*to do to do so many hours in the ward so … clinical skills are up to standard*'.

He described working in the hospital wards as '*useful because you form a relationship with the patients and build on your communication skills with the patients and [learn] how the nurses administer medication and I was doing wound dressings and … urinalyses, blood pressure*'. He also said that he '*loved*' this work particularly '*a lot of*

things that nurses do'. However, he '*wouldn't be at all interested in becoming a nurse because of the hours and the time spent on your feet*'. CB described his preference for his Healthworker role because of the '*wide range of things you do … you're never bored … [you're] sort of like jack of all trades*'. He identified that the '*the most valuable skills and knowledge*' included:

> *looking at the different ways of learning [and] research … plus, the support I was given and the way that I was taught to study. I think I value it. It's something that you can always use … if you just know the basics about something, you can always study it a bit more and then you can elaborate as much as you want.*

Since starting in health promotion, CB described that his role is '*a lot different*' to anything he had anticipated, explaining that this may have been because he was unfamiliar with health promotion concepts and did not realise that they encompass capacity building, illness prevention and equity. Now with more experience, CB suggested that Aboriginal health promotion programs should take '*more of a holistic approach*' and increase their focus on the determinants of Aboriginal health. He argued that although Aboriginal people may be included in health programs, these are still not taking into account '*all the underlying factors*' affecting people's lives. He explained that:

> *An Aboriginal client is more likely to be in contact with alcohol abuse, more likely to be of a lower socio-economic status. They could have mental health problems; they could be coming into contact with domestic violence.*

CB highlighted that there is a problem with this because '*your boss is always going want you to do the diabetes stuff … that's measurable and that they can see results on even though it's only the bandaid approach*'. Despite this, CB expressed optimism maintaining that '*the more people you discuss it with and the more people are aware of what's going on eventually, eventually it'll start becoming addressed*'. In addition, he describes being '*happy to just stay as an Aboriginal Healthworker and deal with equity issues … trying to run different programs.* While he says he also enjoys the education

component of his role when clients give him positive feedback, although compared to clinical treatment outcomes, it is difficult to measure its success.

Regarding the need for qualifications, CB views that '*it's important for Healthworkers to have a qualification*', but there are multiple issues to consider. One issue he raises is that Healthworker roles vary across communities making it difficult to determine the different qualifications needed for each role. A related issue is the '*different ideas about what Aboriginal Healthworkers do*'. For example, CB noted that although '*NSW Health see Healthworkers as a key to capacity building*', they '*haven't got a clear outline about what Healthworkers do*'. Also, some nurses question Healthworkers' clinical roles and ask '*why're you doing this? You aren't supposed to do that, this is what nurses do*'. Furthermore, clinical qualifications must be frequently updated, which according to CB, is '*going to take away some of the communicating with the community and some of the liaison … you do*'. Finally, he notes that, in his experience, '*a lot of senior Healthworkers … are a bit reluctant to change … [and say] why should we change our role; we've been doing it for 30 years?*'

However, regarding to his own qualifications and role, CB considers that '*as part your team dynamic it's good to have a good mix of people*'. He explained that:

> *There's potential for someone of my background to fill an important part of that dynamic because [of] my connection to the Aboriginal community. I think being someone not having a university degree, so not of the same level of education gives a different perspective as well.*

As the only health promotion team member without a university qualification, CB is aware of the advantages of a degree for himself, including that he '*can get paid more and … [learn] new skills, a few I think would be worthwhile*'. He says that '*definitely down the track I'd like to get a university degree of some sort*', but has been approached to complete the ATSIPHC (Community Care) Certificate IV. Although reluctant because he already has a Certificate IV qualification, he has been assured he is eligible for substantial recognition of prior learning and would therefore only have to complete a few units of study.

CB's story illustrates some of the complexity associated with Aboriginal health and Healthworkers' roles and education. Compared with many other Healthworkers, CB's pathway from school to a TAFE health traineeship and then to health promotion has been straightforward. Although he is still relatively new to the field, this pathway has enabled him to develop a set of skills and knowledge, which combined with his understanding of the Aboriginal community have afforded him an awareness of this complexity. This is reflected in his confidence to express a judgement about those issues he identifies as important, and his ability to consider issues from multiple perspectives.

4.3 CO

CO is the Health Services Coordinator at a regional Aboriginal Medical Service where he has worked for a number of years. He has been the Health Services Coordinator for approximately six months, having previously fulfilled other Healthworker roles in the service. CO is one of only two male Healthworkers interviewed for this research.

CB's pathway to this role has been challenging and has taken many twists and turns. It began when he left school at the start of Year 9 and '*just started looking at factory work. I thought that was sort of my demographic and that's where I would sort of stay*'. He then became a young father and, facing personal difficulties, decided to begin a TAFE hospitality course. This led to a short-term position and a leadership role as a '*level three non-qualified chef*', after which, he was once again worrying about what to do next.

Following a suggestion from family members, CO commenced working for the NSW Department of Ageing Disability and Home Care in the Aboriginal Multi-Service Centre, first as a domestic cleaner, then providing financial assistance to the elderly, and later performing administrative work. He said that in this role, he '*realised that I loved being in the community and part of the community, but I liked to be in the background*'. He also became '*aware you can make influences*', in management or administrative positions. Consequently, CO decided to study at an Aboriginal College where he completed a Certificate 3 in Aboriginal and Torres Strait Islander Healthwork, which he

described as difficult but an enjoyable challenge that '*makes me excel and proceed in my ways*'.

Provided with new direction, CO then applied for and accepted voluntary work at the AMS, which in turn led to formal paid employment as an Enhanced Primary Care Aboriginal Healthworker. In this role, he was responsible for conducting clinics for '*chronic care management or diabetes and asthma*', areas that he describes as his '*passion*'. Gaining confidence, and always open to opportunities, CO then commenced as the male Healthworker, describing it as largely clinical *with the* '*core business … looking after men's health*'. He stated that this entailed '*primarily looking at prostate, testicular, breast and impotencies and then … men's mental and sexual [health]*'. It also included a range of clinical tasks such as:

> *blood pressure … blood glucose levels and your eyes and your ears and teeth … family history, because that's a good key indicator that there's diabetes in the family, there's asthma in the family.*

After two years in this role CO, was then appointed as a Health Services Manager, a position he has held for six months. In this position, he has multiple responsibilities for '*monitoring or coordinating, or managing*' a wide range of medical, nursing and allied health staff. This requires that he '*look after their HR, training, OH&S, staff development, staff planning, health services, which is our team, planning*'. Since being in this position, CO has told people that '*I aspire to be the CEO of the … Aboriginal Medical Service*' and that Aboriginal health needs '*fresh eyes … new perspective … young perspectives … different world views*'. For example, he said that the title of Healthworker should change to '*Aboriginal Health Professional*' in recognition that they '*deliver culturally safe and holistic approached care*' and '*really do convey professional duty of care*' as well as '*mediate between the service, the community, the clients, the providers, the allied health providers, you know, so they really are in that pinnacle role*'. In addition, he considers it is time for Healthworkers to be formally registered and to have minimum qualifications with national competencies linked to role descriptions and award wages. Although he recognises this may present difficulties for some.

In conjunction with his senior management role, CO enrolled in a Bachelor of Health Science. As the first person in his family to attend university, he said it '*has played a massive role in my life [and] really opened my eyes*', and enabled him to '*understand…always think outside the square, brainstorm every possibility, every channel [and] try to have solutions to my problems when addressing my problems with others'*. Although CO views a university degree '*as the white man's paper*' he acknowledges that it is '*the higher education of society…where you have to go if you want to be an architect…CEO or doctor*'. In addition, he recognises that it is a path out of the demographic where he thought he would always stay, explaining that:

> *a lot of Aboriginal people didn't have adequate education, housing, employment, support … and therefore could never get that degree. So they never got the good jobs … the good housing … good lifestyles or living. And so that's where in the social scale of things it became like 'us and them', and it sort of really minoritised Aboriginal people … at schools as well … down through generations and generations.*

But CO was also critical of his university course because it does not recognise '*community experience, especially in the Aboriginal Torres Strait Islander world*'. As a result, '*people come across with degrees that don't have a clue how to interact with the community, and therefore could be quite dangerous to the community*'. Moreover, he described university study as challenging, particularly because he has had little academic preparation, additional tutorial support and must juggle it with fulltime work and family responsibilities. Negative consequences include not doing as well as he would have liked and having to reduce his study load. However, he is unequivocal about his priorities, firstly the care of his children and extended family, secondly his community, thirdly his employment, and finally his studies.

CO's story is comparable to that of many Healthworkers who must decide how to resolve the tension that results from dividing their commitment between competing family, community, employment and study priorities. Because most Healthworkers give precedence to their families and communities, this means they forgo opportunities that

could be of personal or professional benefit. CO explained this, saying, '*I am a real community-focused person … But that doesn't enhance me as an individual and doesn't really give me growth or progression*'. To resolve this situation, CO drew on his determination and confidence to achieve his professional and educational aspirations. He has also drawn on his grandmother's advice:

> *to never lose perspective on where you come from, never forget where you've come from to where you are currently, always intertwine and utilise mainstream services … you need to weave in and out of mainstream to make your Aboriginal sector successful.*

4.4 SW

SW is a full-time AHLO in the Social Work department in a large regional hospital in rural NSW. She has been in her role for more than five years. Her discussion of this role was charged with the tension she experiences as she struggles for professional recognition in a health system dominated by non-Aboriginal health practitioners, many of whom she described as having a limited understanding of Aboriginal health.

SW began the interview with how she entered the health and welfare sector. She described that, at the age of nineteen, she had a daughter with special needs but did not realise how little she knew about the services that were available to support her. Knowing that other equally needy Aboriginal people were probably also unaware of the services available to them, SW decided to study in this field. She completed a Diploma in Community Welfare at TAFE while simultaneously working in community organisations, and went on to also complete a Diploma in Aboriginal and Torres Strait Islander Health. SW then gained a position as the AHLO in the Social Work department at her local hospital. This role, combined with her awareness of Aboriginal health inequities and the differences between her professional status and that of her Social Worker colleagues, prompted SW to continue studying. This time, however, she commenced a Social Work degree by distance education. At the time of her interview, SW was completing the final year of her degree.

SW stated that family members helped to energise her commitment to study and work. In particular, she describes her mother's ongoing '*unconditional love, support and guidance*', and the inspiration of her two younger university-educated sisters. She also acknowledged the support of a colleague who encouraged her to enrol in the Social Work degree.

As the only AHLO in one of the largest referral hospitals in regional NSW, SW's role entails contributing to the in-patient care of Aboriginal people in areas such as: emergency, coronary care, intensive care, oncology, palliative care, medical care, surgical care, maternity, paediatrics and rehabilitation. Although AHLO roles may vary according to the specific needs of Aboriginal people in different communities, SW's role generally reflects that of most AHLOs in Australia. These roles are multifaceted and centre on advocacy for Aboriginal patients in hospital and the provision of follow-up care after discharge. One aspect of advocacy entails interpreting medical terminology used by doctors but which patients may not understand. SW points out that many Aboriginal people find this frightening until she can '*explain in lay terms what the doctor's actually talking about and that it's not as devastating as it sounds*'.

Another aspect of SW's advocacy role entails liaising with police and other agencies such as Centrelink, Department of Housing, Family Support, Correctional Services, St Vincent de Paul and the Salvation Army. Typical issues that she deals with in her liaison role may include crisis intervention, child protection, domestic violence and grief and loss. Other issues include those that arise from drop-in patients and patients' extended families who may be affected by their relative's hospitalisation. SW said that issues arising in these situations vary widely and may include anything from making:

> *contact with somebody in prison to let them know the family member's really unwell or writing letters to the governor of prisons to see if somebody can get out to go to a funeral of somebody that's died.*

As member of the Social Work team, SW also participates in case management meetings, team meetings and daily staff meetings. These meetings give rise to a range

of administrative issues, such as the collection of statistics and data, occupational health and safety, and workforce planning.

To effectively fulfil her role in these and other situations, SW described that she needs excellent communication skills, empathy and knowledge about health and welfare systems, sociology, psychology, law, community development and social work theory and practice. She also needs community knowledge such as knowing about differences within the community, Aboriginal language groups in the region, family relationships and the impact of historical events in Aboriginal people's lives. SW described acquiring some of these skills and knowledge at TAFE, which was '*more of a hands on thing*', while others she learnt at university, which was '*like jumping from kindergarten to year 6 with nothing in-between*'. She said that study has made her '*more open minded … and I understand and appreciate where people come from a lot better than I used to*'. While becoming qualified will give her '*that piece of paper that makes me equal*', SW emphasised that her Social Work qualification will not change her practice.

SW identified another component of role as managing workplace challenges. One is working in a multidisciplinary team with other non-Aboriginal health professionals who do not always share the same views. Most doctors and nurses she said '*really respect and understand how difficult, or how challenging the role of the AHLO can be'*. Whereas Social Workers:

> *don't have a lot of respect for my role as the AHLO [or] the skills, the knowledge and experience that I have. And with them not allowing me to practice those skills and knowledge with my clients, that makes me really frustrated.*

Another challenge is Aboriginal patients' preference for SW's support rather than that of non-Aboriginal Social Workers, particularly in sensitive or crisis situations. SW explained that patients say '*I'm not talkin' to them white fellas … I just want to talk about it with you. You're who I feel comfortable with*'. The problem that arises in this situation is associated with SW's job description, which prevents her from counselling or offering support in cases involving '*domestic violence, child protection, grief and*

loss issues'. This means that, for these issues, she must refer clients to the Social Workers who are deemed more qualified.

In many instances, however, SW has opted to work with clients dealing with these issues and to suffer the consequences. Summing up her frustration she said:

> *At work I sometimes feel like the token black fella, the little lap dog that's going to run around after everyone else and pick up the pieces and I'm sure there's a lot of other Aboriginal Healthworkers out there that feel the same … I hope that one day the powers that be can somehow acknowledge and appreciate that Aboriginal Healthworkers do a wonderful job in our communities for our people and we get the recognition that we deserve and we're not always put down the rung, the bottom of the rung, the bottom of the pile scraping our way to the top*.

SW's portrayal of her role was dominated by her struggle for professional recognition and the best care for Aboriginal patients in a mainstream healthcare setting. Her pathway to becoming formally qualified through the completion of multiple TAFE courses and a Social Work degree while working full-time and caring for her family has been challenging. Her success in managing these challenges so confidently reflects her extraordinary resilience, determination and depth of experience. It also demonstrates her clear understanding that having an educational qualification will give her the authority she needs to ensure all Aboriginal patients receive effective and appropriate care.

4.5 RH

At the time of interview, RH was between positions and studying full-time to complete the Bachelor of Health Science (Aboriginal Health and Community Development). RH therefore chose to discuss the numerous Healthworker roles she had performed.

RH's education and work history is comparable to that of many Aboriginal women who are dedicated to their families, communities and the health of Aboriginal people. Her pathway into Aboriginal health began with her family, and with her relationship with her father who she describes as a man '*of very strong convictions and had a lot of drive*'. It entails the impact of her primary school experiences and being singled out and

'*stuck down the back of the classroom doing something else*' while the rest of the class '*were learning about history and Captain Cook*'. It also includes the circumstances that resulted in her leaving school by Year 10 to join the factory workforce then marrying and starting her own family. As RH explained, not only did her family's circumstances limit their expectations of her, but '*in those days you weren't sort of expected to do anything else*'.

Having inherited her father's determination and passion, RH worked '*here and there just to feed everybody*' before taking up a contract cleaning business that she worked in seven days a week for 10 years. This provided her with the flexibility she required to care for her children including one who required extensive medical and hospital treatment. Coincidently, it was this business that also led RH back to education; while cleaning at a university, she became aware of, and enrolled in, an Aboriginal history unit of study.

At this time, RH also recognised her relationship was in trouble and sought support from a community health centre where she experienced '*huge personal growth*' that enabled her to '*put a lot of pieces together*'. The effects of this, combined with her curiosity about '*the way people think and … behave*', resulted in her commencing a Certificate IV in Community Services (Disabilities). Although she successfully completed this course, RH soon found herself needing to support her family, so started work '*gutting chickens, picking mushrooms, anything*'. Before long, however, she decided to focus on '*areas that I thought I could … build more knowledge*' and gained a position as a Family Support Officer. This role entailed implementing an outreach counselling program with non-English speaking and Aboriginal clients, which as RH described, required her to '*meet people in the community, see them in their homes and ascertain what their needs were, and then go set about getting those needs met by whatever services were there*'.

With a colleague's encouragement, RH then completed a Certificate in Domestic Violence and Child Sexual Assault before her '*step into the big deep water*'. This meant moving to take up an Aboriginal mental health role in an acute care unit in a large regional hospital to work with clients '*in drug and alcohol induced psychoses or [with]*

a history of mental illness, schizophrenia, depression … attempted suicide'. This role entailed diverse responsibilities such as monitoring clients and performing mental health assessments as well as managing their general social welfare by liaising with agencies to arrange housing, clothing, furniture and food. The purpose of this was to ensure that when they '*stepped back out into society again they actually had somewhere to go … had all their appointments set up*'.

Continuing in this role RH, extended her knowledge and developed confidence in her capacity to be effective. But she was also aware '*that things were wrong*' and that this wasn't just '*because people didn't want to listen*', but rather because of a '*system problem*'. In particular, RH described the system's inability to appropriately treat Aboriginal clients with mental health problems and suggested that:

> *Even though people become sort of well, they're only a little bit well. They've … been medicated to be stabilised enough to not be a threat to themselves or to the community … but there's just such pressure on the system that they just can't keep them any longer… it's in one end and out the other.*

As a mental Healthworker in a system she viewed as dysfunctional, RH was left feeling '*out of my depth*', so to broaden her knowledge even further, she applied to work in Aboriginal palliative care. In this role she consolidated her skills through fieldwork and the establishment of an Elders group. But feeling a need for further opportunities, RH decided to try working for an Aboriginal organisation. To her disappointment, however, she said it lacked programs and qualified staff and *was* '*really poorly run*'. Despite this, she managed to develop a drug and alcohol rehabilitation program, counselling group and art work project, but after two years described that '*the organisation and the people in the community … chopped me up in little pieces and spat me out*', and that '*the people that were there, that really needed the help … were missing out*'.

During this time, RH had also enrolled in a Bachelor of Health Science (Aboriginal Health and Community Development). Comparing this with her TAFE education, she viewed university as '*a different level, it's really getting at the core, core issues*' that has enabled her to '*learn more and more [about] how I could possibly change those*

things'. Specifically, she acknowledged that university led her '*to understand to a better extent what actually is going on. How … policies are written how they're supposed to be implemented, are they being implemented?*' RH articulated a deeper appreciation of issues such as '*human rights and social justice, professional practice, primary healthcare*', and knowledge about '*how health is delivered and … been delivered in the past to Aboriginal people*'. She explained that:

> *You can't get away from the medical model of health entirely. You've really got to incorporate that holistic approach as well. So trying to blend this all in together I think will really, really help improve the health of Aboriginal people.*

RH also described feeling that she has '*metamorphosed*' as a result of university study, clarifying this as:

> *I've changed in the way that I view things … even in my personal life … I see things that affect me more, that I wouldn't have thought would have affected me before and how they've manipulated me in the ways that I didn't want to go, or ways I wanted to go … not just in the way that I work, but in the whole way I think. In my life personally, and the way I am approaching it, (it) is starting to become really different … I wouldn't have been able to do this, do you know what I mean, I would have been slotted into labouring work all my life, and I wouldn't have been able to help anybody any further in what I was doing there.*

But RH was also pragmatic about university, saying:

> *I don't imagine me going from here and having some top position somewhere. I imagine I'm going to have to work hard and there's still a lot for me to learn … unpack how it all works and how you can actually improve things in communities.*

In communicating her experiences, RH shared some of the extraordinary challenges she has overcome to achieve her professional goals. Her spirit, curiosity and determination have broadened her mental healthcare skills and knowledge. Combined with her life experiences, this has given her a deep understanding of some of the most difficult and

poorly understood of all health issues affecting Aboriginal communities. This is reflected in the strong empathy she expresses for the Aboriginal people she cares for and her commitment to more effective service support.

4.6 DB

DB is an AHEO who works in a mainstream community health service in a large regional town. Her role is in Chronic Care and focuses on Aboriginal clients with diabetes. DB has been in her role just over two years, in both a part-time and full-time capacity.

DB's story began with her childhood recollections of wanting to be a nurse at the age of ten. At the time, she and her siblings were being raised by her grandparents in a small NSW rural community. DB recounted that, after her grandfather died, she and her siblings became responsible for her grandmother's personal care, and that perhaps this sparked her nursing aspirations. For DB, these aspirations became a reality when she left school in Year 10 and commenced Enrolled Nurse (EN) training at the local hospital. Based on an apprenticeship model, the training combined classroom study with learning while working in the hospital. DB remembers it was the 1970s and that ENs had minimal responsibility with their roles largely focused on '*carrying bed pans, wiping backs and washing bottoms*'. Consequently, when later asked to trial an AHEO role, DB was pleased to be seconded while continuing part-time work at the hospital.

As the first AHEO in the community, there was initially no clear job description or office for DB's role, which focused on liaising with, and bringing Aboriginal families to, the health service. DB spent more than 15 years in this role and described growing within herself and learning about the importance of health promotion, primary health and her Aboriginal culture. At this time, she also studied nursing, but withdrew from the course after nine months when work and family responsibilities made the situation too stressful. DB felt that she may be '*left behind*' if she did not study, and enrolled in a Bachelor of Health in Public and Community Health at a regional university. She described university as having many benefits. For example, she explained that at school she learnt nothing about Aboriginal history, whereas university study had given her a

new understanding about Aboriginal culture and the impact of Australia's colonisation. As she stated, the university course:

> *made me more sensitive, gave me understanding, empathy, because it helped me to relate it to my own family. It made me stronger and definitely more educated in certain areas. Education is power … The more you learn, the more you know, the bigger the confidence and the more you want to learn. My strength came from the course … from the understanding of my culture and made me even more proud of where I was at that stage in my life and of the path that I'd chosen to take, it made me look at things differently.*

After completing her degree, DB continued working as the AHEO. During this time, she also engaged in '*self-learning*', and described as the knowledge gained working with your peers and through repeated opportunities to practice skills. She also described taking advantage of the in-house training promoted by her health service. As DB explained, this training was necessary because, although paradoxically AHEO's are defined as 'generalists', in reality, they are expected to have a comprehensive set of skills and knowledge to meet their community's and co-workers' expectations. This includes, for example, knowledge of diseases commonly affecting Aboriginal people, such as diabetes and heart disease. DB views this situation as having emerged from the general lack of understanding that some health professionals have about the AHEO role, which she described as '*jack of all trades … and master of none*'.

While working as the AHEO, DB was approached to support another rural health service some distance from her own community. After deciding that it would be good experience, she was seconded and continued in the role part-time for two years before moving to take it on permanently. Although concerned about the move from her community to risk being an '*outsider*' in another, DB decided the opportunity was worth it and realises now that her enjoyment of her role proves her concerns were unfounded.

In this role, DB has multiple responsibilities such as the provision of diabetes education, school health education, exercise programs, community clinics and encouraging health

service utilisation. She is also involved with the local AMS, visiting fortnightly to provide their clients with diabetes education and also collaborates with Juvenile Justice Centre to provide a monthly diabetes education session. DB acknowledges the critical contribution made by the team in which she works, and her own capacity to cope with an increasing caseload. The team is multidisciplinary and includes local and visiting specialists, educators, podiatrist, psychologist, paediatrician and endocrinologist. Its success is the result of cooperation between members, a professional management style that encourages self-care and an organisational framework that promotes information sharing. As the AHEO in the team, DB feels she makes a valuable contribution particularly being:

> *able to relate to people, to liaise … to talk the talk and walk the walk … to be switched on, non-judgmental … aware …and sensitive to people from all walks of life.*

DB works with a range of groups such as '*dysfunctional families*', different community '*factions*', visiting families from other regions and a variety of professionals. DB pointed out that her holistic view of clients' health needs is also important and are one reason why Healthworkers '*are so successful with our client's compliance*'. This is in contrast to non-Aboriginal health practitioners who are '*just looking at the problem. They're not looking at what's causing it, you know what's festering behind the problem*'.

Establishing good relationships with Aboriginal community members is critical to the success of DB's role. She explained that there are no policies specifying how to achieve this, but that seemingly insignificant strategies, such as transporting clients, strengthen community relations, health service access and continuity of care. Even so, this issue is sometimes contentious as she pointed out:

> *though we're not transport officers, [we'll] bring clients to their podiatry or specialist appointment. Because we know there's no other way they're going to get to that appointment. That whole 3 months work we've done with this client is just going to go out the window if we don't go and get them. So sometimes you*

have to test the boundaries and not get hung up on the policies because there's no proper policy about us transporting and it's been going on and on. It's a very … grey area.

Another strategy is home visits, which DB said allows people to '*look out*' for her in the community. She also drew attention to the importance of her Aboriginal identity and describes that '*being an Aboriginal woman makes you even more sensitive because you're part of that Stolen Generation, part of racism, you're part of always having to … be really sensitive*'.

The skills and knowledge DB identified as critical to her role included knowledge of Aboriginal and other cultures, knowledge of anatomy and physiology, primary health, health promotion and clinical skills, for example, the ability to read a simple blood result. And although saying, '*We never have high expectations in Aboriginal health and that way we don't get disappointed*', she cited motivation as a vital element that helps her to '*love*' her work. She also acknowledged the importance of being confident, assertive and able '*to talk and liaise with doctors who can be very intimidating people*'.

Despite the Healthworkers' comprehensive contribution to Aboriginal health service provision, DB pointed out that their roles are generally undervalued in comparison to other health professionals. Like many Healthworkers, she contended that formal registration could redress this imbalance and improve their autonomy and recognition, '*stop professional jealousy*', increase client referrals and thereby potentially improve Aboriginal health outcomes. At the same time, she questioned whether this alone would change the discriminatory views of some health professionals, and said that '*racism will never go away*'. DB, however, is keen to convey the crucial roles Healthworkers have in the chronic health care program which she describes as '*brilliant and if you hang here for a day and see exactly how it works it's just beautiful*'.

4.7 WH

WH is a Healthworker in a state government health program targeting Aboriginal Otitis Media and Eyesight Screening. She has been in these roles for approximately 12 months.

Like many Healthworkers, WH's pathway to her role has not been easy or linear. She described a family life that made her want to escape home and school, which she left in Year 10, recounting that by the age of 21, she had two children and a '*failed relationship*'. These circumstances demanded she take whatever casual work she could, but without any qualifications her choices were limited to fruit picking, waitressing, cooking and retail work. As her children grew, WH described how she was determined to show them there was more to life and became a school tutor. Her easy rapport with Aboriginal children drew the attention of the school counsellor who requested her support to counsel Aboriginal children, who were more likely to open up when WH was present.

The idea to take up health work arose when WH was working as a high school tutor. She became aware that a colleague was completing an undergraduate teaching degree. After realising she could do the same, she enrolled in an Aboriginal tertiary preparation course at a metropolitan university. On its completion, she enrolled in a three-year Bachelor of Health Science degree (Aboriginal Health & Community Development). However, after one semester, WH withdrew and returned to work in the retail sector because of family responsibilities and a mismatch between the course and her expectations.

As life settled, WH's passion to make changes for Aboriginal people, particularly in health, led her to apply for a ATSIPHC Certificate IV traineeship at TAFE. This 18-month course consisted of week-long study blocks, six times a year, study 'pods', simulated clinical sessions and hospital placements to practice clinical skills. The course, although similar to EN training, did not result in students becoming formally recognised for their clinical skills. Despite this, WH graduated and was subsequently successful in an application for her current healthcare positions.

As she reflected on her role, WH described it as one she didn't initially think of choosing, but which now makes her feel she is '*doing something worthwhile*'. It includes a diverse set of activities that entails visiting schools and pre-schools to conduct hearing screening tests on all infant to 6-year-old Aboriginal children as well as

other children schools are concerned about. Screening involves measuring and recording children's middle ear function and hearing levels to identify disease and infective processes such as Eustachian tube blockages, perforations, and conductive or sensory neural hearing loss, and to organise treatment and follow up. School visits also include health education to promote ear disease prevention and contact with parents to inform them about their children's health and specialist treatment for those with problems. WH described the range of skills she needs to fulfil her role and explained that she is '*still learning*'. She has extensive support from the audiologist in her team and is currently undertaking the Certificate IV in Audiometry through a distance learning education program.

In her role in the Aboriginal Otitis Media program, WH needs a range of clinical skills. For example, she must be proficient using an otoscope (to examine the external ear), conducting and interpreting tympanometry (measuring how sound is reflected off the eardrum) and audiograms (the graphical representation of hearing). She also needs basic statistical understanding to record data relating to ear screening. Reports must also be written for the health service, schools, parents and specialists, and management plans are required for children to ensure they receive the requisite treatment needed.

To ensure these tasks are achieved, WH noted that good communication skills are necessary for working closely with government agencies, schoolteachers, doctors and other Healthworkers. Most important, however, are the communication skills she says are required for establishing rapport with children, along with a sense of compassion and the capacity to be non-judgmental. WH's role in the eyesight screening program requires her to use these skills when she conducts the screening of four-year-olds.

WH's current roles entail dealing with issues common to the practice of many Healthworkers. One issue is liaising closely with families to ensure that their children have access to the health services they need, while at the same reorienting the perceptions of those who think that Healthworkers as community members are professionally available twenty-four hours a day. Dealing with this issue requires great sensitivity as well as pragmatism and means that WH must work with the AMS to distribute workloads, organise transport and encourage doctors to bulk bill. It also

entails regular stakeholder meetings to adjust work plans that must be flexible enough to accommodate the six to eight-month waiting lists for surgery and any unforeseen changes that may arise from the complex interaction of schools, health service and families.

WH also experiences problems related to her role. One is the lack of professional recognition for Healthworkers from other health practitioners who WH explained should give '*a lot more acknowledgement*'. She described part of the problem as '*no-one knows what our role is*'. Another is the attitudes of some health professionals who see Healthworkers as '*slave labour*' and workers to be '*taken advantage of*'. WH's frustration was clear as she described her experiences:

> *They [other health practitioners] couldn't understand and they'd ask 'why are they letting you do this', 'why are they letting you do that' But then when we go out and do it, they say 'well no we haven't got time for you to do that'. And then [when] we do courses, they say 'no you're only trainees you shouldn't be doing courses'. You're trying to explain to them and we are getting knocked on the head every which way.*

WH agreed that a system, which enables Healthworkers to be registered, will help to change these attitudes and validate Healthworkers' knowledge and skills. Specifically, she proposed that the new requirements for Healthworkers to have an equivalent Certificate IV qualification will contribute to their professional recognition. She cited her own experiences, to exemplify the role that education has had in supporting her to achieve her current position. Describing herself as '*more of a hands on, than a book person*' who '*hated studying*' and had '*trouble writing things down*', WH explained that she nevertheless went back to study '*because I wanted to, not because I had to*'.

However WH also considered that those Healthworkers with experience and no formal qualifications can also achieve professional recognition, and pointed out that if they have been in the field for a long time they can apply for recognition of prior learning to have their experience recognised to gain an equivalent qualification. Expanding further, WH stated that it is only those who don't apply for recognition of prior learning, or who

are unable to study, that cannot apply for positions other than the one they currently hold. Maintaining that this situation does not disadvantage Healthworkers, WH explained that knowledge has always been '*passed down generations*' in Aboriginal communities and that Healthworkers with experience, but no qualifications, have '*probably learnt just as much*' as those who have learnt from '*text books*'.

A component of all Healthworkers' experience, as WH described, is having a shared understanding of the lives of community members she cares for. She explained:

> *You've got Aboriginal people that don't go to doctors for one thing, you know they don't feel comfortable with them … that won't go to hospital because you don't come out. You've got some that don't go and do this, don't go and do that because their kids are going to be taken off them. … you've got to have a really good rapport with someone and I mean nine times out of ten they're not comfortable speaking with a white person. They're only comfortable speaking with their own person, especially like women's issues and things like that, … that's where it's good having … female Aboriginal Healthworkers and also with males because you know they go through DV, there's a lot of drugs and alcohol, things like that and they don't feel comfortable talking to other people. And because a lot of us … we've had our families go through it … so we relate to them a lot better than … someone else could'.*

In summing up her role, practice and education WH cited her satisfaction knowing she has done something worthwhile to improve the ear health of Aboriginal children. In particular, she expressed her feelings of obligation to the people who trust her as a Healthworker. She also conveyed her determination '*to know more, and be a lot more knowledgeable'* and to '*prove to them that I can do it'*. In addition, WH conveyed her view that '*it's also showing our kids too, that without an education you're not going to get anywhere. Because these days you need an education to do anything*'.

4.8 Conclusion

The aim of these brief biographies has been to present an explicit account of Healthworkers' personal and professional lives, bringing into focus both the realities of

their individual circumstances and experiences as well as collective commonalities and diversities.

Regarding Healthworkers' personal lives, the biographies have highlighted the diverse and difficult challenges they experienced. For example, as they were growing up, many Healthworkers assumed family and extended family responsibilities, often in difficult circumstances. One Healthworker, while still only a child assumed the care of her elderly grandmother who had been affected by a stroke. Two Healthworkers described the challenge of single parenting and caring for their own children with special needs, while others spoke about the difficulties juggling, family life, work and study as mature aged students. A number of Healthworkers remembered damaging school experiences, such as discrimination and marginalisation and the negative impact of this on their education outcomes. The literature presented in Chapter 2 indicated that these experiences are not unique to Healthworkers but are also experienced by community members that Healthworkers care for (Mitchell & Hussey 2006, Townsend 2008). A consequence is that Healthworkers' have an in-depth knowledge of their communities' histories, membership, issues and concerns and that this is a key factor in their deep understanding of their communities' health needs (Health Workforce Australia Interim Report 2011)

Similarly, in regard to Healthworkers' professional lives, the biographies sought to present the difficulties they experienced and the strategies they used to achieve their goals. For example, a number of Healthworkers had been employed in multiple less skilled and uninspiring jobs through necessity, before deciding to pursue further education and enter the health field. Furthermore, those with limited school education showed extra determination and commitment and were pragmatic in their approach, beginning with vocational courses or bridging programs before progressing to university. This pragmatism was also apparent in the different courses Healthworkers chose to study, including health and community development, nursing, health promotion, and social work, all of which provided them with the skills and knowledge they needed for their generalist and specialist roles. The motivation that is often associated with the commitment and community ties that Healthworkers bring to their roles is also mentioned in the literature (Curtin Indigenous Research Centre 2000,

Mitchell & Hussey 2006, Abbott et al 2008, Health Workforce Australia Final Report 2011).

Viewed as a whole, the biographies bring into focus a number of characteristics that were common to Healthworkers, irrespective of their individual experiences. One characteristic was that, in both their personal and professional lives, Healthworkers demonstrated an intrinsic resilience, determination, and capacity to manage challenging experiences. For most Healthworkers it was apparent that the advice and guidance provided by their families, significant mentors, colleagues or teachers was a key contributing factor in this. A second but related characteristic was the Healthworkers' pragmatism, humour and passion, which appeared to imbue them with energy and enthusiasm for their healthcare roles. A third characteristic, was the high esteem in which Healthworkers held their families and communities, and the strength and inspiration they drew from their relationships with them. Finally, the strength of Healthworkers' Aboriginal identity was a predominant characteristic in all their life stories and was evident as a driving force behind their resilience, determination, and their commitment to social justice and improving the health outcomes of Aboriginal people. These characteristics are also acknowledged throughout much of the literature, which was presented in Chapter 2.

This chapter has presented the first phase of analysis. This phase has involved recontextualising interview transcripts as brief written biographies, by condensing the extensive and complex interview data to provide a global perspective of the nine interviews as a whole data set. The detailed descriptions of Healthworkers' life stories written as biographies provides a context for considering the study's first set of sub-questions that ask about Healthworkers' experiences in regards to their healthcare roles, education, communities. This context is critical for orienting readers to the complexity of the three topic areas and the issues they give rise to. It is also important for considering the more detailed analysis of selected extracts from interview transcripts presented in the following chapters of this thesis.

Chapter 5: Healthworkers' perceptions: roles, practice, education and community

5.0 Introduction

This chapter presents initial findings from the second phase of analysis of Healthworkers' interviews. Its focus is the patterns in individual Healthworkers' discourse to provide insights into their perceptions of their roles, practice education and communities. The sequence of analyses and findings presented in this chapter corresponds to the sequence of biographies in Chapter 4. Chapter 4 recontextualised the information and values, that seven of the nine Healthworkers presented in their lengthy spoken interviews, as a series of chronologically sequenced and abridged biographies. The biographies sought to provide a holistic point of reference for the findings presented here in Chapter 5. This chapter now includes extracts from all nine Healthworker interview transcripts on the basis that all nine Healthworkers' provided permission for the use of their transcripts in this study.

The findings in this chapter respond to questions from the second area of enquiry that is:

- *What are Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities?*
- *How do they evaluate these topics?*
- *How do they present their perspectives and evaluations in their discourse about each of these topics?*

To explore answers to these questions, discourse analysis was applied to Healthworkers' interview transcripts. The method of discourse analysis was explained in Chapter 3, §3.4.2. Reviewing in brief, the analysis was in terms of the three general functions or **metafunctions** of language in social activity. These were defined as: 'i) the **interpersonal** metafunction to enact relationships, ii) the **ideational** metafunction to represent experience and iii) the **textual** function to organise text' (Martin and Rose 2007, p. 7). These three metafunctions of language realise three dimensions of social

contexts, respectively the **tenor** of social relations, the **field** of social activity, and **mode** of communication. These three dimensions of social context give three directions for the analysis of Healthworkers' interviews: the textual organisation in which they present their practice, the ideational perspective on their fields of practice, and the tenor of their evaluations of practice.

As explained in Chapter 3 (3.4.2), extracts are selected from each interview transcript that correspond to the three key domains of interest explored in the thesis, that is, Healthworkers' roles, education and their relationships within family and community. The selected extracts exemplify the ways in which these domains are generally construed in each interview, allowing for comparisons to be made at a later stage across interviews (see Chapter 6). The process results in twenty-seven extracts; three for each of the nine Healthworkers interviewed. This selection process was necessary as interviews averaged 9,000 words, making a full discourse analysis of all nine interviews unfeasible. The analysed extracts are presented in Appendix 1. For each Healthworker, extracts are presented and analysed for their textual organisation, and for their evaluations. On the other hand, their ideational perspectives are analysed by counting the lexical items realising various fields of practice across the entire interviews. This Chapter 5 must be read in conjunction with the extracts and figures in Appendix 1.

In this chapter, I focus on each Healthworker interview in turn, to present findings based on the three perspectives identified above. For each Healthworker, these perspectives are presented in three sections under the following headings: Presenting practice, Perspectives on practice and evaluating practice.

Presenting practice focuses on how Healthworkers organise information in their responses, in other words their textual organisation. For example, is there a preference to present responses as a simple series of events, or to classify and describe aspects of practice, or to explain issues such as the causes and effects of illness? The consideration here is the internal organisation of responses as phases of information. For example, are responses organised as a systematic sequence of information relevant to the question, or as brief anecdotes that are incidental to the question? The analysed extracts in Appendix 1 are formatted to make them easy to read, while making the textual patterns visible.

Interview questions are numbered in bold, and Healthworker responses are set out line-by-line, with one a clause to each line. Each phase of information is outlined, and the topic of each phase is marked in bold. With respect to the three domain areas, extracts for Presenting practice only include responses to questions about Healthworkers' roles and education. This is because I am particularly interested in relations between Healthworkers' roles and education, and how they organise information about these topics.

Perspectives on practice explores how Healthworkers' construe their fields of practice. Here the concern is with the kinds of lexical items Healthworkers use to construe their experience. Lexical items are classified as everyday, specialized, technical, institutional work, institutional education, and other abstract concepts. The working papers for these analyses in Appendix 1 present the proportions of lexical choices in Healthworkers' entire interviews as pie charts and bar graphs, to enable generalized comparisons to be readily made. For example, everyday lexical items are indicative of what Bernstein (1999, p. 159) calls 'horizontal discourse'. Rose and Martin (2012, p. 15) explain that horizontal discourse realises 'everyday or common sense knowledge', and is more likely to be 'learnt through sundry experiences in the context of everyday life, often through demonstration and practice without necessarily naming what is being learnt'. In contrast, technical and abstract items are indicative of what Bernstein calls 'vertical discourse', which he defines as a type of knowledge that is 'a coherent, explicit, systematically principled structure, hierarchically organised' (1999, p. 159). This type of knowledge is not learnt through the context of the everyday, but rather through formal education in educational institutions. It is of interest to discover how varying proportions of everyday, technical, institutional and abstract lexis relate to differences in Healthworkers' roles and education.

Evaluating practice is concerned with how Healthworkers' evaluate their practice, education and family/community experience. The focus here is on the evaluative language resources, or appraisals, that Healthworkers employ. Appraisals include expressions of feelings, judgements of people, and appreciation of things and activities, alongside the strength of evaluations, and the source of evaluation. The analyses of the evaluative language in interview extracts displays Healthworkers' feelings about their

roles, education and family and community relations, their judgements about people in these contexts, such as colleagues, teachers and community members, and their appreciations of their practice and education.

The analyses of each Healthworkers' interview, in Appendix 1, begins with a brief introduction to the Healthworkers' background. This is followed by findings that emerge from the analysis of the textual organisation of two extracts, one pertaining to role and another to education (Presenting practice), then the analysis of lexical choices from the whole interview (Perspectives on practice), then the analysis of appraisals in extracts concerned with role, education, and family and community (Evaluating practice). Within this chapter, the findings are drawn from these analyses for each Healthworker. The following Chapter 6, presents the patterns that emerged from the analyses of interviews across the whole Healthworker group.

5.1 JK

JK is the regional coordinator of a health promotion program in a mainstream health service. The program focuses on screening Aboriginal children for ear disease and hearing loss. JK completed twelve years of school education and has a vocational qualification in audiometry, an undergraduate degree in Aboriginal and Community Health (Indigenous) and a post-graduate degree in Health Promotion (Indigenous).

5.1.1 Presenting practice

The focus of the analyses of textual organisation is on the phases and topics of each phase as outlined above and in Chapter 3, §3.4.3. The analysed extracts include JK's responses to interview questions about her complex management role and her education. These extracts are included in Appendix 1, § A1.1.1.

Role

In terms of textual organization, JK presents a reflective account of her role, organised in phases of information. She begins each phase with a topic, highlighted in bold in the extract. As the phase unfolds these are exemplified and elaborated with further detail. By these means, she systematically builds a comprehensive picture of the intricacies of her role and demonstrates an in depth awareness of its scope in the specialist health care

field in which she is working. This presentation demonstrates that JK has a coherent level of understanding that is most likely to be associated with the experience she has developed in the field and her undergraduate and post graduate university studies.

In response to Question 19: ***'Tell me about your roles and responsibilities as a coordinator?'*** JK begins with a short recount in which she orients readers to having performed *'two jobs for the last 12 months'*, which she then summarises briefly as *'trying to balance clinical with a strategic role'*. Her next responses are a series of phases that comprise short descriptive reports and reflections about the different components of her role.

In response to Question 24, ***'Can you tell me something about the strategic part of your role?'*** JK identifies three general components of her strategic role and exemplifies them by describing some associated activities. This is then elaborated as three more specific activities, '*staying under budget'*, '*making sure appropriate people are getting paid'*, and '*look[ing] for more enhancement funding'*. She follows this by generalizing again as she evaluates her role as *'an odd job'*, then once again specifying, this time as *'whatever comes at my desk'*, as including *'complaints from other Healthworkers'*, *'be[ing] nice to people'*, *'mak[ing] sure that they're accommodated'*, and *'helping the project officers'*. This phase concludes with a summative generalization in '*lots of organisation stuff, with the clinical side of things'*. The third generalized component refers her administrative role in '*area network meetings and things'*. She then elaborates on this by referring to her responsibilities, associated tasks and personnel, concluding with a summative evaluation of her role as '*developing those relationships with those professionals to run an effective program'*. The third generalized component refers her administrative role in *'area network meetings and things*'. She then elaborates on this by referring to her responsibilities, associated tasks and personnel, concluding with a summative evaluation of her role as *'developing those relationships with those professionals to run an effective program*'.

Education

In the extract about education JK responds by describing her university education and what she learnt. The semi-structured interview format meant that questions about

education were dispersed throughout the interview. For each response JK begins with a topic which is directly related to the interview question. She consistently explains the value of the skills she has learnt and relates them to her role, stating *'study actually complemented the work'*. She reflects on three outcomes of her university education that support her to perform her professional role, including the capacity to run a health service, to be critical and analytical, and to *'communicate effectively through writing'*. She then exemplifies the value of university study for running a service, with subjects such as *'project development, project management and project evaluation'*. She exemplifies communication skills as *'written and verbal'*, *'support and advocate for people within the program and…for the community'* and to *' be able to communicate effectively with various groups of people, professionals, and community members and governments and non-government people'*. In each response, JK thereby develops a coherent view of aspects of her education, she reflects and identifies positive outcomes of her education, as well as exemplifying and evaluating their importance to her role. This presentation reflects the kinds of communication skills she has most likely acquired through her university education.

5.1.2 Perspectives on practice

JK's perspective on her practice is primarily a global overview of her current position as the Aboriginal coordinator of a state-wide ear health screening program for Aboriginal children, that includes descriptions of the different activities and people she works with in this multifaceted role. This perspective provides a clear indication that her scope of practice as very much informed by a comprehensive primary health care approach.

The proportions of lexical choices made by JK across the six categories of everyday, specialised, technical, institutional work, institutional education, and other abstract terms, are illustrated in Figure A1.1. Analysis of her lexical choices shows that, alongside everyday terms such as *schools, children*, *people, Aboriginal community*, she uses a significant proportion of institutional terms to refer to her role and education. Examples of institutional work terms are *Area Health Service, budget, enhancement funding, Human Services Advisory committees, Division of GPs, clinics, programs, outreach screening, staff*. Examples of institutional education terms are *study, tasks, assignments, subjects, Aboriginal health education.* JK uses fewer specialised terms,

such as *Aboriginal Healthworkers, audiologist, nurse, doctors, Ear Nose and Throat Specialists (ENTS)*, and few technical terms, such as *audiometry screening, otitis media,* as her practice is primarily institutional rather than clinical.

Figure A1.2 shows proportions of JK's lexical choices for each topic area, including her role, education and community experience. In talking about her role and education, institutional work and education terms predominate. In respect to the community, she primarily uses a small proportion of everyday lexis, and even less institutional work related terms to talk about her pride in *'doing something for the benefit of the Aboriginal community and … in some small way I'm contributing to maybe better health outcomes for Aboriginal children'*.

5.1.3 Evaluating practice

Three extracts were selected to illustrate the types of appraisal JK uses to evaluate her role, education and community, analysed in § A1.1.3. As stated in the introduction, the focus of these analyses is on the evaluative language resources that Healthworkers employ. Chapter 3, §3.4.5 provides a detailed description of how appraisal is analysed.

Role

In the first extract about her role, JK generally affirms her capacities for her program management role, in which she is *'trying to balance clinical with a strategic role*'. Here she also appears to be alluding to the difficulty associated with the complexity and extent of her role. In addition, she values the significance of her role *'ensuring the whole OM strategic plan is…continually implemented across the Area Health Service'*. She sometimes underplays her capacity, as she has been doing both jobs for 12 months, and is '*still trying to find my way through'*. However, she acknowledges the complexity of her role, managing *'whatever comes at my desk during the day'*, such as '*the budget…network meetings and… developing those relationships with those professionals to run an effective program'*. Furthermore she implies a positive judgement about the ethics (propriety) of her role, which is '*to make sure the kids we're concerned about and the urgent kids are followed up'*.

Education

In the second extract about her education, JK is overwhelmingly positive about university, her capacities for learning, and its value for her, its *'enormous impact… educationally, mentally, physically, spiritually'*. It has given her capacities to *'develop a passion for things'* and *'opened up my mind so much'*, and to to communicate on an equal footing with other senior managers in her work, whom she once thought of as superiors who intimidated her. She now has the confidence to *'challenge …and question'*, to '*get what I want'*, but she uses power ethically, to *'do what's right for my program and the community'*.

Community

In the third extract, JK values her community in terms of it being one of three sources that give her strength in her Healthworker role. These include: *'many years of experience in Aboriginal health'*, a *'strong education*', and '*being Aboriginal and being part of the community… able to understand the community and what the community needs and what the community wants'*. She is proud of her healthcare work, expressing it as a positive judgement, *'doing something for the benefit of the Aboriginal community'*. In addition, she views this positively in terms of her capacity recognising it as *'a pretty big achievement',* but is also humble that she is '*contributing in some small way'*, most importantly to *'better health outcomes for Aboriginal children'*. She frames her pride in her achievement by laughing at herself.

5.2 CB

CB works as a health promotion officer in a population health team (mainstream) in regional New South Wales. CB finished Year 12 and at the time of interview had also completed a Certificate IV in Business Administration and a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice) traineeship. In addition, he had been invited to apply for Recognition of Prior Learning (RPL) and complete any outstanding modules in the ATSIPHC (Community Care) Certificate IV.

5.2.1 Presenting practice

Extracts showing how CB presents his practice are presented in § A1.2.1.

Role

In his response to Question 1 ***'What is your job description, title you work under and what does it entail?'***, CB presents his role by classifying, evaluating and reflecting on various aspects. In the first phase he gives a general overview, classifying his role institutionally as a) a population based position, b) in health promotion, and c) focused on prevention, and locating it theoretically '*from the Ottawa Charter'*. He concludes by giving a context for his work, in primary and pre-schools. In the next two phases he exemplifies with two specific health promotion programs - the volunteer network and tobacco control - and the activities they entail, and evaluates them institutionally as '*capacity building'*. Question 12 '***And in terms of the hospital work what did that entail?'*** asks for specific activities that CB did in his training. He responds by evaluating his work in the hospital ward in three ways. Firstly he was useful to the nurses, secondly he built his communication skills, and thirdly his clinical skills. Thus CB reflects on his role in terms of categories that he has clearly thought about previously. On one hand his reflection is informed by the knowledge he has gained through study in the health field, and on the other hand by his experience in the workplace.

Education

CB identifies four sets of skills and knowledge he acquired from his Certificate IV traineeship, including formal study and hospital based components. These include: 1) clinical skills such as administering medication, wound dressings, urinalyses and blood pressures, 2) non-clinical knowledge such as anatomy and biology, holistic primary health care, and health and Aboriginal people, 3) communication skills with patients and others, 4) different ways of learning. He reflects on his education by classifying each set of skills, exemplifying and explaining what he means, and sums up with the value of education.

5.2.2 Perspectives on practice

CB uses similar proportions of specialised, institutional work and everyday lexis as JK, as shown in Figure A1.3. This reflects his role as a health promotion officer working in a mainstream organisation, alongside his community connections. CB's use of more

moderate proportions of institutional educational lexis, some other abstract and very limited technical terms reflect his enrolment in a vocationally based traineeship. It may also suggest his newness to his role working '*out of Population Health in D, and…it's a population based position, and being in health promotion it's from the Ottawa Charter and…it focuses on prevention'*.

In discussing each topic area of role, education and community, CB uses relatively high proportions of specialised, institutional work and everyday terms to describe his involvement in a range of healthcare work, shown in Figure A1.4. This includes a small amount clinical work as a component of his traineeship such as '*doing dressings… regular BSLs, other sort of tests like that'*, and institutional terms in his health promotion role, such as '*programs [that] target primary school and pre-schools and all prevention stuff…physical activity… the volunteer network… training and insurance and support as well'*. This range of clinical and non-clinical activities provides a more specific account of his comprehensive primary health care practice. CB's discussion of education includes a moderate use of institutional work and educational terms, with fewer everyday and specialised terms. This may reflect the impact of his Certificate IV traineeship, and learning skills on-the-job, and '*not having a university degree, so not of the same level of education'*. CB also uses a high proportion of institutional terms, a moderate proportion of everyday terms and some specialised terms to talk about Aboriginal communities and families who are '*more likely to be in contact with alcohol abuse… lower socio-economic status… mental health problems... domestic violence'*.

5.2.3 Evaluating practice

Extracts showing how CB evaluates his practice are presented in § A1.2.3.

Role

CB positively values both the clinical and educational components of his Healthworker role in what could be considered the provision of comprehensive primary health care. However the downside of his role in health education is that it's '*hard to know how successful it has been'*, especially with groups, except when someone gives him positive feedback later. In contrast, one appeal of clinical activities is that success is measurable.

Nevertheless, CB is not interested in a nursing career, because he views a Healthworker role is more varied and interesting.

Education

On the one hand CB is ambivalent about a university education, referring to it as '*only a piece of paper to me'* but then acknowledges it '*does make a difference in the world'* and sees its benefits, such as status, money and skills. On the other hand, his connection to the Aboriginal community enables him to make an important contribution to the '*team dynamic'*. As someone without a degree, who has learnt through life experiences, he can '*give a different perspective'* to the various professions that make up the health promotion team. For these reasons, the team asks for and values his contributions.

Community

CB is critical of the deficiencies in health services for Aboriginal people. This includes a lack of programs that target Aboriginal people, but also those that aim to make Aboriginal people *'more comfortable'*, but that do not focus on their *'health determinants'*. He lists these and questions whether a program such as smoking cessation can be effective. He advocates a holistic approach that addresses *'all the underlying factors'* and focuses on social work based positions.

5.3 CO

CO is the Health Services Coordinator at a large regional AMS where he has worked for a number of years. CO left school in Year 8 and has an ATSIPHC Certificate III which he completed by correspondence through an Aboriginal Registered Training Organisation. At the time of interview he was enrolled part time in a Bachelor of Health Science at a regional university and had completed four units of study.

5.3.1 Presenting practice

Extracts showing how CO presents his practice are presented in § A1.3.1.

Role

In contrast to JK and CB, CO presents his role as a series of lists. In response to Question 1, ***'What position are you in, and what is your title?'*** he lists the health service staff that he manages as the Health Services Coordinator. When asked what his role entails, he briefly lists several management activities '*HR, their training, OH&S, then staff development, staff planning'*, but then lists the teams in the organisational structure. In regard to his prior role as an Healthworker, he starts by presenting his lower status as '*ground staff*' directed by a supervisor and manager. He then returns to listing a) the health issues that were his '*biggest passions'*, b) the various clinics that he ran, and c) the health issues he dealt with in his '*core business'* as a male health worker.

CO's presentation strongly reflects his institutional perspective on his role, 'monitoring or coordinating, or managing'. It is organised as lists of institutional names for staff roles, numerous activities and issues in the health field. This is some indication of the variability associated with his role and practice that is clearly positioned within a comprehensive primary healthcare framework. It also reflects his view of his own professional status, by listing the many professional people and activities he is responsible for, in contrast to his previous Healthworker position, in which he was supervised by registered nurses.

Education

As with his work role, CO lists three general components of the mainstream health science university degree he is studying part time including core Indigenous subjects, nursing subjects and management. He also lists examples of issues he has studied in first year and names two Indigenous subjects he hopes to study later, including 'Aboriginal Identity' and 'Contested Knowledges'. CO's use of lists to present his role and education may be associated with the structure of the TAFE Certificate III he has studied, which is organised as lists of competencies. Similarly he lists subjects in his degree study, but does not describe their contents or relate them to his work role. His focus on Indigenous subjects suggests that he views these as particularly important, but does not elaborate.

5.3.2 Perspectives on practice

CO's marked affiliation to his workplace is reflected in his extensive use of institutional, everyday and specialised lexis to talk about the different roles he has had at the service, shown in Figure A1.5. His use of lower proportions of other abstract and technical terms may be more likely to reflect his completion of the skills based ATSIPHC Certificate III which he describes as having '*more of a community level feel. It's a real grassroots feel, whereas the academia is definitely not. It's definitely what it is. It's the higher education of society'*.

In discussing each topic area of role, education and community, shown in Figure A1.6, CO uses variable proportions of lexis throughout the interview. For example he uses a high proportion of institutional work terms to describe his role in terms of activities and service types such as '*internal referrals to other internal services.. community support worker…Department of Housing'*. In addition he uses a moderate proportion of specialised terms to identify professional colleagues he works with such as GPs, nurses, optometrist, podiatrist, and medical students. Fewer everyday terms refer to '*community members, they come, they go away, they go on walkabout, so we might not see them for another 2 or 3 years'*. CO's limited use of technical terms is restricted to clinical measures and tests such as '*blood glucose levels, blood pressure, ECGs'* and illnesses such as '*diabetes, asthma'*.

CO's discussion of his education is dominated by institutional education terms to describe his study pathway from Year 8 to TAFE and university. He also uses some everyday lexis to explain '*the way I entered the academia world, I dived in headfirst and I nearly failed'*. Fewer but equivalent proportions of specialised and institutional work terms reflect his view that '*we shouldn't be Healthworkers; I think we should be Aboriginal health professionals… professional in our role… professional duty of care and service'*. In his discussion of community and family CO mainly uses everyday terms to identify his priorities, which include '*children and my family as well, and then the second on my list is the community'*.

5.3.3 Evaluating practice

Extracts showing how CO evaluates his practice are presented in § A1.3.3.

Role

CO's evaluation of his role is characterised by a focus on his and his colleague's capacity to do their job well. For example, they are '*always improving and enhancing'* clients health checks and making them '*really friendly and really fun'*. He praises team members including doctors and nurses as the '*main ones always looking'* at health checks. He praises Healthworkers, including himself as '*actually the ones on the ground'*. This structure, where Aboriginal staff '*can determine',* is appreciated as '*primarily what we want'*. However, CO does not boast, rather he diminishes his own capacity with *'I suppose myself'*. He also appreciates taking time to share with clients and community members, to '*get a really good snapshot'*. The overall impression is that CO values his role as a team leader who respects his colleagues and community, along with his own capacities.

Education

With respect to education, CO strongly appreciates university education for himself, but he judges others that '*don't have a clue how to interact with the community and therefore could be quite dangerous'*. He appreciates TAFE training as '*grassroots'* but draws a strong distinction with academic study. He begins by valuing his capacity to '*always critically analyse'*, but university has extended his skills to '*understand exactly, always think outside the square, brainstorm every possibility, every channel'*. University has '*opened my life to this whole new world'* amplified as '*just so much to learn'* and playing '*a massive role in his life'*. While TAFE is appreciated as '*more of a community level/grassroots feel'*, academia is strongly distinguished as '*the higher education of society'*. While CO makes it clear that he perceives academia as invaluable he is also forthright about how challenging he finds it.

Community

CO compares himself with others who have achieved a qualification but do not respect their communities, whereas he is a '*real community focused person'*. However CO

experiences conflict between community work and having a management role and university qualification. The community values his capacity in his management role but '*kept asking and wanting'* him *'back out there in the community*. But this will not '*enhance him as an individual'* or *'give him growth'*. In respect to his university qualification CO is ambivalent '*yes it does in a way, but then it doesn't take me away from the community'*.

5.4 SW

SW is an AHLO working as a member of the Social Work department in a large regional hospital in rural New South Wales. She left school during Year 12 and has completed Diplomas in Aboriginal Health and Welfare. At the time of interview she was completing the final year of a Bachelor of Social Work.

5.4.1 Presenting practice

Extracts showing how SW presents her practice are presented in § A1.4.1.

Role

SW presents on her role in terms of its value for her Aboriginal clients, and her qualifications for this role, from her education, her personal experience as a community member, and her professional experience in the field. In contrast she is sharply critical of the devaluation of her role by the non-Aboriginal health staff she is forced to report to. She presents her argument as a clearly articulated series of steps, backed by evidence. This type of textual organisation reflects the kinds of discursive skills normally developed through tertiary study. It is significant that SW had almost completed mainstream degree level studies at the time of the interview.

In response to the first question, ***'Can you tell me what your role is and what it entails?'*** SW begins with a general overview of her hospital-based role as '*a support person'* with three key functions to '*advocate for Aboriginal patients', 'follow up'* and *'liaise between the doctors and nursing staff'*. She follows this in the second phase with an anecdote to justify the need for her role and illustrate its importance to Aboriginal people. In the first phase of her response to Question 3 '***And can you describe the***

teams. You work in the Social Work department, how does that work?' SW evaluates her role as '*bottom of the rung'* and emphasises its low status by listing all the positions that are above her, she is '*even below Admin'*. The non-Aboriginal social workers are her line managers. In the second phase she lists the issues that affect her Aboriginal clients, but for which she is '*not supposed to counsel them'*, even though she has the qualifications. In the third phase she lists her qualifications, to counsel, support and advocate for her clients. In the fourth phase she explicitly condemns the position she and her clients are put in by the institution as '*degrading'* and *'unfair'*.

Education

SW focuses mainly on her university study, identifying theoretical knowledge, and exemplifying it as *'research and readings'*. Other knowledge learnt at university includes Aboriginal history, basic welfare, social work theory, sociology, law, counselling, grief and loss and psychology. Skills include communication and social work practice and are exemplified as *'one-on-one client and group work'*.

SW reflects on her education in terms of its relationship to her AHLO role, on the one hand acknowledging its importance but on the other arguing that *'it's not going to change the way I work'*. This presentation and SW's capacity to classify, exemplify and reflect are suggestive of a university education that typically requires students to relate theory to practice, use evidence, and interpret and evaluate information.

5.4.2 Perspectives on practice

SW uses higher proportions of everyday and institutional work lexis as shown in Figure A1.7. This is similar to other Healthworkers in this study who have been employed in the health field for an extended period and who have a marked and close affiliation with the communities in which they work. She uses a moderate proportion of specialised and institutional education terms, reflecting her role working with numerous other health professionals, and her vocational and university education. TAFE has equipped her with the practical skills to '*talk on behalf of the family with their permission and just give them a bit of an idea about where the family is socially and emotionally and physically'*, while university has taught her theoretical knowledge such as '*sociology*

knowledge and a bit of law knowledge, obviously counselling, grief and loss stuff, and we do social work theory and practice'.

SW uses a high proportion of everyday terms across all three topic areas, as shown in Figure A1.8. In talking about her role she uses moderate proportions of institutional work, everyday and specialised terms, to describe her work structure, '*the Social Work department… Allied and Community Health Manager, Allied Health Manager, Social Work Manager… Social Work One, Social Work Two, Admin and ALO [Aboriginal Liaison Officer], so even below admin'*. Education is discussed using a higher proportion of everyday, institutional work and education terms and fewer specialised terms. The everyday lexis she uses to discuss community and family far exceeds the smaller proportions of specialised and institutional work lexis. Here she makes detailed references to the history of the community and its different language groups but also acknowledges that '*my mum, and my two younger sisters who have both been to university, and I'm the oldest and I haven't'*.

5.4.3 Evaluating practice

Extracts showing how SW evaluates her practice are presented in § A1.4.3.

Role

SW strongly evaluates her capacity by listing the numerous roles she fulfils. She expands on her advocacy liaison role by emphasising the '*huge, great big medical terminology'* that doctors use with Aboriginal patients who are not educated, and who fear the worst when they do not understand. She is able both to explain and reassure patients, and get the doctors to use lay terms that are more appropriate. This suggests that SW is very cognisant of key comprehensive primary health care principles that are a component her role, such as equity, empowerment, and community participation. However, her role is devalued by the hierarchy in the hospital Social Work department as '*merely a support role to work …behind the social workers'*. She expresses strong negative judgements about the ethics of the social work team, as '*degrading for me as the ALO and it's degrading for…my clients'*.

Education

While SW strongly values the knowledge and power that education gives her, she argues that Healthworkers '*have a lot of informal qualifications and can actually deal with our clients very well without the formal qualifications'*. In respect to herself, she acknowledges that education has broadened her judgements and understanding of others, and given her the capacity to apply for '*just about any job'*. However she emphasises that it will not change the way she practices. Here she is referring to her practice in working with Aboriginal clients as an AHLO, which she contrasts with the approach of her social worker colleagues in Q6-10. This also lies behind her statements that '*knowledge is power'* and *'it's going to give me power'*, as she is frustrated by the inequality in her relationships with the social workers who are university educated. On the other hand she has also been frustrated by her experience with university and '*academic writing which is so, so hard'*.

Community

SW contrasts the trust that Aboriginal people have in her as both a community member and professional with the displeasure they feel at having to tell their stories to non-Aboriginal social workers. However, she is expected to refer her clients to the social workers, who have '*sometimes kind've caught me out'* for not doing so. To avoid this conflict her solution is to involve the social workers when she talks with the clients, to '*bring them along'*. In this respect her professional capacity is well beyond that of the social workers who are incapable of making Aboriginal clients feel comfortable. However, in general she is by no means biased against social workers and acknowledges her former boss was her professional role model, who supported and encouraged her to study. Equally important was the support, guidance and unconditional love from her mother and the example of her siblings who preceded her to university.

5.5 LT

LT is an Aboriginal Health Education Officer (AHEO) based in a mainstream health service in a small rural town. As the sole Healthworker her role includes community health and hospital liaison. LT completed Year 12 and an ATSIPHC (Practice)

Certificate IV as a traineeship. She also commenced but withdrew from a Bachelor of Commerce in the first year of study.

5.5.1 Presenting practice

Extracts showing how LT presents her practice are presented in § A1.5.1.

Role

LT often expresses uncertainty about her role, as she reflects on it while describing it. This appears to be the first time she has had an opportunity to talk through some of the issues and activities of her role, and she clarifies as she goes. For example, when asked for a typical case, she replies that '*there's probably not so much of a typical'*, but '*a multitude of things'*. Like all the Healthworkers in this study, these descriptions of the breadth of her role and practice provide some indication that she consideres them under the umbrella of comprehensive primary health care, although she does not use this term. In addition, although LT does not define her role sharply, she shows insight into its scope and complexity.

LT begins by specifying her role as non-clinical health education for groups, and clarifies that it is by referral. She then lists some of the activities involved '*provide information, support, advocacy'*, and recounts some of the steps involved. She responds to Question 2 '***Is the focus of the health education based on the individual rather than the population, or is it both?'*** by explaining that her work targets the Aboriginal population, but may include non-Aboriginal individuals, giving the example of smoking cessation education programs.
In response to Question 3 '***So maybe if I just ask you about the self-referral, can you give me an example of a typical case?',*** LT reflects on the tension between her employer's perception of her role and the community's perception, which she calls her '*real role'*, when '*somebody comes to you'*, i.e. self-refers. She then gives the example of cases involving housing issues, which involve '*a lot of talking with a client and working out what is that they need'*. She concludes by reflecting on the complexity of her role, which reflects the complexity of Aboriginal health issues '*all of those things impact on their health'*.

Education

LT identifies four focus areas of study in her Certificate IV traineeship including clinical work, community development, community programming, and education. She highlights the clinical component and exemplifies two aspects, firstly '*knowing a little bit about the medical side'* exemplified as '*why your body works the way it does'*, and secondly the '*skill to be able to explain that'* to other professionals as well as to clients '*in their own terms'*. LT's descriptions of competencies and the clinical focus of her training is characteristic of traineeships where the workplace and classroom are equally important as sites of learning.

5.5.2 Perspectives on practice

Like most of the Healthworkers in this study, LT uses a higher proportion of everyday lexis to talk about her role, education and community, as shown in Figure A1.9. This is likely to be associated with her experience of moving to a new community, and the effort she has made to get to know people and demonstrate her worthiness as a trustworthy Healthworker. LT uses a comparable proportion of institutional lexis but this is split unequally, with twice as many references to work than education, which has not always been a positive experience. She also uses a low level of specialist terms and even less technical lexis to refer to a few clinical procedures and measures such as blood pressures, urinalysis. More outstanding is her moderate use of metaphoric lexis which may reflect her advocacy role and the close contact she has with other health professionals. It could also reflect her broader work experience in fields other than health and her educational background which although primarily vocational includes some university study.

When discussing her role, LT uses fewer specialised and everyday terms, and far more institutional lexis, as shown in Figure A1.10. This reflects the focus of LT's daily activities on the broad health and social wellbeing of people, '*to provide information, support, advocacy and just a generalised information and education'*. In her discussion of education however, the proportion of everyday terms is slightly greater than the proportions of specialised, institutional and technical lexis. This reflects her diploma qualifications in both Aboriginal health (Practice) and Community Services. She describes these and the importance of '*knowing a little bit about the medical side… why*

your body works the way it does' and *'having that skill to be able to explain that*'. In discussing her community and family, the proportion of everyday lexis is dramatic. This reflects LT's focus on stories about struggling for community acceptance and her experiences growing up, feeling that '*I'm in no man's land because white society were calling me black, black society, at that point we weren't recognised from birth as such'*.

5.5.3 Evaluating practice

Extracts showing how LT evaluates her practice are presented in § A1.5.3.

Role

In discussing her role, LT focuses on classifying its various components, with little explicit evaluation. It is basically a non-clinical role, providing '*information, support, advocacy'*. She must recognise the education needs of clients, and use various programs to support them. Although she is classified as an Healthworker, she also works with non-Aboriginal clients who are referred to her. As well as health issues, she also has a social work role. The boundaries of practice are not sharp, so she uses a lot of words that soften their focus, such as *basically, generalised, kind of, probably a little bit of both, sometimes may*. She implicitly evaluates her practice when she contrasts what her employer sees her role as, and what the community thinks it is. At this point she sharpens the focus to '*the other side of the real role'*, advocating and supporting her community clients, spending '*a lot of time'* on the '*multitude of things [that] impact on their health'*. Without saying so explicitly, she clearly sees this as the most important side of her role. But she is more explicit when she exemplifies an aspect of her role and explicitly values her positive capacity to undertake it and thus meet her client's needs.

Education

In discussing skills and knowledge, LT focuses on her ability to be non-judgmental and build rapport with Aboriginal clients. She contrasts this with the perceived arrogance of some other health professionals who might tell clients to *"shut up and do what I expect"*. She explains that Aboriginal clients are suspicious of racist attitudes, whereas she is able to make them '*feel comfortable'*. Without this choice they may be '*reluctant to access the Health Service'*. On the other hand, LT is emphatic that Healthworkers

should '*be able to offer them the best service you can'* so that clients need not fear that the Healthworker lacks capacities such as '*can't read the urine stick'*. In respect to her capacities in formal education LT is ambivalent. On one hand she '*actually did Year 12'* but *'didn't have any idea as to what I wanted to do'*. Furthermore, English was '*always probably a little bit of a downfall'* because she *'could never really write essays'*. She reiterates her insecurity about her direction after school but decides she '*might as well go and do it'*. Although she was '*very, very good'* at studying accounting, it *'was so boring'* and she had a *'drive to want to make a difference'*, but the jokes about the difference that studying beauty therapy makes. Like many of the other Healthworkers in this study, LT highlights the difficulty she had with writing and the frustration she felt about the mismatch between her capacity to study and make a difference and not knowing what field she wanted to go into.

Community

LT outlines her family's story about the suppression and rediscovery of their Aboriginal identity. Her father's grandmother married a white man and was ostracised by her parents. Thereafter she denied her Aboriginality, a common story for Aboriginal people in those days, sometimes known as 'crossing over'. The family suspected it, had it confirmed, and were '*gob smacked'*. Her non-Aboriginal cousins were '*really cruel'*, using racist names. As she was studying, people assumed she was non-Aboriginal, as she was '*always a high achiever...the A grade student'*, and held stereotypical views of Aboriginal students as '*low grade'*. This has left LT feeling '*in no mans land'*. Although she '*kind of got accepted'*, problems with identity have '*always been a hindrance'*. LT and her great grandmother have both struggled with their Aboriginal identity. Her grandmother endured ostracism from her Aboriginal family and denied her identity. LT has reclaimed her Aboriginal identity but has endured cruelty and stereotyping, and the dilemma of a double identity.

5.6 RH

At the time of interview RH was between healthcare positions but had extensive Healthworker experience in a variety of roles that mainly specialised in mental health . She left school in Year 10 and had completed a Certificate IV in Community Services (Disability), Certificate IV in Welfare (Domestic violence and Child Sexual Assault). At

the time of interview RH was completing her final year in the Bachelor of Health Science (Aboriginal Health and Community Development).

5.6.1 Presenting practice

Extracts showing how RH presents her practice are presented in § A1.6.1.

Role

RH's perspective on her role is primarily focused on the clients that she works with, and her responses to their needs. In response to Question 7 '***Out of those positions can you describe to me what the work has been about?'***, she first lists the types of services she puts them in contact with, and then recounts the steps she would go through in her '*outreach work'*, to ascertain and meet their needs, and manage her cases. In response to Question 8 '***So had they [clients] been referred into the Unit?'*** she first lists the mental health issues of her clients '*my guys'*, and evaluates their severity. She then describes and evaluates the severity of their social situation. Then she again recounts the steps she would go through in assessing them, ascertaining their needs and getting their needs met. She then evaluates the hospital staff she worked with, on one hand *'particular ones that were really excellent'*, and on the other hand the negative attitudes of some nursing staff. She reasons that their training should have given them a better understanding of the issues, reasons and underlying factors.

In these extracts RH presents her role as completely focused on ensuring the needs of her Aboriginal clients were met '*in an appropriate manner'*. Like SW she expresses a strong empathy for her clients and the challenges they face and also judges different healthcare staff and their level of understanding of Aboriginal health issues

Education

RH identifies and exemplifies the knowledge she has learnt and is still to learn through her education, and relates it to her role. She prioritises knowledge about policies, particularly how they are written and implemented in the delivery of health to Aboriginal people. In addition she lists four essential areas of knowledge: human rights and social justice, professional practice, primary health care, and community

development. On the other hand, she also argues that education should be '*whatever you love to do'* because there is always something more to learn. As well as identifying and exemplifying what she has learnt, RH also reflects on the relative significance of her education to her role and '*how you can actually improve things in communities'*. Her capacity to articulate this relationship is perhaps more likely to be associated with having completed a university education.

5.6.2 Perspectives on practice

Like a number of other Healthworkers RH uses of a high proportion of everyday and institutional work associated lexis throughout the interview, as shown in Figure A1.11. She expresses a strong orientation to the community and work '*trying to get Indigenous people in contact with health services, which range from alcohol and other drug, mental health, family counseling, relationships counseling, all of the areas that you could see in health'*. She uses a low proportion of specialised and metaphoric terms and minimal technical terms suggesting her education did not have a health science or clinical focus.

RH uses high proportions of everyday and institutional work lexis to discuss the three topic areas, shown Figure A1.12. In respect to her role, she uses everyday terms to refer to her drug and alcohol rehabilitation work supporting clients with mental health problems. Institutional work terms include the types of support clients needed such as '*Centrelink, housing… population… society'*. RH also uses some technical terms to clients' specific mental health conditions that for example depression, psychoses and schizophrenia. In education, RH's lexical choices are also predominantly everyday and institutional work terms. This reflects her varied educational experiences beginning with school where she '*was stuck down the back of the class room doing something else while they were learning about…history and Captain Cook'*. It was followed by the completion of TAFE and then university '*understanding human rights and social justice, professional practice, primary health care'*. It also reflects her view that it is important to have '*that other knowledge and that other understanding in your being'*. RH's discussion of community and family is similarly characterised by the strong use of everyday and some institutional lexis. As with other Healthworkers this reflects her use of story telling to talk about her life when she '*did the factory bit which was horrible,*

got married and had kids cause that's what was expected of me. Tried to work here and there just to feed everybody and I…ran my own business for 10 years'.

5.6.3 Evaluating practice

Extracts showing how RH evaluates her practice are presented in § A1.6.3.

Role

RH evaluates the complexity of her role by iterating the range of health services she puts her Aboriginal clients in contact with, the wide range of tasks she does in her outreach work, and the seriousness of her clients' mental illnesses. Her professional approach involves '*hooking up with them'* while they are still in the acute mental health unit, and then waiting until '*they came back down'* to ensure that their needs are addressed appropriately. Implicit in this is her capacity to address these needs and the breadth of her practice as an Indigenous health professional. Although her perspective is pragmatic, her empathy for her clients comes through calling them '*my guys'*, and describing the dire situation many live in, without money, shelter or even food.

Education

RH strongly values both the skills and knowledge that education has given her, and the skills and '*moral stance'* that come from her family, community and professional experience. She emphasises her communication and organisational skills, but the knowledge about systems, policies and topics such as *'human rights and social justice, professional practice, primary health care'* that university education has given her '*really opened my eyes up'*. However she also emphasises that skills and knowledge are not effective without a moral stance, that together form a '*conglomerate of personal being'*. She elaborates further and describes the importance of balancing '*your connection to your land, you know connection to your country, connection to your culture'* with going to university so that communities do not think education is '*trying to turn us white'* or that Healthworkers are going to tell them '*you have to do it like this'*. Comparing her university and TAFE training RH emphasises that 'at *university it's at a different level and really getting at the core issues'*. She further stresses the

capacity that university education provides in contrast to TAFE, changing *'not just in the way that I work but in the whole way I think, in my life personally'*.

Community

RH attributes her drive and conviction to her relationship with her father and culture. She recalls her racist treatment at primary school, and the effect this could have had on her life, if not for her convictions and '*a really good connection'* with her father. Although he died young, it was the drive and conviction she inherited from him that enabled her to survive '*horrible'* factory work and an unhappy marriage. Not only did she go on to run her own business, but singlehandedly raised a family with a chronically ill child without complaint. She recounts her extraordinary story matter of factly.

5.7 DB

DB is an Aboriginal Health Education Officer (AHEO) who works in a mainstream community health in regional New South Wales. Her role in Chronic Care focuses on Aboriginal clients with diabetes. DB left school in Year 10 and has completed an EN qualification, a 3-year Bachelor of Public and Community Health degree and a range of professional development workshops.

5.7.1 Presenting practice

Extracts showing how DB presents her practice are presented in § A1.7.1.

Role

DB presents her practice as a series lists with little evaluation. She first lists five activities she and her co-worker, her '*partner in crime'* do in their role in diabetes education. Secondly she lists the four clinics they deliver to different factions in the community. In response to the clarifying Question 2 '***Tell me what you mean when you say that'***, she explains humorously that each faction must have its own clinic as they do not get on with each other (like Native American tribes). She then lists the activities they do in the clinics, each fortnight. In response to the third clarifying question, she explains that the fortnightly cycle allows them to manage their increasing workload. DB

presents little evaluation of her practice, but describes it as lists of activities consistent with the provision of comprehensive primary health care. She specifies examples as: '*deliver education, exercise programs, follow-up home visits, blood pressures, blood sugar checks'*. Evaluations are only presented in response to interviewer prompts, explaining the *factions 'so we don't caught up in the politics of such', and explaining the increasing workload 'because we're getting more and more referrals… now that the word's got out there'*, but she does not explain what this means.

Education

When prompted, DB lists some clinical skills and knowledge, and lists some sites where she learnt them, including her enrolled nursing course, '*self learning, peer support and workshops'* and '*a little bit'* in the degree. Clinical skills she acquired on-the-job included blood pressures, blood sugars, and reading pathology results. Knowledge learnt in courses included '*basic anatomy and physiology'*. Responding to a prompt about learning primary health care knowledge, DB describes it in general terms as health promotion, prevention and '*what works for Aboriginal people and what doesn't'*. As well as listing what she has learnt, DB also reflects on its value. She argues that workplace practice has been a critical component of her education as study provides you with basic information but '*it's only when you're working with it that you know'*.

5.7.2 Perspectives on practice

DB's discourse is characterised by high proportions of everyday lexis to describe her community focused work in a range of settings such as in the health clinic, people's homes and schools, as shown in Figure A1.13. She uses moderate proportions of institutional and specialised lexis, with some technical, and a low proportion of metaphoric terms. This reflects the components of her role in *'primary health'* which she says is *'to target the Aboriginal clients [and] educate them on management of diabetes, deliver education to the schools on chronic disease, diabetes'*.

Everyday lexis is dominant in DB's discussion of her role, education and community, shown in Figure A1.14. In respect to her role DB uses everyday terms to describe working at the clinic as '*we might see Joe Blow at a clinic one day and then because we won't be back at that clinic for a fortnight we'll go and see him at home in between'*.

She also uses moderate proportions of institutional work and specialised terms to refer to a '*caseload that's increasing'*. Her discussion of education includes institutional and everyday terms, such as '*self learning and your peers that you work with, "tell me what this is, how do I read this"*. Her use of specialised, institutional work, and some technical terms, reflects her clinical training as an Enrolled Nurse, such as '*blood pressures and your blood sugars and that's knowing how to read a pathology result'*. Her Aboriginal health degree has also extended her use of institutional terms such as '*health promotion and primary health'*. Her discussion of community and family is overwhelmingly dominated by everyday lexis to tell stories about her experiences growing up.

5.7.3 Evaluating practice

Extracts showing how DB evaluates her practice are presented in § A1.7.3.

Role

DB is concerned to present a measured evaluation of her role and the program she works in. To start with, she implicitly criticises '*all the different factions in the community'* that she has to work with, but she and her colleagues '*don't caught up in the politics'*, and overcome the problem by offering fortnightly clinics in different locations. This also allows them to deal with the workload, which she repeatedly evaluates as expanding, in contrast to her previous part-time role. Again she expresses both an optimistic and pessimistic view of the program, it has started slowly, but they '*don't get disappointed'* as they '*never have high expectations'*. Finally she is equivocal about the Aboriginal focus of the program, '*not saying Aboriginal only'* but *'encouraging Aboriginal [clients] only sort of'*. DB's role is to encourage as many Aboriginal people as possible into this mainstream chronic care program. She understands the complexities of the community, their health issues, and the program. Her attitude to the task is positive but pragmatic.

Education

DB acknowledges the enormous contribution her education has made to both her personal and professional development. After years of hospital work and a short

registered nursing course, which '*I wasn't hungry for'*, she finally completed a Public and Community Health degree with an Aboriginal health focus that met her needs. The personal impact of this course made her '*a lot more confident'*, and '*taught me a hell of a lot of more about my culture that I ever knew'*. She contrasts her previous role in a hospital as '*a little pan carrier, back wiper…and bum washer'* with the knowledge that she need '*never go back to the wards'*. The professional impact of the course was the '*knowledge in all areas'* to meet her community and co-workers' expectations. She is convinced that '*education is power'*, that it brings confidence, pride in oneself, and the ability to '*look at things differently'*.

Community

DB contrasts two critical sets of skills that derive from her Aboriginal community membership and her professional role. On one hand she is '*aware and sensitive to people from all walks of life'*. She is an Aboriginal woman who is a part of the Stolen Generation, has experienced racism, and sees '*lots of dysfunctional families…that float in and out of your town'*. On the other hand her clinical role requires her to be '*confident and assertive…to talk and liaise with doctors [who] can be very intimidating'*. Although she is not as confident as she would like, her motivation and love for her job help her to traverse the professional/community divide, on behalf of her people.

5.8 PN

PN works as a Healthworker with a clinical role at a large metropolitan AMS. She first worked for this organisation for a number of years but took extended leave before she was asked to return. PN left school in Year 7 and has completed a private Pathology Course, an Assistant in Nursing (AIN) qualification and an ATSIPHC Certificate III. In addition she commenced but withdrew from a Bachelor of Nursing degree in the first year of study.

5.8.1 Presenting practice

Extracts showing how PN presents her practice are presented in § A1.8.1.

Role

PN presents her role primarily as recounts and lists of the activities she undertakes on different days of the week. First she recounts the activities on three days when *'I look after our diabetic and chronic disease clients'* in home visits. She then lists the activities she does in her clinical role '*general observations, bloods, hearing tests, wounds, fixing up appointments'*. In response to clarifying Question 2 '***On those three days when you're out in the field, describe a typical day'***, PN gives a more detailed recount of what the home visits entail. In response to clarifying Question 3 '***So when you say health check, what do you mean by that?'*** she gives a more detailed recount of the activities in a health check. All of the activities that PN recounts are highly proceduralised. She initially simply names the activities in general terms as '*health checks, GP management plans, diabetes plans, referrals'*. Prompting is needed to clarify her actual role in these activities. Sometimes she makes this clear, particularly for referrals, '*any specialist appointments they need, any bloods they need done, I do that'*, but the specific roles of herself and the doctor in home visits remain unclear. She is most specific about the types of referrals she makes. She offers no evaluation of her practice.

Education

With prompting, PN names three sets of knowledge and skills she has learnt in her AIN and Certificate III courses. These include aged care skills, exemplified as '*sprains and skin tears'*, knowledge about Aboriginal history, '*to understand where Kooris have come from…to know what you're dealing with today, their health their mental issues'*, and clinical skills such as taking '*blood and doing ECG's and swabs'*. These three sets of knowledge and skills derive from competencies in the vocational courses that PN has studied. Examples of such competencies include working in Aboriginal healthcare contexts, providing information about social and emotional support, and planning and implementing basic health care.

5.8.2 Perspectives on practice: lexis

Like WH, PN used a high proportion of everyday lexis throughout her interview, shown in Figure A1.15. This reflects her strong personal affiliation with her community, and

her work role in an AMS, with a significant community component visiting clients in their homes. Also like WH, she uses moderate proportions of institutional lexis, with some technical, and a very low proportion of metaphoric terms, reflecting her vocational training. However she uses a relatively high proportion of specialised terms which reflects the breadth of her role, training and years of experience in clinical care.

In discussing her role, PN uses moderate proportions of everyday, specialised and institutional lexis that reflect the clinical, community and administrative components of her role, shown in Figure A1.16. She tends to list the activities she does, for example '*We check them head to toe. We run through questions, their family history, their medications, any illnesses they've got, any cancers in their family. We check their blood pressure, pulse, temperature, check their ears, eyes, teeth… any mental issues they have, I come back and I refer to our counselors'*. As with other Healthworkers in this study, this combintion of clinical and non-clinical activities indicates that PNs role and practice can be broadly categorised as comprehensive primary health care. Everyday specialised and institutional terms refer to people, equipment health conditions and the program activities she is involved in. She uses less technical lexis to refer to a few clinical and administrative procedures. PN's discussion of education is dominated by everyday lexis as she tells stories about her experiences with education. She also uses a moderate proportion of specialised and educational lexis to refer to vocational certificates she has completed including workplace practicums. Her discussion of community is also dominated by everyday lexis to refer to family and community members. Her community knowledge and relationships are an integral component of her work. For example *'I know everyone over that side. I didn't know anyone over this side. So when these fellas would come in and I'd check them over and they'd say "oh where are you from" and I'd tell them and they say "who's your mum and dad" and I'd tell them, "oh I know them, you're daughter". I said "yeah. We're related you know"'*.

5.8.3 Evaluating practice

Extracts showing how PN evaluates her practice are presented in § A1.8.3.

Role

PN recounts the clinical tasks in her role with relatively little evaluation, except that she is '*trying to get through'* them and *'turn all those red ones blue'*, i.e. clients due for health checks. She describes the care plan simply as '*making sure'* various tasks are done correctly. However the clients '*love us coming out'* and she affirms her own capacity to assess their living conditions and the effects on their health.

Education

Despite leaving school in Year 7 to support her family, PN is quietly confident about her capacity to study. She deliberately returned to TAFE to get '*back into like school type things'*, and then took on the Assistant In Nursing course because her TAFE teacher insisted *'you've got the brains'*. She also '*tried uni for a year'*, but whereas she enjoyed the Aboriginal TAFE course, she was offended by the overt racism of her classmates in the mainstream clinical AIN course. She also felt angry about how '*they teach you at the unit'* and critical of the lack of recognition for her pathology certificate. On the other hand, she is far more positive about the Certificate III Healthworker course that she did subsequently, which addressed '*the person's whole health and their family and everything around it'*, whereas the AIN was just '*cold type clinical'* skills.

Community

PN talks about her family and community throughout the interview, such as the discussion about her education above. In this extract she discusses the personal/professional conflicts associated with her role, and the advantages of knowing the community well. She feels a personal responsibility to her clients, attends their funerals and stays at work when they are dying, in contrast to the attitudes of mainstream health workers who want to '*get the client in and out in 15 minutes'*. Her intimate knowledge of the community accentuates her responsibility, and the expectations of others, so much that '*sometimes I just want to run away',* yet she loves working at the AMS and being in healthcare.

5.9 WH

WH is a Healthworker with the NSW Health Aboriginal Otitis Media program and an eyesight-screening program for preschool children. She left high school having completed only three years, has completed an ATSIPHC (Practice) Certificate IV, a university tertiary preparation course (Indigenous) and commenced but withdrew from the first year of a Bachelor of Health Science (Aboriginal Health and Community Development). WH has also considered applying for RPL for the ATSIPHC (Community Care) Certificate IV. She is currently enrolled in a Certificate IV in Audiometry.

5.9.1 Presenting practice

Extracts showing how WH presents her practice are presented in § A1.9.1.

Role

WH presents her role in everyday terms, recounting it as very general activities, people and places. In response to Question 1 '***Can you tell me about your job, your job title and what you do?'***, she identities her positions in two health promotion programs, and then describes how '*I go around and do the kiddies ears [and] we go around and do the kiddies eyes'*. She then digresses to explain that the program is not just for Aboriginal children, '*which is good'*. In response to clarifying Question 8 '***Just what do you do? What does it entail, as a job?'***, WH does not give more detail about the actual activities entailed in her job, except that '*we contact schools'*. Instead she digresses several times, firstly to the issue of referrals '*which we thought, well no that's not going to work'*, secondly to a '*big portfolio'* that she and two others have put together, thirdly to '*a new approach'*, which appears to be a change in '*the target group'*, but it is unclear exactly what this target group is. Finally she returns to activities with schools, '*we ring the schools and we go around'*, but she does not yet say what this involves. A series of prompt questions were subsequently asked to elicit more details of these activities. At this point she only names the towns that she visits and the audiologist she works with. In describing her role, WH is primarily concerned with the people she works with, the children she sees, her work schedule and the towns she visits. She did not provide an explicit account of the activities in her role, without considerable prompting. This lack

of articulation of her role is consistent with the uncertainty she expresses about it, as described above under Evaluating Practice.

Education

WH identifies the skills and knowledge she has learnt in her audiometry and Certificate IV courses. This includes learning how to use equipment, writing up paper work and working with stakeholders exemplified as '*government agencies, schools, doctors and kiddies'*. She names two technical skills: audiograms or '*what numbers to push',* and bone conductive screening, which she has not yet learnt. WH lists a few basic clinical skills, and non-clinical knowledge including reporting, case studies, drug and alcohol, first aid and primary health care. These lists, the prompting required to elicit responses and WH's reference to sundry components of her study suggest she is still assimilating her learning with the demands of her role.

5.9.2 Perspectives on practice

WH's strong orientation to the community, working with children and families, is reflected in the very high proportions of everyday lexis she uses in the interview extracts, shown in Figure A1.17. She uses moderate proportions of specialised and institutional lexis, with some technical, and a very low proportion of metaphoric terms, reflecting her vocational competency based training and clinical support role in childrens' ear and eye health screening. For example '*I go around with an audiologist and then with the STEPS which is the State-wide Eyesight Preschool Screening, we go around and do the kiddies eyes'*.

WH uses very high proportions of everyday lexis in each topic area, shown in Figure A1.17. In respect to her role, she also uses moderate proportions of specialised and institutional lexis, referring primarily to roles of health specialists she works with, and the program activities such as '*tympnometries, where you know it tells you what middle ear pressure. Like it'll tell you whether they're working, whether the middle ear drum's working properly and whatever'*. WH uses fewer technical terms, which probably reflects her novice status in her position, still learning the technical field on-the-job. Her discussion of her education and skills is dominated by everyday lexis, reflecting her focus on on-the-job skills and community based experience, '*you learn… it's more by*

experience than, you know out of a text book, especially when you're looking at our people, it's things that've been passed down generations'. The moderate proportion of educational terms refers primarily to the vocational certificate courses she has studied. Her discussion of family and community is almost entirely everyday, as it consists primarily of stories, '*like I was at the pub last weekend for my daughters twentieth. We went out to tea and then we went out afterwards. This fella comes up and he's talking to a friend and says, looks straight at me and says "Is she a Koori'?"'*.

5.9.3 Evaluating practice

Extracts showing how WH evaluates her practice are presented in § A1.9.3.

Role

WH evaluates her role as '*just basic'* eye tests. She distinguishes between issues that are a '*high priority'* and *'small issues'*. She uses continual soft focus, low probability and '*you know'* to downplay the value of her role. If an issue is '*high priority'* it is referred to the clinical nurse consultant or the optometrist. Implied in this is that their roles have higher values than her own. The evaluation is not organised, but goes back and forth iteratively, which has the effect of amplifying her uncertainty.

Education

WH evaluates her education in the form of a family narrative. She starts with her father's illiteracy, and her own negative experiences with school, despite being '*good at writing and reading'* (though '*not essays'*). Now she is proud of what she has achieved with education and hopes to be an inspiration to her children and grandchildren. She reiterates her previous incapacity and her pride in what she has 'actually achieved'. She is grateful for the opportunity she has been given and is determined to prove herself worthy. The story evokes a mix of pride and humility.

Community

WH talks about her family and community throughout the interview, for example she recounts a family narrative about her education in response to Question 57 '***What difference has your education made to you?'*** In the brief extract shown in § A1.9.3,

she evaluates her feelings about working for her community. Her strong commitment to her people is the reason she wanted and enjoys her job, although another factor is that '*it's so hard to be able to relate to other people'*, by which she presumably means non-Aboriginal people. One reason for this is the racism she continues to experience.

5.10 Towards initial findings

This chapter has presented initial findings as they emerged from the analysis of extracts to explore what each Healthworker said about their practice, their education and their family and community experience, and how they talked about it, including their textual organisation, their lexical choices and their appraisals. In terms of textual organisation, initial findings showed that some Healthworkers listed and recounted the various activities they performed and told anecdotes about their different life experiences. Others exemplified different topics, explained issues and presented arguments for their points of view in regards to their education, roles, practice and their communities. A smaller number of Healthworkers also reflected on the complexity of their roles, and classified and exemplified components. In addition they related their roles to their education thereby systematically developing a comprehensive picture of their professional field. In regards to the analyses of lexis, findings showed patterns in Healthworkers' use of everyday, specialised, technical and other abstract terms to talk about their practice, education and family and community experiences. For example, most Healthworkers used moderate to high levels of everyday terms to describe each topic area, in particular their communities and families. Some Healthworkers also used comparatively moderate to high levels of institutional terms to refer to their roles and education, whereas all Healthworkers used fewer specialised terms and even less tehnical terms to talk about these topics. In regards to the analyses of appraisals to show how Healthworkers evaluated each topic, findings showed there were both commonalities and differences in Healthworkers presentations, perspectives and evaluations. Some Healthworkers expressed limited evaluation of their practice and others more. The majority positively valued the broad scope of their practice, which could be considered comprehensive primary healthcare. In addition, they all positively judged their capacity to perform their roles, but also showed a level of humility. Most Healthworkers also appreciated the various vocational and university healthcare courses, they studied, particularly those that were specific to Aboriginal health.

However, some of these Healthworkers negatively evaluated issues such as academic writing which they found challenging. In regards to their communities and families, most Healthworkers positively evaluated the contribution they made to their roles and professional identities, although some also indicated feeling some tension between their institutional roles and their personal lives in their communities. Perhaps most importantly each Healthworker expressed postive feelings about the central importance of their Aboriginal identity to their professional healthcare roles.

These initial findings from the analyses the individual interview extracts of the nine Healthworkers, showed there were patterns in their presentations, perspectives and evaluations. These patterns provide a basis for making comparisons across the group. Chapter 6 therefore presents further findings based on such comparisons. It also presents a discussion of the findings organised around the three topic areas.

Chapter 6: Further findings and discussion

6.0 Introduction

Chapter 5 focused on each of the nine Healthworkers as individuals to present initial findings from the analyses of interview extracts. These findings were in regards to the information Healthworkers presented, how it was presented and how it was evaluated. Chapter 6 now presents further findings about the patterns that emerged in interview analyses across the Healthworker group. The chapter is organized around the three topic areas of education, professional roles, and families and communities. Within each of these fields, patterns are identified in what the Healthworkers discussed, and how they presented and evaluated it. These patterns form the bases for grouping Healthworkers together as well as for distinguishing individuals from one another. Patterns in each of these fields emerged in response to questions such as: what types and levels of education do Healthworkers have?; what are the programs and activities that they perform in their scope of practice?; what are the relationships between their education and practice?; and what are the relationships between their practice and family and community experience?

The first section discusses education, focusing on institutions, course types and qualifications that Healthworkers attained. The section focuses on what was learnt in these courses, as well as on how education was discussed and evaluated. The second section addresses professional roles including health service types, program types, and the activities that Healthworkers performed and how aspects of practice are presented and evaluated. The final section on family and community identifies six themes that emerged in the interviews and discusses how Healthworkers presented and evaluated these themes. Each section concludes with an interpretation of the patterns that emerged. Issues that arise from these interpretations will be related to the broader contexts of Aboriginal health, Healthworker practice and education in the concluding Chapter 7.

6.1 Education

Healthworkers' education was considered in terms of three dimensions. The first is where and how they learnt, in terms of their institutions, program types and qualifications, The second has to do with what they learnt, that is subjects, skills and knowledge. The third focuses on how they talked about their education, how they presented and evaluated it. The patterns that emerged are interpreted and discussed as findings.

6.1.1 Where and how Healthworkers learnt

Information about Healthworkers' educational institutions, program types and qualifications is summarised below to contextualise findings about what they learnt and how they talked about it.

Healthworkers undertook their education at three types of education institutions including:

- Universities in Sydney and regional New South Wales;
- Technical and Further Education (TAFE) institutes in regional NSW, including the Open Training and Education Network (OTEN);
- a registered Aboriginal training college.

Seven of the nine Healthworkers had been enrolled at university at some time, eight at TAFE, and six at both university and TAFE. One had completed vocational studies at an Aboriginal training college. Seven Healthworkers commenced their vocational studies as mature aged students without prior experience or qualifications, and two immediately after completing Year 12. In contrast, those who attended university all had prior vocational qualifications or health work experience.

In terms of how Healthworkers learnt, their education included four types of programs: block mode, TAFE traineeships, distance education, and in-class attendance. Block mode programs typically included two to three, week-long study blocks per semester combined with independent study in the intervening periods. Study blocks usually comprised full time attendance at a combination of in-class lectures and tutorials,

whereas independent study entailed participation in distance learning activities and assessments often completed online. Workplace placements were also a core component of some block mode programs. JK, RH, SW, DB and WH had participated in university block mode programs.

TAFE traineeships commonly included intermittent lectures, workshops and tutorials combined with paid employment in the field. This program type included the workplace as a context for learning, enabling students to apply their knowledge and skills with guidance. Some traineeships also entailed block mode study. Traineeships were competitive, were only available at some TAFE institutes, and involved collaboration between the educational institution and employer. CB, WH, PN, DB and LT had participated in Aboriginal Health Worker TAFE traineeships.

Distance education included an Aboriginal Health Worker study program undertaken online without attendance at lectures or study groups. This program type was offered by a regional registered Aboriginal training college described as employing 'a kind of Aboriginal learning style' because 'Aboriginal people learn more from doing.' CO completed his Certificate III through this distance education program. In-class programs were those that required regular weekly participation in classes, lectures and/or tutorials and a time limited professional placement in a workplace setting. In-class programs may vary across courses and institutions. PN and RH had participated in these in-class programs at TAFE.

The qualifications of the Healthworkers varied. They included a masters' degree, bachelor degrees, diplomas, and certificates. Some of these were specialised Indigenous health qualifications and others were 'mainstream' social work, welfare and/or disabilities qualifications. All the Healthworkers had completed one or more qualifications and some were continuing to study. Information on educational institutions, program types and qualifications for each Healthworker is summarised in Table 2.

Table 2: Educational institutions, program types and qualifications

	institution	program type	qualification
JK	University	block mode	Bachelor of Health Science (Aboriginal Health & Community Development
	University	block mode	Master in Indigenous Health
	TAFE OTEN		Audiometric Assessment
CB	TAFE	traineeship	Cert IV Business Administration
	TAFE	traineeship	Cert IV Aboriginal and Torres Strait Islander Primary Health Care (Practice)
CO	Aboriginal training college	distance education	Certificate III Aboriginal & Torres Strait Islander Primary Health Care
	University	block mode	Bachelor of Health Science in Indigenous Health Studies - current/ first year at time of interview
WH	University	block mode	Indigenous Tertiary Preparation Course
	TAFE	traineeship	Cert IV Aboriginal and Torres Strait Islander Primary Health Care (Practice)
	TAFE OTEN	traineeship	Cert IV Eudiometry -current/incomplete
	University	block mode	Bachelor of Health Science (Aboriginal Health & Community Development) – withdrew after one semester
PN	TAFE	in class	Cert III Aboriginal and Torres Strait Islander Primary Health Care
	TAFE	traineeship	Cert III Health Services Assistant (AIN)
DB	TAFE	traineeship	Cert IV in Nursing (EN)
	University	block mode	Bachelor of Health Science (Indigenous Health)
RH	TAFE	in class	Cert IV Disabilities Studies
	TAFE	in class	Cert IV Community Services
	University	block mode	Bachelor of Health Science (Aboriginal Health & Community Development) –current/ final year at time of interview
LT	TAFE	traineeship	Cert IV Aboriginal and Torres Strait Islander Primary Health Care (Practice)
	TAFE	in class	Diploma of Community Services Work (Alcohol and Other Drugs) – current/incomplete
	University	N/A	Bachelor of Commerce - withdrew
SW	TAFE	block mode	Diploma Aboriginal and Torres Strait Islander Primary Health Care (Community Care)
	TAFE	block mode	Diploma of Community Services Work (formally Community Welfare)
	University	block mode	Bachelor of Social Work – current/ final year at time of interview

The above table shows that that even within this small group there are considerable variations in the educational institutions that Healthworkers attended, the types of programs and learning modes they undertook, and in their qualifications. It is possible that this finding reflects both the diversity of Healthworker education and the lack of a distinct, articulated Healthworker educational pathway. The table also indicates that all Healthworkers have multiple qualifications, most of which are in health and community services at a level Certificate IV or above. This is likely to have implications for the Healthworker field. For example, a quick review of two major on-line job seeking sites, revealed that many Healthworker positions did not specify qualifications as essential criteria. The problem with this is twofold. Firstly, if Healthworkers roles are perceived not to require qualifications then there may be reduced incentives to obtain them. Secondly, Healthworker roles not underpinned by qualifications could demean Healthworker roles that are. Moreover, this might hinder efforts to increase the numbers of Healthworkers with qualifications and improve professional recognition.

Another important finding evident in Table 2 is that more than 75% of Healthworkers in this group had been enrolled at university yet only three had completed degrees. The issue arising here is that despite Healthworkers' cognisance of the benefits of university study and their motivation to acquire a university qualification, there were obstacles that prevented them from achieving these goals. The final finding in regards to where and how Healthworkers learnt, was the apparent relationship between Healthworkers' work circumstances and the types of programs and learning modes they undertook. For example, some Healthworkers' positions were integrated with their study, such as those whose positions were predicated on their participation in a Healthworker TAFE traineeship, whereas, others studied part time in either block mode or distance education programs to be enable them to work fulltime and meet their family and other responsibilities.

6.1.2 What Healthworkers learnt

This section addresses the variety of subjects, healthcare skills and knowledge that Healthworkers studied, focusing on two key areas identified in interviews, broadly categorised as clinical and non-clinical.

Clinical areas of study that were identified included theory, as anatomy, physiology and biology, as well as a range of basic and more specialised clinical skills. JK, CO, CB, PN, DB, LT and WH identified basic skills such as how to perform health checks, urinlayses, blood sugars, blood pressures, wound dressings and first aid. JK, CB, PN, DB and WH also identified specialised clinical skills such as audiometry screening, administration of medications, venepuncture and electrocardiograms (ECG), read pathology results and audiograms. SW and RH did not explicitly identify learning any clinical subjects. Common non-clinical areas of study identified included healthcare knowledge, historical and cultural contexts of Aboriginal health, communication skills and critical learning skills.

A variety of healthcare knowledge identified by most Healthworkers ranged from broad topics, to specific subjects studied at university. Broad topics identified by RH were *'human rights, social justice and professional practice'*. CO identified *'old public health new public health, the Aboriginal holistic health model'*. SW identified *'basic welfare, social work theory, sociology and law'*. More specific topics identified by LT, RH and DB were primary health care, community development, health promotion and prevention. Most specific subjects identified by JK were *'community profiles, business plans, project development, project management and project evaluation'*.

Historical and cultural contexts of Aboriginal health were identified as topics of study by nearly all Healthworkers. PN described this as a need *'to understand where Kooris have come from…to know what you're dealing with today, their health their mental issues' and DB as 'knowledge of Aboriginal culture'*, and learning about *'what works for Aboriginal people and what doesn't'*. SW exemplified it more specifically as *'knowledge of the historical events in Aboriginal peoples' lives like the Stolen Generation and how that has impacted on Aboriginal people over the last one hundred years'*. RH also exemplified it specifically as learning about *'policies, particularly how they are written and implemented in the delivery of health to Aboriginal people'*. In contrast, CO merely listed two subjects he intended to study as *'Aboriginal Identity and Contested Knowledges'*.

Communication skills were also identified by the majority of Healthworkers. These included building rapport, being non-judgmental and empathetic, and talking to both professionals and clients. LT emphasised the need to explain to clients *'in their own terms'*. JK said that education had enabled her to acquire *'written and verbal skills'*, and *'to communicate effectively with various groups of people, professionals, and community members and governments and non-government people'*. SW also highlighted that learning how to communicate was critical for her advocacy role and enabling her to *'get the doctors to explain to the patients in lay terms what he's actually talking about so it's not as devastating as it sounds'*.

Some Healthworkers, particularly those who had attended university, also said that education had facilitated their acquisition of critical learning skills. JK described learning to *'be analytical and critical'*, CO to *'critically analyse, think outside the square and brainstorm every possibility, every channel'*, DB *'to look at things differently'*, and RH to *'have the conglomerate of both'* knowledge and skills.

In summary, interviews reveal that Healthworkers learnt a diverse range of subjects, healthcare skills and knowledge across clinical and non clinical domains. The majority all learnt basic clinical skills although only some had clinical roles. Most of these skills were acquired through vocational education healthcare courses such as enrolled nursing, assistant in nursing and the Certificate IV ATSIPHC (Practice). Most Healthworkers had also learnt a broad range of non-clinical knowledge in their vocational and university courses. For those who had been to university specific topics were identified such as *primary health care, professional practice and community development*, whereas in vocational courses Healthworkers identified non-clinical knowledge in more general terms such as *the person's whole health, and old and new public health.* In addition, all Healthworkers who had been enrolled in Aboriginal specific vocational and university courses had studied Aboriginal health in its historic and cultural contexts. Furthermore, the majority of the group had learnt a range of verbal and written communication skills. Finally, Healthworkers who had completed a university degree, or who were currently undertaken university study, also mentioned acquiring critical learning skills. This diversity of skills and knowledge points to the breadth of content in the healthcare courses undertaken by Healthworkers. While there was some common

content across vocational and university courses, it was apparent that clinical skills and knowledge were principally learnt through courses in the vocational rather than university sector.

6.1.3 How Healthworkers talked about their education

Varying patterns were identified in how Healthworkers discussed and evaluated their education. In presenting their discussions of education, Healthworkers fell into three broad groups. One group presented the content of their education as lists and recounts; another group identified topics and then exemplified and explained issues, presenting arguments about their education. A third group exemplified and explained, but also reflected on relations between their education and their work roles. Healthworkers in all groups also told stories about their education. In addition there were variations in the proportions of everyday, specialised, technical or institutional lexis used by Healthworkers in each group to discuss their education that appeared related to their roles and education

The first group included three Healthworkers who primarily used lists to identify general components of their study. PN listed the content of her AIN aged care course at TAFE as *'sprains, tears, skin tears'*, the content of her pathology short course as *'bloods, ECG's, swabs'*, and the content of her ATSIPHC Certificate III as *'what everyone went through, getting taken away'*. WH also listed the skills and knowledge she acquired in two vocational TAFE traineeships, for example in the ATSIPHC (Practice) Certificate IV these were *'blood pressures, pulses…urinalysis…blood sugars… reporting, case studies…drug and alcohol, first aid…primary health care'*. WH exemplified a few skills such as audiograms in simple terms as *'know how to, what numbers to push, or you know or what decibels to screen them at'*. CO listed topics in his degree that he is either studying or plans to study, including *'core subjects in the Indigenous health program, …nursing subjects, …hopefully some management, …Aboriginal Identity and Contested Knowledges'*. In common with PN, CO's only study prior to enrolling in university was a Certificate III in Aboriginal Health, but unlike PN, he studied this solely through a distance education program.

CO, PN and WH also told stories about their further education. CO told an anecdote about applying for a scholarship, being accepted into an undergraduate degree, and his reaction as '*absolutely stoked because I'm the only one that's ever gone into the academia world in my whole family'* (Q18). In contrast PN made three brief observations about her dissatisfaction with a nursing course (Q25): her *'teeny-bopper'* classmates who *'didn't have a clue about how everything works out in the real world'*, the mismatch between *'the way they teach you at the unit [and] the way it is out there'*, and the lack of recognition for her clinical skills and practical experience, which led her to withdraw from university. WH told a series of stories, including a generalised recount of the program in her TAFE course (Q29). Both PN and WH required considerable prompting to elicit this information about their education.

The second group included two Healthworkers who identified components of their study, but also exemplified them and presented arguments. LT identified four focus areas of study, and exemplified the clinical skills she learnt. DB also identified clinical skills, such as *'blood pressures and your blood sugars and…how to read a pathology result'*, which she exemplified as '*a blood test result which comes with the patient or client'*. DB also exemplified studying primary health, as *'preventative and about health promotion…different ways to get the word out there and what works for Aboriginal people and what doesn't'*. LT argued that clinical education should be prioritised because *'people want to see the Aboriginal Health worker and know [they're] competent to be able to pick up and do the basic assessments'*. DB also argued in favour of learning basic knowledge about topics such as anatomy and physiology *'so that I can explain it simply, and people really get the gist of it and they really understand it'*. In addition, DB argued for skills and knowledge acquired from working in community health, through *'self learning and your peers that you work with'*.

LT and DB also told stories about their struggles with further education. For example, LT told a brief story about starting an accounting degree, but found it boring as it lacked *'personal contact'* and she *'always had that drive to want to make a difference within things'* (Q63, Ch 5). DB recounted how she left school at Year 10, was an enrolled nurse for 15 years, briefly tried a nursing degree, but instead completed a degree in Public and Community Health (Q5-6, Ch 5).

The third group included four Healthworkers who identified and exemplified components of their study, but also reflected and related their education to their work roles. For example, RH listed four essential and specific areas of knowledge, as human rights and social justice, professional practice, primary health care, and community development. She prioritised knowledge about policies, particularly how they are written and implemented in the delivery of health to Aboriginal people. She also reflected on the connection between *'personal attributes, what you're capable of doing, and what your own code of conduct are, and what you think about ethics, what's your moral stance'.*

SW focused on specific knowledge learnt at university, such as basic welfare, social work theory, sociology, law, counseling, grief and loss, psychology and Aboriginal history, which she exemplified *as 'the historical events in Aboriginal peoples' lives…the Stolen Generation…how that has impacted on Aboriginal people'.* She acknowledged the importance of her education for her AHLO role, but reflected that *'it's not going to change the way I work'*, which is based on her commitment to her community.

CB classified and exemplified four components of his formal study and hospital based learning, as clinical skills, non-clinical knowledge, communication skills, and different ways of learning. He reflected on the value of his hospital traineeship to *'build on your communication skills with the patients'*, and like SW, also argued that *'my connection to the Aboriginal community'* is as important as having a university degree.

JK directly linked the skills and knowledge in her university education to her professional role. Outcomes of her university education included the capacity to run a health service, to be analytical and critical, and *'communicate effectively with various groups of people'*. She identified relevant areas of study such as community profiles, business plans, and project development, management and evaluation. She reflected on her education systematically by identifying its outcomes, exemplifying and evaluating.

In this group, three Healthworkers also told stories about their education. For example, RH recounted the stages in which she started study at TAFE, returned to manual work, studied a Certificate IV in welfare, and then went on to study at university. SW explained how her daughter's disability was the trigger to her studying social work and CB recounted how he came to enrol into his Aboriginal health traineeship.

In terms of evaluating their different kinds of education, Healthworkers' experiences of school education were generally negative, in relation to their treatment by the school and their academic success. RH and LT cited explicitly racist treatment, RH because she *'was stuck down the back of the class room doing something else while they [white students] were learning about…history and Captain Cook'*, whereas LT was *'always a high achiever...the A grade student'*, which conflicted with stereotypical views of Aboriginal students as *'low grade'*. Other Healthworkers reported poor academic outcomes. CB *'finished Year 12…and couldn't do a simple maths equation'*. Although LT was *'good at school science and maths'* she *'could never really write essays'*. Similarly WH saw herself as *'good at writing and reading'* but *'not essays'*. WH *'absolutely hated school…I hated studying then and I still hate it now'*.

In contrast Healthworkers' experiences with further education were far more positive. Vocational programs were positively appreciated by SW, CB, LT, PN and CO. SW valued TAFE in general terms as *'really, really good, more of a hands on thing'* [in comparison to university study]. CB was more specific, valuing his Aboriginal health traineeship for *'the support I was given, the way I was taught to study and so many different ways you can research'*. On the other hand LT valued TAFE because it *'is starting to become equal with a university qualification… it will definitely give me a little bit more pull'*. PN and CO had both studied the Cert III in Aboriginal and Torres Strait Islander Primary Health. PN saw it as *'the best course I ever done'*, particularly because *'it was an Aboriginal class'*. Although CO studied it by distance, it gave him *'more of a community level/grassroots feel'* and *'the opportunity to work on the face and get community experience'*. In contrast, PN described a mainstream TAFE clinical Assistant in Nursing course as a *'very cold type, clinical'*.

University programs were strongly appreciated by JK, RH, DB and CO who studied specialised Aboriginal healthcare degrees. Overall, JK *'really enjoyed researching and learning so much'*, and DB *'really learnt'* in her university course, which she described as *'pretty magic'*. In contrast to her skills based TAFE study, RH valued university as *'really getting at the core, the core issues, the core inception of where sort of everything starts from'* and CO described it as *'the higher education of society'*. On the other hand, two participants had negative experiences with mainstream university courses. PN withdrew from a nursing degree as she *'didn't like it at all'*, and LT withdrew from an accounting course, saying she *'hated it because it was so boring'* although she acknowledges *'university education has always been looked upon as a higher thing'*.

Several Healthworkers evaluated their study at university, particularly academic writing, was a challenge. WH, for example, had *'trouble writing things down'* and LT *'could never really write essays'*. CO *'nearly failed'* saying that having to *'study, research and then convey that down in paper and reference it'* was his *'biggest downfall'*. SW struggled *with 'academic writing which is so, so hard'*, as it never allows *'your own words' but demands 'research, referencing…something to back it up'*.

The contribution of higher education to their professional roles was specifically valued by several Healthworkers. DB and RH studied specialised Aboriginal healthcare degrees, and valued the skills and knowledge that education has given them; DB because she acquired *'knowledge in all areas…to meet her community and co-workers' expectations'*, RH because it has affected *'the way that I view things not just in the way that I work but in the whole way I think'*. JK studied two specialised Aboriginal healthcare degrees, specified particular tasks and assignments such as *'community profiles and business…were directly related to what I was doing on the job, [so] I was able to understand the process of running a service a lot better'*. LT also specified the clinical component of her TAFE education and strongly valued its contribution to her Aboriginal Health Education Officer role, being *'competent to be able to pick up and do the basic assessments and pick up on the abnormalities and then refer [Aboriginal clients] to the specialised services'*.

Other Healthworkers' were more circumspect about the value of education for their roles. For example CB saw his TAFE course as *'something that you can always use as a Health Education Officer, because you are jack of all trades'*, but argued those who don't have degrees can still *'give a different perspective and can come up with more of a common sense sort of answer'*. Similarly, SW was adamant her degree would give her *'the theoretical knowledge…the research and the readings and everything else that you learn at uni, but its not going to change the way I practice as an ALO'*. LT was quite pragmatic and said she was studying *'for more of a money thing because once you're a graduate, your pay rates go almost double'*. On the other hand WH merely recognised that her TAFE study was a condition of her role and *'something that I have to do'*.

Healthworkers' also strongly valued education for its contribution to their personal lives. For some, education had strengthened their self-esteem, confidence and understanding of themselves. JK said university study had *'an enormous impact…mentally, physically, spiritually'* so that she now *'has a passion for things'* and is *'not intimidated anymore'*. DB also said university *'helps you to find yourself [and become] a lot more confident'*. She specified learning *'a hell of a lot of more about my culture that I ever knew'*, now *'looks at things differently [and is] even more proud'*. Like DB, WH linked her TAFE and university education to being *'proud of what I've actually achieved*' and *'hopes I'm an inspiration to my kids and to their kids'*.

Other Healthworkers valued university education for the knowledge and power it conferred. SW strongly valued her Social Work degree for the power it would give her to apply for *'just about any job'* and acknowledged it had taught her to be *'more open minded [and] appreciate where people come from a lot better than I used to'*. CO generally appreciated university as having *'opened my life to this whole new world…the higher education of society, where you have to go if you want to be an architect or a police officer or CEO or doctor'*. On the other hand, some Healthworkers valued education but also expressed reservations. CB viewed a university degree as *'only a piece of paper to me'* but acknowledged *'it would be worthwhile [because of] the way society looks on university degrees… I can get paid more [and] learn a few skills'*. RH noted the importance of balancing a university education with *'your connection to your land, you know connection to your country, connection to your culture'*.

In line with RH's comments, some Healthworkers were critical of education that did not incorporate Aboriginal community and/or family perspectives and experiences. CO noted that *'academia'* does not consider *'community experience, especially in the Aboriginal Torres Strait Islander world*', so that some people *'with degrees don't have a clue how to interact with the community and therefore could be quite dangerous to the community'*. In contrast, CO spoke of health workers *'who have got great community skills but just can't get that what we call "the white man's paper"*. SW similarly contrasted university educated Social Workers and their *'very formal'* communication style with her own community *friendly 'general yarn…everything'll come out and…it's nice and casual, it's not daunting…I'm not being a dominant participant in the interaction'*. CB also argued that, as an Aboriginal person, he had the experience of what it was like *to 'struggle'* and would therefore be more qualified than his non-Aboriginal university educated colleagues to solve problems and could *'come up with more of a common sense sort of answer [and] sort of enlighten them'*. Conversely, RH was concerned about communities' negative perceptions that education was *'actually trying to turn us [Aboriginal Health Workers] white'*. She exemplified this as *'going to go back to our communities and saying "you have to do it like this"*". CO was similarly concerned that university *'took me away from my family'*.

6.1.4 Summary: What and how Healthworkers learnt

With respect to what they learnt, Healthworkers identified a very broad range of clinical and non-clinical skills and knowledge. Almost all identified clinical skills, most of which were basic clinical procedures. Historical and cultural contexts were identified by most as important for understanding current socio-economic determinants of Aboriginal health. Communication skills were also identified by the majority, ranging from rapport derived from community membership, to written skills learnt in formal education, and liaising and interpreting between medical staff and Aboriginal clients, which were also acquired through formal education. These skills were deemed crucial to roles in respect to engaging with clients and other professionals. Healthworkers who had or were completing university degrees also emphasised that non-clinical healthcare knowledge, including primary health care, social work and community development were fundamental to their understanding of effective health service provision in the context

of their client's health and wellbeing. This group also identified the value of critical learning skills for problem solving in both study and practice.

However, not all Healthworkers acquired this very broad range of skills and knowledge. For example, a Certificate III in ATSIPHC, which includes just 13 competencies covering some clinical, communication and contextual knowledge, is unlikely to equip Healthworkers with the range of knowledge and skills discussed above. A Certificate IV would seem to be the minimum level of qualification needed for this complexity of knowledge and skills. In fact, more complex healthcare knowledge and critical learning skills were only acquired by Healthworkers who had been or were studying relevant university degrees. One exception was CB who had studied a Certificate IV in Business Administration and had experience in a multidisciplinary population healthcare team.

It is noteworthy that most Healthworkers who had or were studying university degrees, began their further education with vocational study and had qualifications and/or workplace experience in community service programs, before going on to university study. As such, most of this group had come to university with preparation for study at a vocational level together with practical experience of the complexity of the Aboriginal health field. This appears to be a common and effective pathway for Healthworkers, and one that may have given them an advantage in managing the complexity of university study.

In terms of how they learnt, Healthworkers noted a number of benefits and disadvantages associated with different modes of learning. For example, Healthworkers who had undertaken vocational traineeships perceived them as enjoyable and found integrated classroom based learning with opportunities to practice skills in real healthcare settings particularly *'useful'*. Other Healthworkers who had participated in courses that provided flexibility, such as part-time study or block-mode options, also perceived them as effective methods of learning. This was largely because they enabled study to be combined with family and work responsibilities. However, one Healthworker who had completed an ATSIPHC Certificate III entirely by correspondence had found it *'difficult'*, despite its flexibility. Access to tutors, mentors

and having Aboriginal teachers were also viewed positively by Healthworkers, irrespective of the mode of delivery.

With respect to how they presented their education, differences between Healthworkers appear to be associated with differences in the types of education programs, qualifications and the subjects they studied. Healthworkers who listed and recounted the content of their courses had effectively only studied at Certificate III level. One had an ATSIPHC (Practice), Certificate IV the national baseline qualification for registration as an Aboriginal Health Practitioner, but stated that she had been 'RPLed' (recognition for prior learning) for much of the qualification. Another had completed the Certificate III entirely by distance education. The acquisition of qualifications through Skills Recognition without undertaking further study and distance education programs that do not include practical components are both accepted educational practice. However quality assurance that underpins these practices must be rigorous and explicit to avoid the supply of qualifications that do not prepare people for workplace practice or further education.

The two Healthworkers who identified, exemplified and argued for the content of their education had studied at Certificate IV, diploma or degree level and had multiple qualifications. Both had studied in traineeships, giving them the experience of applying what they learnt in the workplace. This gave them the capacity to classify areas of study and exemplify the skills they acquired. Both argued for the value of clinical skills in Healthworker education. Integrating workplace practice with classroom learning appears to be a sound and growing practice in Healthworker education.

Healthworkers who identified, exemplified, reflected and systematically related their education to their work roles, had or were completing university degrees (with the exception of CB's Certificate IV in Business). All had multiple qualifications and extensive workplace experience across fields. They were all able to identify a range of specific topics of study, and to link them to specific fields of practice in their roles. As well as identifying concrete subjects such as clinical skills, counselling or project development, they reflected on abstract concepts such as codes of conduct, ways of learning and the capacity to be analytical and critical. This level of education would

seem to be a crucial component of Healthworker education options for ensuring they acquire the skills and knowledge needed for managing the immensely complex challenges of the Aboriginal health field.

With respect to how they evaluated their education, differences between Healthworkers were less pronounced than in their presentation. While many had negative experiences at school, further education at TAFE and university was highly valued by all. The two major problems with school were discrimination and low educational outcomes associated with weak literacy and poor teaching. TAFE programs helped to overcome these problems because students were given support and taught to study, and programs incorporated Aboriginal perspectives, particularly Indigenous specific programs. Traineeship programs with clinical components were also appreciated for their hands on pedagogy, provision of basic clinical skills and workplace practice opportunities.

University programs were appreciated differently as a 'higher level of learning' about core social issues that affect Aboriginal health, as well as specialised knowledge that inform Healthworkers' professional roles. Both TAFE and university had an impact on Healthworkers' personal lives, giving them confidence and pride in what they could achieve, but university gave people knowledge and power to 'apply for any job', to 'not be intimidated' by others, and to open their minds to 'a whole new world'.

On the other hand some Healthworkers also expressed reservations about further education. Some had problems with mainstream programs, from a lack of Indigenous perspectives, to discrimination by other students, as well as irrelevance of content. Some reported community concerns that education could marginalise their Indigenous identity, *'trying to turn us all white'*. Others made the point that Indigenous people without degrees could still contribute valuable knowledge, to *'give a different perspective'*. The strongest statement about the relative value of Indigenous knowledge and practice was that a degree is *'only a piece of paper…the white man's paper… and it's not going to change the way I practice'*.

The major stumbling block to a university pathway, reported by some Healthworkers, was academic literacy. The most significant problems with academic literacy were

experienced by Healthworkers who had the least school education and had only effectively studied to a Certificate III level, as discussed above. Another Healthworker who experienced difficulty had studied a mainstream degree through a TAFE/university articulation. When she arrived at university in her last year she struggled with academic literacy.

In sum, differences in the ways Healthworkers presented and evaluated their education appear to be associated with the different types of education programs, qualifications and the subjects they studied. One group had effectively studied only at Certificate III level and tended to simply list and recount the content of their courses. The second group had studied at Certificate IV or degree level and had multiple qualifications, and identified, exemplified and argued for the content of their education. The third group had a university degree or a mainstream Certificate IV, and identified, exemplified, reflected and systematically related their education to their work roles. University study was valued as an ideal goal by all the Healthworkers. The pathway from a TAFE Certificate IV or Diploma qualification to university was identified by many as effective preparation for the challenges of university study. However, it was argued that vocational programs should be relevant to the needs and experiences of Aboriginal people and the roles of Healthworkers; they should provide adequate support to develop academic skills, particularly literacy; and they should include adequate in class teaching and professional practice. Traineeships were identified as an ideal mode to meet these criteria and were highly valued by Healthworkers who had undertaken them. Distance education without adequate support, and prior skills recognition without rigor, would appear to provide ineffective preparation.

6.2 Roles and scope of practice

Healthworkers' discussion of their professional roles were in terms of the types of health services in which they worked and their formal job titles, whereas their discussion of their practice was in terms of specific program types and the corresponding activities performed.

6.2.1 Role diversity and scope of practice

Participant's descriptions of their roles and practice identified noticeable variations in relation to:

- Organisational health service types
- Healthworker position titles
- Healthcare programs and activities

These three categories constitute a framework for considering the diversity of Healthworkers' roles and their scope of practice.

6.2.2 Service types and Healthworkers' position titles

At the level of organisation, Healthworkers were employed in three types of health service. These included a large regional community controlled Aboriginal Medical Service, four mainstream community health organisations, and two hospitals. However at the level of position title, each of the nine participants had a different designation, indicating an extraordinary level of diversity. Service types and participants' position titles are listed below in Table 3.

Table 3: Health service types and Aboriginal Healthworkers position titles

AHW	Service Type	Position Title
PN	Aboriginal Medical Service	Aboriginal Health Worker/Enhanced Primary Health Care Worker
CO	Aboriginal Medical Service	Health Services Team Manager
DB	mainstream community health	Aboriginal Health Education Officer (Chronic Care)
JK	mainstream community health	Health Service Manager Aboriginal Otitis Media Strategy
WH	mainstream community health	Aboriginal Otitis Media/ Steps Project Officer
RH	mainstream community health	Aboriginal Health Worker (Mental Health)
CB	mainstream community health	Health Promotion Officer
LT	mainstream community health/ regional hospital	Aboriginal Health Education Officer
SW	regional hospital	Aboriginal Hospital Liaison Officer

6.2.3 Programs and activities

At the level of practice, a range of healthcare programs and activities were described by Healthworkers. As introduced in Chapter 3, programs and activities were classified according to three categories: i) clinical, ii) community care or iii) program management. Healthworkers in clinical programs performed activities commonly associated with nursing, such as measuring blood pressures, blood glucose levels, reviewing medications and audiometry. This category included WH, PN and DB. Healthworkers in community care programs performed social work type activities such as counselling and supporting clients to manage issues such as grief and loss, family violence, housing and financial issues. This category included LT, RH and SW. Healthworkers in program management predominantly focused on activities such as program planning and evaluation, budget management and staff development. This category included CB, CO and JK.

Despite the classification of Healthworkers' roles as clinical, community care or program management, the interviews revealed considerable overlap with respect to their practice and the health care activities they performed. For example those in clinical roles also performed non-clinical activities such as community support, advocacy, liaison, home visits and referrals while Healthworkers in community care also either performed basic clinical activities such as mental or nutritional health assessments or required knowledge of such activities to be able to provide information about them to their clients. On the other hand, Healthworkers in program management performed a combination of clinical, administrative, educational, managerial and supervisory activities, including coordinating school screening & outreach clinics, Healthworker training, program management & evaluation, program budget management and clinical service planning. The range of programs and activities across these role categories and scopes of practice is consistent with both comprehensive primary health care (PHC) and an holistic concept of Aboriginal health and healthcare delivery. The PHC approach as described in Chapter 2, encompasses the provision of a range of clinical and non-clinical healthcare services for treating and managing illness, preventing disease and promoting health. According to NACCHO (2007, p. 6), an holistic concept of Aboriginal health which is closely aligned with PHC, incorporates the consideration of 'body, mind, spirit, land, environment, custom and socio-economic status'and therefore

includes healthcare programs and activities that address these. Program and activity types in the clinical, community-care and program management categories are exemplified for each Healthworker in Table 4 below.

Table 4: Healthworkers' titles, program and activity types

HW title	Program type/role	Activity types
	Clinical	
WH: OM/Steps Project Officer	ear & eye screening	paediatric audiometry, tympanometry & eye screening, school liaison, follow-up, referrals
PN:AHW/Enhanced PHC Worker	primary health care	clinical procedures e.g.: BP, BSL, urinalysis, venepuncture, community support, advocacy, liaison, home visits, referrals
DB: AHEO (Chronic Care)	primary health care	clinical procedures e.g.: BP, BSL, urinalysis, community support, advocacy, liaison, home visits, referrals
	Community Care	
RH: AHW (Mental Health)	mental health rehabilitation	case management, mental health assessment & support, service liaison, advocacy & referrals
LT: AHEO	hospital and community liaison	community support, advocacy & liaison, home visits, health education, counselling
SW: AHLO	hospital liaison	advocacy, liaison, family support & counselling, funeral attendance, case management, referrals
	Program Management	
CO: Health Services Team Manager	health services	staff coordination, planning, meeting participation, networking e.g.: NSW leader Quality Assurance for Aboriginal Medical Services
CB: Health Promotions Officer	health promotion & education	primary school and pre school health education, agency networking, coordination of health promotion groups & training
JK: Health Service Manager Aboriginal Otitis Media Strategy	ear & eye screening	coordinate school screening & outreach clinics, coordinate AHW training, program management & evaluation, program budget management, clinical service planning

Participants also identified professional colleagues and client groups in their programs. Professional colleagues included people in generalist and specialist positions in health, education and community services. Client groups were broadly categorised as Aboriginal community members. However some specific groups such as kindergarten and primary aged schoolchildren, people with specific health needs and non-Aboriginal people were also identified. Participants, colleagues and clients are listed below in Table 5.

Table 5: Professional healthcare colleagues and clients

AHW	Professional colleagues	Clients
	Clinical	
WH	AHWs, teachers, audiometrist, nurses, doctors, ENT specialists	Aboriginal & non-Aboriginal children & parents
PN	AHWs, nurses, doctors, podiatrist, medical specialists	all Aboriginal community members
DB	AHWs, nurses, doctors, podiatrists, medical specialists	all Aboriginal community members
	Community Care	
RH	nurses, doctors, police, psychiatrists, psychologists, agency officials e.g.: Centrelink, Dept of Housing, Corrective Services	Aboriginal community members with mental health issues
LT	nurses, doctors, psychologists, medical specialists, agency officials e.g.: Centrelink, Dept of Housing	Aboriginal & non- Aboriginal community members
SW	nurses, social workers, doctors, agency officials e.g.: St Vincent de Paul, Centrelink, Dept of Housing, Corrective Services	Aboriginal hospital in-patients & their families
	Program Management	
CO	AHWs, nurses, social workers, GPs, medical students, health service administrators	all Aboriginal community members
CB	volunteers, dieticians, nutritionists, nurses, social workers, teachers	Aboriginal & non-Aboriginal community members
JK	AHWs , GPs, ENT specialists, Education and Hearing support teachers, nurses, audiometrists	Aboriginal & non-Aboriginal children & parents

In sum, interviews showed there was considerable variability in Healthworkers' roles and scopes of practice, the types of health services where they were employed and the range of healthcare programs and activities they performed. Interviews also showed that

all Healthworkers roles and practice were underpinned by Aboriginal concepts of health, a comprehensive primary health care approach and their Aboriginal identity. This combination of factors suggests that Healthworkers' roles are unique. These findings confirm research that describes the comprehensive nature of Healthworkers' roles and practice in wide ranging contexts dealing with a multitude of healthcare and related issues in multiple organisational settings (see Chapter 2). They also confirm reports that Healthworkers' roles are difficult to define and that there is confusion about their varying scopes of practice and the elements of this practice that make their roles distinctive (Curtin Indigenous Research Centre 2000, Health Workforce Australia Final Report 2011).

6.3 How Healthworkers talked about their practice

In regards to how Healthworkers talked about their practice findings showed there were differences in the patterns of presentation and evaluation in Healthworkers' clinical, community care and program management roles.

6.3.1 Presentation: in clinical roles

In terms of the presentation of clinical roles, clinical practice was the focus for DB, PN, WH. While their roles varied, their scope of practice was comparable in terms of multiple clinically related activities performed in settings such as health clinics, schools and client's homes. Examples of activities are summarised as follows.

WH paediatric audiometry, tympanometry & eye screening, school liaison, follow-up, referrals

PN clinical procedures e.g.: BP, BSL, urinalysis, venepuncture, community support, advocacy, liaison, home visits, referrals

DB clinical procedures e.g.: BP, BSL, urinalysis, community support, advocacy, liaison, home visits, referrals

Interview analyses showed common patterns in the way these Healthworkers presented their practice, as lists and recounts of the activities they performed. An example is PN, who presented her practice as lists of clinical activities, the days and places she performed them, and the clients and colleagues she worked with, for example:

> *Three days of it is I look after our diabetic and chronic disease clients. Two days of those I'm out in the field seeing up to five or more people. We run through their health checks, GP management plans, diabetes plans, and then come back chase up my referrals for all those… Thursday and Fridays I am an Aboriginal Health Worker in the clinic, needed down in the clinic, any general observations, bloods, hearing tests, wounds, fixing up appointments.*

On the other hand, the ways in which each Healthworker presented their practice differed in the degree of specialisation. One difference was in the terms they used. WH used mainly everyday terms to identify people, her work schedule and the towns she visited; PN used general terms such as *'bloods, hearing tests, wounds and fixing up appointments'*; DB used more specialised terms such as *'exercise programs, follow-up home visits, blood pressures, blood sugar checks'*. A second difference was in the way that activities were discussed. WH recounted activities very generally, such as *'I go around and do the kiddies ears [and] we go around and do the kiddies eyes'*; PN listed and recounted activities she undertook on different days of the week, including clinics on some days and home visits on others; DB listed five activities in her role in diabetes care, and introduced four clinics delivered to different factions in the community, each fortnight.

These participants also differed in the level of autonomy they described in their work. WH worked with an audiologist and specifically says that she could not do her job without her. PN conducted home visits with a doctor who did the clinical examinations while she recorded the results. DB worked with another Healthworker with whom she enjoyed a relatively high level of autonomy, referring to him as her 'partner in crime'.

Healthworkers whose presentation of their clinical roles mainly comprised recounts and lists of clinical activities, clients, schedules and settings is consistent with clinical practice which is likely to entail procedures that are expected to comply with specified standards of practice. However, differences in the lexical choices that was apparent between Healthworkers in this group may reflect differences in the extent of their experience and level and type of education. For example, WH's use of very general recounts and mainly everyday terms appears congruent with the limited clinical

experience she has in her new role and her as yet incomplete Healthworker training. This was in contrast to DB who used more specialised terms to specify and list clinical activities and who had extensive clinical experience and a university degree. Similarly, the variation in autonomy that each Healthworker enjoyed in their workplace was also seemingly consistent with their professional experience and education. For example, WH being least autonomous, also had the least experience and education, whereas DB had a high level of autonomy, extensive healthcare experience and a university qualification, while PN fell somewhere in-between the two.

6.3.2 Presentation: in community care

Healthworkers in roles with a community care focus were RH, LT and SW. Although this group's roles and scope of practice varied they included very similar activity types across institutional and community settings. Examples of activities are summarised as follows.

LT advocacy, liaison, community support, counselling, home visits, health education, referrals
RH advocacy, liaison, support, mental health assessment, case management, referrals
SW advocacy, liaison, family support, counselling, funeral attendance, case management, referrals

These activities can be grouped within institutional and community settings. In institutional settings such as hospitals and health centres, community care activities may include conducting groups, assessing client's social and emotional needs, supporting hospital inpatients, advocacy, and liaising with other agencies. In less formal community settings such as client's homes, parks or other outdoor locations, activities may include community outreach, follow-up home visits, and attending funerals.

In contrast to the clinical practitioners discussed above, this group of participants do not recount proceduralised activities, but generalise about the types of services they provide, their roles as Healthworkers, and the issues that affect their clients, and they give examples that illustrate these generalisations. Where they do recount activities, they group them in named phases such as assessing clients, and ascertaining and meeting their needs. Furthermore they reflect on and evaluate their roles and people they work with, and build arguments for their points of view.

Examples of generalising about services and roles include RH '*trying to get Indigenous people in contact with health services'* and doing *'a lot of outreach work'*. LT listed her activities as *'provide information, support, advocacy'*, and SW listed three key functions to *'advocate for Aboriginal patients…follow up, and…liaise between the doctors and nursing staff'*. With respect to issues that affected clients, RH discussed her clients' mental health problems and evaluated their severity. LT discussed social issues, as *'a multitude of things'* that impact on Aboriginal health, and SW also listed social issues that affect Aboriginal clients, such as *'domestic violence, child protection, grief and loss issues'*.

With respect to recounting phases of activity, RH described her outreach work as *'meet the people in the community… ascertain what their needs were, and then go set about getting those needs met'*. LT recounted phases of a community consultation as *'recognising what is it that they need… getting a program together… and then implementing it'*. SW recounted her hospital role *as 'support them whilst they're in hospital…follow up with them whilst they're there, when they go home and…liaise between the doctors and nursing staff'*.

Examples of reflections on their practice include RH reflecting on her role as ensuring the needs of her Aboriginal clients are met *'in an appropriate manner'*. LT reflected on the tension between her employer's perception of her role and the community's perception, which she called her *'real role'*. In addition, she saw the complexity of her role as reflecting the complexity of Aboriginal health issues. SW reflected on the conflict between the complexity of her role and her qualifications, and the low status it is assigned by the non-Aboriginal staff in the hospital. All three Healthworkers in this group were critical of the attitudes of some of their non-Aboriginal colleagues, but SW also mounted a well-supported argument for her judgment.

Some marked differences between these community care Healthworkers emerges in the topics they focused on. RH focused on her clients and responses to their mental health needs. She empathised with her clients and the challenges they faced, and she judged different healthcare staff and their level of understanding of Aboriginal health issues.

Her perspective was thus relatively personal and concrete. LT focused on the scope and complexity of role. She was able to interpret it in relation to theoretical concepts such as individual or population based health education. On the other hand, she was often uncertain as she reflected on and clarified her role while describing it, as this appeared to be the first time she had an explicit opportunity to do so. SW was particularly concerned with the inequity of the status of her role in the hospital hierarchy. Another difference was in the level of autonomy, which was also determined in part by the institutional setting in which the Healthworker practiced. RH worked with a wide range of professionals across a variety of community health, hospital and welfare settings and had a high level of autonomy. LT, who also worked across hospital and community settings, had a similarly high level of autonomy, whereas SW's role was mainly confined to the hospital setting and her autonomy limited by requirements to report to the social work team.

In sum, Healthworkers in community care roles tended to generalise, reflect on and evaluate their roles and practice while focusing less on recounting or listing activities. This type of presentation may be more consistent with the broad-spectrum nature of their practice which commonly involved providing various kinds of social, emotional and personal support. From their accounts it was apparent that LT, RH and SW's community care roles and practice were complex, messy and often required them to be closely engaged in the personal lives of clients. Unlike clinical practice, the complexity and personal engagement associated with Healthworkers' community care practice cannot be presented as procedures or lists. Rather it is perhaps more likely to require Healthworkers to evaluate and reflect on their roles, clients and the people they work with.

6.3.3 Presentation: in program management

Healthworkers in program management roles were JK, CO and CB. Findings show their roles and scope of practice varied across different organisations and programs yet they performed comparable management activities. JK and CB were both employed in mainstream rural community health services, whereas CO worked in a large regional Aboriginal Medical Service. Their activities included:

JK school screening & outreach clinic coordination, AHW training coordination, program management & evaluation, program budget management, clinical service planning

CB primary and pre school health education, agency networking, health promotion coordination groups & training

CO staff coordination, planning, meeting participation, networking e.g.: NSW leader Quality Assurance for Aboriginal Medical Services

Although their roles had different foci, on disease screening, population health, and service management respectively, one similarity between these Healthworkers was the generic management activities they performed. These included 'delivering programs, coordinating, planning, networking, training and capacity building'. On the other hand a particular difference between them was the complexity of their roles. JK and CB both had responsibility for performing and organising multiple activities, including administrative, clinical, educational and primary health care activities. In contrast, CO's role primarily focused on administrative tasks.

There were noticeable similarities between CB and JK's presentation of their roles and practice. These included a general overview of their roles, classification of components of practice, which were also exemplified, and the use of reflection and explanations. JK presented a general overview of her 'coordination and strategic roles', and classified three practice components, as 'monitoring the budget, managing people and administration'. She exemplified 'monitoring the budget' as 'staying under budget…making sure appropriate people are getting paid…and looking for more enhancement funding'. She thus built a comprehensive picture of her practice and reflected on its complexity. CB presented a general overview of his program management role in health promotion and classified three of its components as 'population based, focused on prevention and capacity building'. He exemplified two health promotion programs, including the volunteer network and tobacco control/smoking cessation training. In addition, he reflected on his experiences, including a previous clinical role related to his training, which was 'still useful'. He presented his practice as wide-ranging and inclusive, to manage programs that could address 'all the underlying factors' that impact on Aboriginal peoples' health.

In contrast to CB and JK, CO presented his management role in an Aboriginal Medical Service primarily as a series of lists. These included a short list of generic program management activities such as 'monitoring or coordinating or managing', as well as more specific lists of health service teams, staff, management activities, organisational hierarchy, health issues and various types of clinics.

In sum, two Healthworkers including CB and JK presented their program management roles and practice by providing a general overview, classifying and exemplifying the activities they perform, and by reflecting on and explaining their experiences. These presentations appear to reflect both Healthworkers clear understanding of the complexity and breadth of their roles and practice. This may be associated with their extended health care experience across a number of roles and also their broad vocational and university education. On the other hand, CO mainly presented his program management role and practice as a series of lists. This may be the legacy of his previous long-standing clinical role which is perhaps more consistent with the use of lists for presenting clinical activities many of which are procedural. However, his use of lists to present his practice might also be associated with his Certificate III level vocational qualification. Furthermore as CO was new to his program management position he may have been relying on the use of lists as a way of organising and familiarising himself with the individual components of his role and practice.

6.3.4 Presentation: as lexical choices

Differences between clinical, community care and program management roles were also apparent in the lexical choices Healthworkers used to describe them. Table 1 in Chapter 3 showed that each group used different proportions of everyday, specialised, technical and institutional terms to describe their practice. These proportions are summarised as percentages in Table 6 below.

Table 6: Proportions of lexis by role

Role type	Lexis proportions			
	everyday	**specialised**	**technical**	**institutional**
clinical	43	17	7	18
community care	39	13	3	26
program management	26	17	4	33

Participants in clinical roles used a relatively high proportion of everyday terms, but fewer institutional terms, whereas those in management roles used the highest proportion of institutional terms, but the least everyday terms. Community care practitioners were midway between these groups in their use of everyday and institutional terms. On the other hand, those in clinical or management roles used similar proportions of specialised terms, but clinical practitioners used the highest proportion of technical terms.

These proportions are related to work roles and education. For example, clinicians are likely to use technical terms for their clinical activities and equipment, whereas program managers and community care practitioners are more likely to use institutional terms for abstract categories. Examples of these terms include *coordination, strategic roles, monitoring the budget, administration* for management, and *outreach, information, support, advocacy* for community care. These types of abstractions are commonly associated with tertiary education, whereas technical terms tend to be associated with vocational training. The higher proportions of everyday terms used by clinical and community care practitioners reflect their roles working directly with community members, whereas program managers are more likely to interact with their staff and other administrators.

A comparison of lexical types across Healthworker interview extracts with brief contextual notes shows the differences between individual Healthworkers in Table 7 below.

Table 7: Comparisons of lexical types across Healthworkers' interviews

AHW	Lexical type as %						Context
	Every day	spec	tech	Inst:work	Inst:ed	Other abstract	Healthworkers' strength of community connection, health service type, roles, education
WH	48	14	7	18	11	2	Strong community focus, mainstream community health, new to role, specialist health promotion role, Cert IV ATSIPHC, incomplete Aboriginal specific health degree
PN	42	21	8	17	11	1	Strong community focus, AMS, experienced, clinical/PHC role, Cert III AIN, Cert III ATSIPHC, incomplete nursing degree
DB	39	16	7	20	13	5	Strong community focus, mainstream community health, experienced, chronic care role, Cert III EN, completed Aboriginal specific health degree
LT	38	12	5	21	10	14	Strong community focus, mainstream community health, limited experience, generalist role, Diploma CS&H, incomplete accounting degree
RH	42	9	2	30	9	7	Strong community focus, mainstream community health, experienced, specialist mental health role, Cert IV CS&H, completed Aboriginal specific health degree
SW	36	18	2	26	14	4	Strong community focus, hospital, experienced, generalist role, Cert IV & Diploma CS&H, completed Social Work degree
CB	27	21	1	31	16	4	Strong community focus, mainstream population health, moderate experience, specialist health promotion role, Cert IV Business Admin, Cert IV ATSIPHC
CO	23	20	5	30	15	7	Strong community focus, AMS, moderate experience, PHC coordinator role, Cert III ATSIPHC, incomplete mainstream health degree
JK	26	11	5	36	19	3	Strong community focus, mainstream community health, experienced, specialist coordinator role, Cert IV CS&H, completed Aboriginal specific health degree, completed Masters level Aboriginal specific HP degree

6.3.5 Evaluation: in clinical roles

The three Healthworkers in clinical roles all expressed some evaluation of their practice, although it was relatively limited and often only in response to interview prompts. WH expressed considerable doubt about her capacity and underplayed her role as performing 'just basic' eye tests. On the other hand, she expressed strong positive feelings about her work, and expected to get better at it, *'I love it and I'd love to, you know, be more, a lot*

more knowledgeable about it, and yeah, I can see in a couple of years time that I'll be really good at what I'm doing'. PN expressed a pragmatic view of her professional capacity, recounting the clinical tasks in her role with relatively little evaluation, but *'making sure'* that various tasks were done correctly. However she was happy that her clients *'love us coming out'* to visit them in their homes. DB's evaluation was considered, pragmatic and positive as she described her expanding role. She and her colleagues were optimistic that their program was *'slowly kicking off'*, but as they *'never have high expectations'* they *'don't get disappointed'*. Rather she looks for constructive strategies to avoid getting *'caught up in the politics'* and provide a service to *'all the different factions in the community'*.

6.3.6 Evaluation: in community care

The community care practitioners expressed more evaluation of their roles and practice than the clinical group. They all saw their roles as highly complex, but positively evaluated their capacity to perform them, expressed empathy for their clients, and sometimes criticized their non-Aboriginal employers. RH described her complex role in mental health, collaborating with other health services, participating in outreach work, and dealing with her client's acute mental health illnesses. Her capacity to perform these activities was implicit in this description of their complexity. She also expressed strong empathy for her clients as *'my guys'*, and praised some of the doctors she worked with. LT's role as an Aboriginal Health Education Officer was also highly complex. It was *'mostly to provide information, support, advocacy… education, housing issues'*. These activities involved *'a lot of talking'* and *'working out what it is that they need'*. Like RH, her judgment of her capacity is primarily implicit in the description of her activities, but is made explicit in terms of the community's expectation that *'their Healthworker should know a bit about everything'*. She criticized her employer's simplistic view of her role, in contrast with her community's expectation that she spend *'a lot of time'* on the '*multitude of things [that] impact on their health'*. SW's Aboriginal Liaison Officer role involved a wide range of activities on behalf of her clients. She strongly evaluated her capacity by describing these numerous activities, such as interpreting for doctors who used *'huge, great big medical terminology'* with clients who were *'not educated and come from smaller communities'*. She criticized the social work team for devaluing her role as *'merely a support role…behind the social*

workers', judging their attitudes as *'degrading for me as the Aboriginal Liaison Officer and degrading for my clients'*.

6.3.7 Evaluation: in program management

The program management group were not dissimilar to the community care Healthworkers in terms of a comparable level of evaluation. They viewed their roles as complex and positively evaluated their capacity to perform them, although perhaps more modestly. CO valued his role as a team leader who respected his colleagues and community, along with his own capacities. He praised doctors and nurses as the *'main ones always looking'* at health checks, and Aboriginal Health Workers, including himself as *'actually the ones on the ground'*, who also controlled *'what we want'* in this Aboriginal Medical Service. However, CO did not boast but expressed humility in his own capacities. CB described a highly complex range of activities he undertook as a health promotion officer in population health. His evaluation of his capacities was largely implicit in the description of these activities, but became more explicit in his discussion of his role. He criticised programs that *'didn't really target the Aboriginal population'*, and *'the delivery of services to Aboriginal people which are still lacking'*. But he also made constructive suggestions to address these issues, including *'more focus on the health determinants for Aboriginal people…programs that can make them more comfortable…more of a holistic approach…and health positions that are more social work based'*. JK emphasises the complexity associated with her role which she has been in for 12 months as an *'odd job'* as it includes many and varied tasks. However she also demonstrates some humility and downplays her capacity because her work *'is difficult to talk about' and she is 'still finding my way'* in this role.

6.3.8 Summary: How Healthworkers talked about their practice

With respect to how roles and practice were presented and evaluated, findings showed there were significant differences between Healthworkers in clinical, community care and program management roles. Healthworkers in clinical roles identified their activities as clinical procedures, client support and health education. They presented their practice as lists and recounts of these activities, the days and places that they worked, and the clients and colleagues that they worked with. They offered relatively little evaluation of their practice, often only with prompting. They were generally happy

about their work and their clients, but their evaluation of their own professional capacity ranged from doubt to pragmatic accounts of their work activities, and the service they provided to the community. There were also differences between these Healthworkers in their degree of specialisation and the workplace autonomy they described. One Healthworker primarily recounted activities in everyday terms, another listed and recounted activities using more general health terms, and another listed activities using more specialised terms. The first was most dependent on the specialist's support, the second collaborated with a doctor, and the third had a relatively high level of autonomy.

Four factors may contribute to the clinical group presenting their practice as lists and recounts with little evaluation. Firstly, clinical activities tend to be practical procedures with defined steps, often performed in collaboration with other clinical practitioners such as nurses, doctors and/or allied health workers. Organisational and clinical protocols often list proceduralised activities to guide and standardise such procedures irrespective of the practitioner performing them. Secondly, lists, recounts and procedures can be used to frame clinical roles, particularly when time constraints and program efficiency are priorities, when practice requires the integration of multiple activities or entails working with a range of different practitioners in multiple settings. Thirdly, listing of activities may be associated with vocational competency training, which focuses on 'observable ability', and 'has a particularly strong role in teaching and assessing the basics of procedural skills' (AMA 2010 Position Statement). Finally, Healthworkers' levels and types of education may have been factors contributing to the presentation of their practice as lists and recounts. The Healthworker who simply recounted had been 'RPLed' for a substantial proportion of an ATSIPHC (Practice) Certificate IV. The second had completed a mainstream Certificate III Health Services Assistant course, and ATSPHC Certificate III. The third had completed a mainstream Certificate IV in Enrolled Nursing as well as a Bachelor of Health Science in Indigenous Health.

Healthworkers in community care roles identified activities primarily associated with client support and education in hospital, community health centre, and outreach settings. These Healthworkers presented their practice by generalising about, reflecting on, and evaluating their roles and types of services they delivered. They listed and recounted

their activities, but they organised their recounts in phases of activity, which they also named. Furthermore they discussed and exemplified issues affecting their clients, and presented arguments to support their points of view about their practice. In these respects, their presentation of their practice differed significantly from the lists and recounts presented by Healthworkers in clinical roles. Healthworkers in community care roles also expressed more evaluation than those in clinical roles, without prompting. They expressed empathy for clients, and emphasised the complexity of their roles, particularly in communicating between clients and the health system, but had confidence in their capacity to manage these tasks. They could also be critical of employers and colleagues, particularly for their limited understanding of Aboriginal clients, and lack of respect for the Healthworkers' roles.

This group's presentation and evaluation of their practice may be associated with its multifaceted characteristics such as managing various activities, disparate health needs, professional issues and collaborating with a range of professionals and agencies in diverse settings. To organise and articulate the complexity of this practice, these Healthworkers need to be able to generalise, reflect and argue. These capacities may also help them to delineate activities that are more effectively undertaken by Healthworkers in these roles than by other practitioners, such as advocacy, liaison and interpreting. Such differentiation is particularly important when clients' issues require collaboration with multiple other practitioners and/or agencies. It is also essential for developing education programs to equip Healthworkers with the skills and knowledge they need to deal with the complexity of community care practice.

Healthworkers' presentations of their community care practices may also be related to their level and type of education. One, who had a relatively personal and concrete focus on her clients, was completing an Indigenous specific health degree. Another, who was less certain about her role than the others in the group, clarifying it as she described it, had completed both a mainstream Certificate IV and Indigenous specific health qualification. The third presented her argument as a clearly articulated series of steps, backed by evidence, reflecting the kinds of discursive skills often developed through tertiary study. This Healthworker was in the final year of a mainstream degree at the time of the interview.

Healthworkers in program management roles defined their roles in terms of generic management activities such as program delivery, coordination, planning and training. Like those in community care roles, they also emphasised the complexity of their roles and their capacities to fulfil them. However they also all framed this self-confidence with humility, and often praised their colleagues. They were more likely to be critical of programs that failed to meet community needs, and to offer constructive solutions. However there was a marked difference between these Healthworkers in the presentation of their practice. Two of the Healthworkers presented a general overview of their roles, classifying and exemplifying various components. They also reflected, explained and built a comprehensive picture of the complexity and breadth of their practice. The third Healthworker primarily presented lists of management activities, the organisational hierarchy and health issues.

Two factors contributing to these differences in presentation were the complexity of their roles and their level and type of education. The first two Healthworkers managed and performed a diverse range of administrative, clinical, educational and primary health care activities whereas the scope of practice of the third was more restricted and primarily focused on administrative tasks. The first two managed in mainstream health services, where they were responsible for large-scale Aboriginal health programs. In order to meet the needs of their communities, they had to identify the communities' needs, prioritise issues, develop programs and argue for them on the communities' behalf. This level of organisation and reflection is shown in how they present their practice. On the other hand, the third Healthworker managed one aspect of an Aboriginal community controlled service, where the communities' needs were already well understood, the programs were already established, and primarily required administering.

In regard to their education, the first two Healthworkers had both completed multiple qualifications. One had a Certificate IV in Business Administration and in ATSIPHC (Practice). The other had a Bachelor of Health Science (Aboriginal Health) and a Masters in Health Promotion. In contrast the Healthworker in the Aboriginal community controlled setting had a Certificate III in ATSIPHC completed entirely by distance and had recently commenced part time study in a Bachelor of Health Science.

In summary, the differences between how Healthworkers in clinical, community care and program management positions presented and evaluated their roles and practice, were associated with differences in the nature of their practice and their education. The practice of Healthworkers in clinical roles primarily consisted of relatively proceduralised activities, and their education was effectively at a Certificate III vocational level. These two factors were reflected in their presentation of their practice as lists and recounts of procedures, with comparatively little evaluation.

The practice of Healthwokers in community care roles consisted of multifaceted activities involving diverse interactions with clients and colleagues that required flexible self-direction. Their education included Certificate IV and university study. These factors were reflected in their presentation of their practice as organised recounts in which they exemplified issues and argued to support their points of view. They evaluated their clients and colleagues and the complexity of their roles, and expressed confidence in their own capacities.

The practice of Healthworkers in program management roles consisted of complex administrative, clinical, educational and primary health care activities. Two Healthworkers working in mainstream services had to identify needs, prioritise issues, develop programs and present arguments, and had multiple educational qualifications. These two presented overviews of their practice, classifying, exemplifying, reflecting and explaining. The third working in an Aboriginal community controlled service whose principle responsibility was administering one aspect of the service, only had a Certificate III qualification. This was reflected in his presentation of practice as lists of activities, organisation and issues. However, all these program managers evaluated their practice similarly, emphasising its complexity, praising their colleagues, criticising ineffective programs, and expressing confidence in their capacities, framed with humility. In fact all the Healthworkers expressed humility in relation to their educational achievements, their confidence in their practice, and the contribution they made to their communities. This humility appeared to be a defining characteristic of their identities as Aboriginal Healthworkers.

6.4 Family and community

Healthworkers' discussion of their families and communities was a recurring theme in all their interviews. While information about their education and professional practice tended to be presented in discreet segments, references to their families and communities were dispersed prosodically throughout interviews. This was partly a product of the semi-structured interview format. It was also because I considered this topic required more sensitivity than either of the other two (roles and education) which meant that I did not ask as many probing questions. Rather I introduced the topic for discussion and took my lead from each Healthworker as they opted to reintroduce, elaborate or curtail their discussion as they saw appropriate.

The prosodic pattern made the discourse analytic approach impractical as it would have required the detailed analysis of each Healthworkers' whole interview. A thematic approach was therefore applied to the discussion of family and community. Drawing on all interview extracts, findings revealed there were five themes including:

- Diversity within and between Healthworkers' communities
- Social justice issues in Healthworkers' communities
- The significant roles of families in motivating Healthworkers to become health practitioners
- Important connections between Healthworkers' community membership and professional roles
- Tensions between community and family relationships and Healthworkers' education and work roles
- Racism in education, community and workplaces.

With respect to diversity, Healthworkers' lived in five different communities including two large and two small rural towns in western NSW and one regional city in southern NSW. Many pointed out the diversity and mobility of their communities. The diversity was largely a consequence of historical factors, in particular government policies of segregation, assimilation and resettlement. Under the Aborigines Protection Board (1883) and Aborigines Welfare Board (1940), families and communities were frequently removed from their traditional areas and resettled in larger centres. For

example, SW described the large rural town where she lived as a *'resettlement town'*, comprising Aboriginal families who had been forcibly relocated. Similarly, LT said the small rural community that she had recently moved to was '*a mission and people were dumped there. So there's still a lot of that in-fighting that happens…and not always a sense of community'*. JK, WH and DB were from another large rural town, which had also been impacted by such policies. DB highlighted the consequences for both diversity and mobility, as the community included *'different factions…lots of dysfunctional families…lots of people that float in and out'*. CO also highlighted his community's mobility, as *'they come, they go away, they go on walkabout, so we might not see them for another two or three years'*.

Diversity was also evident in the different geographic locations and populations of Healthworkers' communities. For example RH's community was 400 kms from Sydney and had a population of 1300 of which 23% were Aboriginal people. LT's community also about 400 kms from Sydney had a population of 3,000 of which 14% were Aboriginal people. In contrast PN and CO lived in a large regional city whose populations was approximately 200,000 but the Aboriginal population less than 2%. The remaining five Healthworkers lived in two towns each an estimated population of 39,000 each, of which about 2.5% were Aboriginal people. These differences can have a significant impact on Healthworker roles. For example in smaller more remote communities health infrastructure is commonly limited and socioeconomic conditions poorer. This can place increased pressure on health services and particularly Healthworkers in communities with sizeable Aboriginal populations where equity of access and outcomes are healthcare issues.

Social justice issues that Healthworkers described included the Stolen Generations, variable access to education, unemployment, poverty, family dislocation, and institutional and individual discrimination. These were factors that affected Healthworkers but also motivated them. For example several talked about leaving school early because of pressing family responsibilities or discrimination, and the impact this had on their confidence and educational opportunities. Others described raising children as single parents, of years working in manual jobs and of having to leave their homes to work in new communities. While these experiences clearly had an

indelible effect on those describing them they are not uncommon in Aboriginal communities.

Healthworkers' shared personal and professional experiences of social justice issues appears to be a defining feature of their roles that distinguishes them from other health practitioners, whose experience and understanding of social justice issues is perhaps more likely to have developed through formal study. Their insights may contribute to the strong empathy they express for their clients and can assist non-Aboriginal practitioners to develop a better understanding of issues in Aboriginal communities. For example CB contrasted his own experience with that of his colleagues and explained that *'while they were at university I was struggling … I was an Aboriginal person on a minimum income, so I can sort of enlighten them'*.

Most Healthworkers described how their families motivated them to engage in Aboriginal health and/or in further education. CO cited his grandmother's influence to *'follow in her footsteps'* and become an Aboriginal Health Worker. PN and DB also said that their interest in nursing was motivated by their grandparents. RH said the *'connection to my culture and my father…and [his] very strong convictions and drive'* gave her strength to strive for a better job and an education. CB cited his mother's work in nursing homes and his parents as *'role models for me and are hard workers as well…and I knew without saying they … would be proud of what I was doing'*. Conversely, WH hopes that her work and study in Aboriginal health allows her to be a role model, stating *'I hope … I'm an inspiration to my kids and to their kids. To just say … if you really put your mind to it you can do it'*. The needs of SW's severely disabled daughter led to her interest in health work and subsequent study in this field. Furthermore her mother and university educated sisters were inspirational in offering her support to pursue tertiary education. In contrast, LT told the story of her family's suppression and rediscovery of their Aboriginal identity, as the background to her struggle to establish an identity as an Aboriginal Health Worker and be accepted by the Aboriginal community.

The connections between their community membership and their professional roles was foregrounded by all Healthworkers. Some emphasised the contribution of their work to

their communities. For example, WH felt *'very passionate about making changes for our people…there's not a job there for you if you can't be like that'*. JK said that being a Healthworker *'means a lot because I know that I'm doing something for the benefit of the Aboriginal community and Aboriginal children'*. Others emphasised the value of their community experience to their work. For example, CB asserted that as an Aboriginal person he could *'fill an important part'* in a health service team, and his *'connection to the Aboriginal community… gives a different perspective'*, to ensure his non-Aboriginal colleagues understood the community's needs. Similarly, SW said that Aboriginal people disclosed their problems to her because they trusted her more than the non-Aboriginal Social Workers. DB also said that as a community member with a healthcare role she understood the community and was more *'aware and sensitive to people from all walks of life'*. PN was described as an '*oracle'*, who '*knows everything…that's going on'*, because her community involvement was *'twenty-four seven'*. Others simply emphasised their Aboriginal identity. CO saw himself as a '*real community focused person'* who was valued in his management role by the community who *'kept asking and wanting'* him to be *'back out there in the community'*. RH saw that '*your connection to your land, you know connection to your country, connection to your culture'* gave her a moral stance in her work role. Irrespective of their nature, these connections highlight Healthworkers' strong personal and professional commitment to their fellow community members, their healthcare roles and shared history. In addition, the connections distinguish Healthworkers' roles from those of other health practitioners, and like social justice issues appear to arise from their shared community experiences.

However, some Healthworkers also experienced tension between their community and family relationships and their education and work roles. For example, LT recounted the conflict she experienced when some Aboriginal community members questioned her Aboriginality and whether she was entitled to work as an Aboriginal Liaison Officer. DB discussed the conflict between community factions, which she avoided by not '*getting caught up in the politics'*. RH was concerned about community fears that university education might 'turn us all white', that *'we're going to go back to our communities and say "you have to do it like this"'*. CO was also concerned that university education *'took me away from my family'*.

Racism in education, community and workplaces was the final key theme identified in the majority of Healthworker interviews. In education, RH and LT both experienced racism as children in school, and PN as an adult at university in a mainstream nursing course. In the community, WH recounted an incident of racism when non-Aboriginal community members told her that as an Aboriginal person she should *'go and get proof because you get a lot of money out of that'*. DB had not personally experienced racism but had *'seen it'* in the community and believed that *'racism will never go away'*. In contrast, LT had struggled with racial stereotyping by some Aboriginal community members and non-Aboriginal family members who did not acknowledge her Aboriginal identity. In the workplace, SW had experienced racism and said that *'I sometimes feel like the token black fella, the little lap dog that's going to run around after everyone else and going to pick up the pieces and I'm sure there's a lot of other Aboriginal Health Workers out there that feel the same'*. Disappointingly, these reports suggest that racism is a familiar experience that negatively impacts on both Healthworkers' education and professional recognition.

How Healthworkers talked about their families and communities

Each of the themes identified above is interpreted here in the context of their association with Healthworkers' personal and professional identities, roles, and education.

In terms of personal and professional identities, Healthworkers appear to derive their Aboriginal identity in the first instance from the families they belong to. Aboriginal communities consist of relationships between these families and their members. Consequently Healthworkers' memberships of Aboriginal communities derived initially from their family relationships. Secondly, their identity was shaped by the experiences and relationships they shared with other community members, and thirdly by relationships between the Aboriginal community and the wider society.

As Healthworkers' key role was to provide a service to the Aboriginal community of which they were members, their professional identities as Healthworkers appeared to be shaped by their personal identities as Aboriginal community members. This is in contrast to most other health practitioners, whose professional identities appear primarily framed by their educational preparation, professional discipline and the

institutions where they work, and not necessarily their personal connections to the community they serve.

All Healthworkers emphasised that their families and community membership had given them both motivation and the capacity to pursue their health careers, and their education. Some identified their parents, grandparents or siblings as role models, either as health practitioners or simply for their determination and drive. Others described how their own children had been their motivation, to be *'an inspiration to my kids and to their kids'*. Another motivation was the desire to contribute to their communities, *'making changes for our people'*, or '*doing something for the benefit if the Aboriginal community*'.

Several reported their community membership and experience had given them the professional capacity to be effective Healthworkers. On the one hand their connection to the community had given them knowledge, awareness, empathy and sensitivity to the needs of Aboriginal clients and the ability to communicate with them. On the other hand their shared experience of social justice issues in their communities had given them an understanding of the effects of these issues on Aboriginal health and how to manage them. Along with issues such as poverty, family dislocation and limited education, racism was experienced by Healthworkers in their education, professional practice and communities. Healthworkers' community knowledge also gave them an advantage in managing the diversity of the communities they serve. They reported dealing with issues such as the politics of community factions, in-fighting between families, mobility of families and individuals, and particular families identified as '*dysfunctional'*.

These issues are distinguishing features of Healthworker practice. Not only do they share these experiences with their communities, they must deal with them as professionals in their practice. These are experiences and issues that other health practitioners may only learn about through education, if at all. As such Healthworkers are better placed than other practitioners to support community members whose experiences they share.

Conversely, Healthworkers' family and community membership sometimes created tensions in their professional and personal lives. Two had experienced hostility in the communities they were serving, as they were new to the community. One had to prove her Aboriginal identity before being accepted by the community, while another felt the community had *'chopped me up in little pieces and spat me out'*.

Another tension was between Healthworkers' families and community and their education. Some community members feared that education might *'turn us all white'*, while at least one Healthworker found that university study interfered with family relationships. On the other hand all Healthworkers valued the impact that education had on their personal and professional identities. What they learnt about Aboriginal history, culture and politics helped them to see their own and their families' experiences in a wider context, broadening their understandings of the problems they and their families had experienced. Furthermore achieving an education gave them new confidence in their own capacities and determination in their careers.

In summary, Healthworkers connections to their families and communities shaped their personal identities as Aboriginal people, and in turn their professional identities as health practitioners. Their families and communities had motivated them to become Healthworkers and achieve an education. At the same time, the experiences they shared with their communities gave them an insider view of issues such as determinants of Aboriginal health, and a unique perspective about how to manage these issues. Despite the tensions that sometimes arise within and between their personal and professional identities, Healthworkers' Aboriginality remains dominant, takes precedence, guides their practice and distinguishes it in comparison to the practice of other health professionals working in Aboriginal health.

6.5 Summary findings in Healthworkers' interviews

Chapter 6 has presented findings from the analyses of individual Healthworkers' interviews in terms of the three topic areas: firstly education, focusing on what Healthworkers learnt in different types of institutions, courses and qualifications, and how they discussed and evaluated their education; secondly professional roles, including types of health services, programs, and activities that Healthworkers

performed, and how the presented and evaluated their practice; thirdly family and community, including six themes that emerged in the interviews and how Healthworkers presented and evaluated these themes.

With respect to education, Healthworkers identified a broad range of clinical skills, and non-clinical skills and knowledge, including historical and cultural contexts, communication skills, healthcare knowledge, and critical learning skills. However, the more complex healthcare knowledge and critical learning skills were only acquired by Healthworkers who had or were studying relevant university degrees. Most of this group had come to university with preparation for study at a vocational level together with practical experience of the complexity of the Aboriginal health field. This appears to be a common and effective pathway for Healthworkers, and one that may have given them an advantage in managing the complexity of university study.

Differences in how they presented their education were associated with differences in the types of education programs, qualifications and the subjects they studied. Healthworkers who listed and recounted the content of their courses had effectively only studied at Certificate III level. Healthworkers who identified, exemplified and argued for the content of their education had studied at Certificate IV, diploma or degree level and had multiple qualifications. Healthworkers who identified, exemplified, reflected and systematically related their education to their work roles, had or were completing university degrees. This level of education seems essential for managing the complexity of the Aboriginal health field.

However, academic literacy was reported as a major stumbling block to a university pathway, particularly by Healthworkers who had the least school education and had only effectively studied to a Certificate III level. The pathway from a TAFE Certificate IV or Diploma qualification to university, was identified by many as effective preparation for the challenges of university study. It was argued that vocational programs should be relevant to the needs and experiences of Aboriginal people and the roles of Healthworkers; they should provide adequate support to develop academic skills, particularly literacy; and they should include adequate in-class teaching and professional practice. Traineeships were identified as an ideal mode to meet these

criteria and were highly valued by Healthworkers who had undertaken them. Distance education without adequate support, and prior skills recognition without rigor, would appear to provide ineffective preparation.

With respect to roles and practice, findings show there are differences between Healthworkers in clinical, community care and program management roles. Healthworkers in clinical roles identified their activities as clinical procedures, client support and health education, presented as lists and recounts of these activities, with little evaluation. While there were differences between these Healthworkers, they had relatively little workplace autonomy and variable levels of confidence. Factors contributing to this type of presentation include 1) the proceduralised nature of clinical activities, often standardised in organisational and clinical protocols; 2) organisation of clinical roles as lists, recounts and procedures, in order to integrate multiple activities, practitioners and settings; 3) listing of 'observable abilities' in vocational competency training.

Healthworkers in community care roles presented their practice by generalising about, reflecting on, and evaluating their roles and types of programs they delivered, organising their recounts in named phases of activity. They discussed and exemplified issues affecting their clients, and presented arguments to support their points of view about their practice, expressed more evaluation than those in clinical roles, and expressed confidence in their own capacities. Factors in this type of presentation include 1) multifaceted activities and professional interactions, requiring Healthworkers to generalise, reflect and argue; 2) types of education, including an Aboriginal specific health degree, a mainstream Certificate IV and Aboriginal specific health qualification, and a mainstream degree.

Healthworkers in program management roles defined their practice in terms of generic management activities, emphasising the significant level of complexity and their capacity to manage this. They were critical of programs that failed to meet community needs, and to offer constructive solutions. Two of these Healthworkers managed and performed a diverse range of administrative, clinical, educational and primary health care activities. They identified the communities' needs, prioritised issues, developed

programs and argued for them on the communities' behalf. These Healthworkers had both completed multiple qualifications at Certificate IV, degree and masters levels. The complexity of these Healthworkers' practice, and their management of this appears to indicate that their vocational, university education pathway had made a contribution by providing them with a necessary level of skills and knowledge. Furthermore, those with higher education were more confident in their professional capacities, although all the Healthworkers expressed humility about their educational achievements, their practice, and the contribution they made to their communities. This humility appears to be a defining characteristic of Aboriginal Healthworkers' identities.

Six common themes emerging in family and community connections were 1) diversity within and between communities, 2) social justice issues, 3) roles of families in motivating Healthworkers, 3) connections between community membership and professional roles, 4) tensions between community and family, education and work roles, and 5) racism in education, community and workplaces. These themes were interpreted here in the context of Healthworkers' personal and professional identities, roles, and education.

Healthworkers' personal identities as Aboriginal community members derived firstly from their family relationships, secondly from the experiences and relationships they shared with other community members, and thirdly from relationships between the Aboriginal community and the wider society. Their professional identities were thus shaped by their personal identities as members of the Aboriginal communities they served. The central contribution of Healthworkers personal Aboriginal identities to their professional identities appears to be a key factor that makes Healthworker practice unique. This is in contrast to other health practitioners, whose professional identities are primarily framed by their education, profession and institutions.

All Healthworkers emphasised that their motivation and capacity to pursue health careers and education derived from their families and community membership. Their connection to the community had given them knowledge, awareness, empathy and sensitivity to the needs of Aboriginal clients and the ability to communicate with them. The experience of social justice issues they shared with their communities gave them an

understanding of the effects of these issues on Aboriginal health and how to manage them. These family and community connections, along with their education are arguably key factors that contribute to the unique nature of Healthworkers' roles and practice. On the other hand, Healthworkers' family and community membership, along with their education, sometimes created tensions in their professional and personal lives. However all Healthworkers valued the effect education had on their personal and professional identities, broadening their understandings of the problems they and their families had experienced, and giving them confidence in their capacities and determination in their careers.

6.6 Conclusion: How Healthworkers presented and evaluated their education, roles and family and community connections

In conclusion, Healthworkers fell into three groups according to differences in how they presented and evaluated their education and professional roles. The three groups in education included those who primarily listed the content of their study, those who identified, exemplified and argued for certain aspects of Healthworker education, and those who identified, exemplified, reflected and systematically related their education to their work roles. The first group had effectively studied to Certificate III level, the second group had multiple vocational qualifications or Indigenous degrees, and the third group held a university degree or had multiple vocational qualifications, which included a mainstream Certificate IV.

The three groups in professional roles included those in clinical, community care and program management roles. The clinical group primarily listed and recounted activities that were highly proceduralised. The community care group organised the presentation of their more complex practice, exemplified its activities and argued for points of view. The program management group included two Healthworkers in mainstream services who presented overviews of their multifaceted practice, classifying, exemplifying, reflecting and explaining, and one Healthworker in an Aboriginal community controlled service who presented his practice as lists of activities, organisation and issues.

However, despite the patterns of similarity in these groups, there were considerable variations between individual Healthworkers. There was overlap between the groupings

of education and professional roles, and there were differences between Healthworkers in each group. These differences and overlaps are displayed in Table 8.

Table 8: Overlaps in groupings of roles and education

role type		qualifications	presenting education	presenting roles
clinical	PN	Cert III	listed, recounted	listed, recounted
	WH	Cert IV (RPLed)	listed, recounted	listed, recounted
	DB	Cert IV/degree	exemplified, argued	listed, recounted
community care	LT	Cert IV/Diploma	exemplified, argued	exemplified, argued
	RH	Cert IV/degree	reflected, related	exemplified, argued
	SW	Cert IV/degree	reflected, related	exemplified, argued
program management	CB	Cert IV/Cert IV	reflected, related	classified, explained
	JK	Post-grad degree	reflected, related	classified, explained
	CO	Cert III	listed, recounted	listed, recounted

In the clinical group, PN and WH had effectively only studied to Certificate III level (WH had been RPLed for a Cert IV), but DB had an Indigenous specific health degree. Significantly, DB had extensive health work experience and a high level of autonomy in her practice, and was one of the group who presented her education by identifying, exemplifying and arguing. On the other hand, DB listed and recounted her clinical practice, in common with PN and WH.

In the community care group, LT had a Certificate IV in Aboriginal health and was completing a Diploma in community services, whereas RH and SW both had two vocational qualifications, extensive healthwork experience, and were close to completing degrees. Whereas LT presented her education by identifying, exemplifying and arguing, RH and SW were in the group who identified, exemplified, reflected and related education to roles. On the other hand, all three presented their roles by exemplifying and presenting arguments about the different components of their more complex practice.

In the program management group, only JK had completed a post-graduate health degree. CB had a Certificate IV in Aboriginal Health and in Business Administration, which was the only qualification of any Healthworker outside the health and community services field. Both these Healthworkers identified, exemplified, reflected and related

education to roles, and classified and explained their practice. In contrast CO had only completed a Certificate III in Aboriginal Health by distance (but was enrolled in the first year of a degree), and primarily presented his practice as lists and his education as recounts. In this respect, CO was comparable with PN and WH in the clinical practice group, who also used lists and recounts and had effectively studied to Certificate III level. Another commonality between CO, PN and WH was early school leaving in Years 7-8, whereas the other six Healthworkers had left school at either Year 10 or Year 12.

In contrast to the differences shown between Healthworkers in their education and practice, their discussion of family and community shared common themes. All were motivated in one way or another by their families, and shared experiences with their communities that gave them an insider view of Aboriginal health and commitment to serving their communities. All appreciated education for widening their understanding of Aboriginal history, culture and issues affecting health, although university education was seen as providing a higher level of understanding.

These complex interrelations between community experience, education and Healthworker practice have implications for Healthworker education programs, professional role definitions, health service provision and ultimately Aboriginal health outcomes. These implications will be discussed in the concluding chapter.

Chapter 7: Conclusion

7.0 Introduction

The previous chapters presented the findings that emerged from Healthworkers' interviews. Chapter 5 focussed on Healthworkers' individual interview extracts that exemplified each of the three topic areas: their roles and practice, their education, and their families and communities. Findings from these were the information that each individual Healthworker presented about these topics, how they presented it, and how they evaluated it. Chapter 6 then focussed on the patterns that emerged from across the nine interviews and presented findings showing that Healthworkers could be differentiated and grouped along several dimensions. This concluding chapter now draws on Chapters 5 and 6 to discuss the three key findings. These relate firstly to the uniqueness of Aboriginal Healthwork as a professional field, secondly to the diversity and complexity of Healthworkers' roles and scopes of practice, and thirdly to the critical importance of education pathways to Healthworkers' practice.

The chapter briefly reiterates the research questions addressed in the study, and then considers the findings and their implications for policy development in Healthworker practice and education, for future research, and the study's contribution to knowledge in the Healthworker field.

7.1 The research questions reiterated

This study sought to explore, *'What is the relationship between Healthworkers' workplace roles, their education, their families and communities and their discourse and these topics?* This question encapsulated the study's focus on two areas of enquiry and subsets of questions. The two areas of enquiry were 1) the relationships between Healthworkers' workplace roles, their education, their families and communities, and 2) Healthworkers' discourse about these three topics.

In the first area of enquiry, the research asks:

1. *What roles and scopes of practice do Healthworkers perform?*
2. *What types of education and training do Healthworkers undertake and what skills and knowledge do they acquire in order to perform those roles in their scopes of practice?*
3. *What interconnections are there between Healthworkers' families and communities, their roles and the skills and knowledge they bring to their roles?*

Questions in the second area of enquiry asked:

4. *What are Healthworkers' perspectives on their roles, scopes of practice, education, and families and communities?*
5. *How do they evaluate each of these topics?*
6. *How do they present their perspectives and evaluations in their discourse about each of these topics?*

The findings of Aboriginal Healthwork as a unique professional field flow from the first area of enquiry, specifically questions 1 and 3, about Healthworkers' roles and scopes of practice, and their interconnections with their families and communities. The findings of diversity and complexity of Healthworkers' roles and scopes of practice flow from questions 1, 4, 5 and 6, regarding their roles and scopes of practice, and their presentations, perspectives and evaluations of their practice. The findings in relation to education pathways flow from questions 2, 4, 5 and 6 regarding their types of education and training, and their presentations, perspectives and evaluations of their education

7.2 Findings of the study

The following three key findings of the study are a distillation of findings made in the previous chapters. They include three sets of findings: Aboriginal Healthwork as a unique field of practice, diversity and complexity in Healthworker roles and scope of practice, and education pathways for managing diversity and complexity.

7.2.1 Aboriginal Healthwork as a unique field of practice

Aboriginal Healthwork constitutes a unique field of practice that is distinct from the practice of other healthcare practitioners, along two dimensions. Firstly, Healthworkers' roles and practice are intimately connected to their Aboriginal identities, which influence both their perceptions of themselves as professionals and their views of health and wellbeing. Secondly, their practice is informed by Aboriginal concepts of health, which are consistent with the principles of primary health care. Each set of findings refers to, and synthesises, information from analyses and discussion of interview data and literature.

Aboriginal identity

Healthworkers' professional identities are unique amongst health practitioners because they are formed in the first instance by their personal identities as members of the Aboriginal communities with whom they work, as discussed above. The centrality of Aboriginal identity to Healthworkers' roles is recognised in job descriptions and statutory definitions of Healthworkers such as Health Workforce Australia, the Aboriginal and Torres Strait Islander Health Practice Board and the National Aboriginal Community Controlled Health Organisation (NACCHO). The Australian Health Ministers' Advisory Council (2004, p. 6) also states this explicitly in the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004 -2009, that 'culture and identity are central to Aboriginal perceptions of health and ill-health'. Healthworkers, in this study, all foregrounded the importance of their Aboriginal identities over other aspects of their health care practice. The effect of Healthworkers' community membership on their work has two dimensions. Their experience as members of families and communities gives them a unique set of knowledge, skills and values. Conversely, their communities recognise their authority, both as trusted community members and as knowledgeable in the health field.

Firstly, Healthworkers' experience as members of their communities gives them an in-depth knowledge and understanding of their communities' histories, membership, issues and concerns, in other words, of the diversity within and between communities discussed above. On one hand, Healthworkers' knowledge of their communities'

histories, such as the impact of the Stolen Generations on individuals and families, enables them to comprehend and manage these impacts on their clients' social and emotional wellbeing. On the other hand, as members of their communities they are aware of the day-to-day events, issues and concerns in the community. This knowledge is an advantage in managing issues such as community tensions, mobility, health and social problems of families and individuals. As Marjorie Gilmour said in the Aboriginal and Islander Health Worker Journal (2000, p. 9) 'we are part of the community, but as Aboriginals we are community…We see things and we know things are going on in our communities … We should be able to bring that knowledge into our work scenario'. All Healthworkers in this study irrespective of their roles, practice or education highlighted the significance of this experience and understanding to their professional healthcare work. For example, PN was viewed as an *'oracle'* because of her in-depth local knowledge about the daily lives and histories of Aboriginal people in the community. DB also felt that her Aboriginality meant she was *'even more sensitive'* to her community's needs . JK was explicit about the importance of her Aboriginality, stating that it *'helps to understand the community, what the community needs and ...wants'*. CB on the other hand felt that his own experiences as an Aboriginal man he can *'enlighten'* his non-Aboriginal colleagues to improve the care they provide to Aboriginal people. It is this global knowledge of their communities' histories, combined with their specific knowledge of their members, that places Healthworkers in a unique position and qualifies them to support their communities far better than non-Aboriginal health professionals.

Secondly, Healthworkers' community membership gives them distinctive skills in communication, cultural brokerage, interpreting and advocacy. Their skills in communicating with other community members are vital for empathising and responding to others. Healthworkers in this study emphasised the importance of these skills in circumstances where they had to prepare and counsel families at the passing of a terminally ill family member, to resolve community and family tensions, to represent the needs of hospitalised people to medical and other healthcare staff and to support community members through mental health crises. Healthworkers' understanding of both their communities' cultural practices, and the culture of the health system, gives them very specific skills for effective cultural brokerage, which are critical to presenting

Aboriginal perspectives to their non-Aboriginal health care colleagues, and explaining the health system and its concepts to their Aboriginal clients. Their knowledge of both Aboriginal ways of speaking, and the technical language of the health field, gives them skills in interpreting that are equally important for explaining complex medical terminology and health procedures to Aboriginal clients, and interpreting their clients' ways of speaking to non-Aboriginal health professionals. Healthworkers' knowledge of both their communities' and members' needs, and the structures and processes of the health system, gives them unique skills to advocate for their communities, to ensure their needs are understood and met. This is a critically important skill particularly in the context of mainstream health services. The historical and ethnographic literature shows that these skills have always been part of Healthworkers' and Aboriginal women's roles. Contemporary studies surveyed in Chapter 2 document the importance of communication, cultural brokerage, interpreting and advocacy skills in current Healthworker practice (Clapham & Gosden 2001, Curtin Indigenous Research Centre 2001), Health Workforce Australia 2011, McGrath et al 2007).

Thirdly, Healthworkers bring a unique set of values to their professional roles, derived from their families and communities, including a commitment to working for the well being of the community and for social justice. RH saw these values as *'personal attributes, what you're capable of doing, and what your own code of conduct are, and what you think about ethics, what's your moral stance'.* She derived these values directly from her family and community, her *'connection to my culture and my father…and [his]very strong convictions and drive'*. A commitment to community is a central ethic in Aboriginal culture, which Healthworkers also see as central to their work. WH expressed this explicitly as *'very passionate about making changes for our people…there's not a job there for you if you can't be like that'*. Gilmour (2000, p. 9) also emphasises this, 'we as health professionals within the local community have a sense of responsibility that is Aboriginal… to put the stamp of Aboriginality upon our working responsibilities …it is our duty'. While many health professionals have an ethical commitment to the wider community in a general sense, the commitment of Healthworkers is qualitatively different as it is part of their personal cultural identity, which they share with their communities. Healthworkers' commitment to social justice is also qualitatively different, as it derives directly from their personal and communities'

experiences of disadvantage and discrimination. Their experience of social justice includes the Stolen Generations, limited education, unemployment, poverty, family dislocation, and institutional and individual discrimination. CB stated this explicitly as a contrast between his own experience and that of his non-Aboriginal colleagues, *'while they were at university I was struggling… I was an Aboriginal person on a minimum income'*. As discussed in Chapter 6, Healthworkers' social justice commitment is another defining feature of their roles that distinguishes their practice.

Fourthly, Healthworkers are recognised by their communities as trustworthy, approachable and empathetic, as people they could disclose their problems to, and ease their access to the health system. PN's clients saw her as an authority in the community, describing her as an '*oracle [who] knows everything that's going on'*. Moreover, communities recognised that Healthworkers had valuable healthcare skills and knowledge to prevent ill-health, treat illness and promote wellbeing. They relied on Healthworkers for support and for those skills identified above such as advocacy, cultural brokerage and interpreting. In some cases community members preferred to consult with Healthworkers and were reluctant to consult other health practitioners in comparable roles. For example, SW explained that Aboriginal people disclosed their problems to her because they trusted her more than the non-Aboriginal Social Workers. This is also documented in the literature, such as Giblin (1989, p. 361) who reports that Healthworkers share a 'verbal and non-verbal language, an understanding of their communities' health beliefs, barriers to health care services, and an enhanced empathy with, and responsibility toward a communities and its health service needs'.

However, Healthworkers also explained that communities' high expectations of them sometimes created tensions, particularly in blurred boundaries between their personal and professional lives. Demands were often made on them, irrespective of their official work hours. Mitchell & Hussey (2006, p. 530) report that 'the load of community expectation can be very tiring combined with the responsibilities of work and family'. Jackson et al (1999, p. 100) report that Healthworkers are 'answerable to the local people first, then family and also a Western health system'. Nevertheless, Healthworkers generally accepted this situation, as PN put it, it is just part of '*living in a community of Kooris*'. As part of their value system, they prioritise the needs of fellow

community members, and the satisfaction they derive from working for their communities outweighs the disadvantages. Again this dimension of Healthworkers practice distinguishes them from other health practitioners.

Aboriginal concepts of health

The second dimension that makes Healthworkers' practice unique is its foundations in Aboriginal concepts of health and holistic health care. In a review of the literature. Long (2007) argues that these concepts are used frequently but their meaning is assumed and not explicitly defined. In NACCHO's view however Aboriginal concepts of health and holisitc health care are closely aligned with comprehensive primary health care and a view of health that incorporates 'body, mind, spirit, land, environment, custom and socio-economic status' (NACCHO 2007, p.6).

The concepts were articulated by a number Healthworkers in this study. For example, in his program management role, CO said that Healthworkers provide *'culturally safe and holistic approached care'* and use *'the Aboriginal holistic health model'*. CB argued that in the mainstream service where he worked there needed to be '*more focus on the health determinants for Aboriginal people…programs that can make them more comfortable…more of a holistic approach'*. RH however, proposed a medical model of health was necessary but that to improve Aboriginal health it needed to *'incorporate that holistic approach as well, so trying to blend this all in together'*. On the other hand Healthworkers in clinical roles such as DB described the importance of health promotion and prevention and looking *'at clients holistically and I think that's why we are so successful'*.

This view of health, health determinants and health programs appears to derive in part from Healthworkers' and their communities' experiences of disadvantage and discrimination. This view is formalised in the NACCHO (National Aboriginal and Community Controlled Health Organisation 2011, p. 55) definition of health, as 'not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community'. This view of health is consistent with a definition of primary health care, that NACCHO in its Constitution (National Aboriginal and Community Controlled Health Organisation 2011, p. 54), states,

‘provides the sound structure to address all aspects of health care arising from social, emotional and physical factors…In addition to the provision of medical care’. This definition is in keeping with the principles of comprehensive primary health care set out in the Alma Ata Declaration (World Health Organisation 1978), introduced in Chapter 1. It is considered to be a social view of health in that it recognises the impact of social determinants such as poverty, discrimination, housing, unemployment and limited education on the health and wellbeing of individuals and communities. Many of the healthcare and health related activities that address these determinants are underpinned by principles such as equity, empowerment, community participation, self determination, and inter-sectorial collaboration. These principles are also aligned with Healthworkers’ own values and commitment to social justice and working for the wellbeing of their communities, discussed above.

7.2.2 Diversity and complexity in Healthworker roles and scope of practice

The second set of findings is that Healthworkers performed diverse, complex and difficult roles. Four factors contribute to this complexity, including the historical development of their roles, complicated health issues in communities, foundations of Healthworkers’ practice in comprehensive primary health care, and lack of clarity in Healthworkers’ roles. Firstly, the literature review showed that Healthworkers’ roles have developed in an ad hoc fashion, from women’s traditional caring roles, through cultural brokerage in the colonial period, and assistant roles during segregation. Healthworkers now fulfil a bewildering array of roles, as described by both the Healthworkers in this study, and the literature.

Today, a major factor contributing to the complexity of contemporary Healthworker roles is the diversity, complexity and gravity of health issues in Aboriginal communities. Healthworkers encounter complexity in health issues, in co-morbidity and prevalence of health issues, and in the contexts in which they occur. Examples of complex health issues identified and dealt with by Healthworkers in this study included diabetes, cardiovascular disease, otitis media in children, mental health, drug and alcohol dependency. Moreover, the higher prevalence of co-morbidities in Aboriginal communities made Healthworkers’ practice more demanding. Examples that Healthworkers described were diabetes and renal disease, respiratory disease and

smoking, pregnancy and family violence. Many of these illnesses are complex in their own right but the contexts in which they occur make their management even more difficult. In Healthworkers' communities these contexts included poverty, homelessness, high levels of community mobility, family discord and limited access to transport. Other social issues such as the absence of support, or limited access to services, further complicates these issues and makes Healthworkers' practice more difficult. Healthworkers explained, that in mainstream services, these contexts were not always understood by non-Aboriginal practitioners, thus placing clients at risk of further health complications.

A second factor in the complexity of Healthworkers' practice is the scope of comprehensive primary health care activities they perform in all their roles. Healthworkers in this study identified activities generally as health treatment, education, promotion, illness prevention and program/service coordination. Despite the classification of Healthworkers' roles as clinical, community care or program management, the interviews revealed considerable overlaps with respect to their primary health care activities. Clinical roles included activities such eye screening, blood pressure, blood sugar levels, urinalysis and venepuncture, as well as non-clinical activities such as community support, advocacy, liaison, home visits and referrals. Community care Healthworkers performed mainly non-clinical primary health activities, such as support, service liaison, advocacy and referrals, home visits, case management, health education and counselling, but also performed clinical activities such as mental health assessment. Program management Healthworkers performed a combination of clinical, administrative, educational, managerial and supervisory activities, including coordinating school screening & outreach clinics, Healthworker training, program management & evaluation, program budget management and clinical service planning.

The scope of Healthworkers' primary health care activities is also discussed in the literature. The NATSIHWA (National Aboriginal and Torres Strait Islander Health Worker Association 2013) mentions 'clinical and primary health care for individuals, families and community groups…patients, clients and visitors to hospitals and health clinics [and] arranging, coordinating and providing health care'. Curtin Indigenous

Research Centre (2000, p.16) distinguishes 'clinical procedures… counselling, program development and health service management'. Health Workforce Australia (Health Workforce Australia Final Report 2011, p. 11) likewise differentiates 'clinical, complex and acute care roles…roles that focus mainly on health promotion programs and cultural brokerage activities [and] varying roles depending on the employer'. Health Workforce Australia proposed a broad 'conceptual map' to represent a national Healthworker scope of practice (Health Workforce Australia Interim Report 2011, p.78) three domain areas including: i) culturally safe healthcare, ii) primary health care, and iii) areas of specific focus.

A third factor in the complexity of Healthworkers' practice is the diversity of settings and professional teams with whom they work. Healthworkers in this study worked in multiple settings, including clinics, hospitals, homes, schools, community outreach and residential rehabilitation centres. Their practice commonly entailed working with multidisciplinary teams, which included practitioners from varied disciplines. It also involved cross-sectorial collaboration, between government and private service providers in health and non-health sectors. This complexity of settings and professional interactions is also noted in the literature. Mitchell and Hussey (2006, p. 529) describe having to juggle the multiple, social, emotional and medical needs of clients and communities and being 'everything to everyone'. Abbott et al (2008) list a range of Healthworker activities, including clinical care, health education to support clients with chronic diseases, health promotion, leadership, advocacy, and the cultural mentoring of non-Aboriginal health practitioners. Genat (2006, p. 12) describes 'myriad demands and pressures' and multifaceted activities, including 'welfare services, clinical monitoring, making appointments, recording client statistics, counseling, organising social visits, personal care assistance, transport, advocacy, referral, rehabilitation support, paramedical assistance, hospital visits, palliative care, shopping and liaison with other sections of the Aboriginal Health Service and other service providers'.

This complexity in activities, settings and professional interactions is less common for other healthcare practitioner roles, which typically specialise in a defined set of activities, work in a limited range of settings, and interact with a limited set of other

health specialists. It is another feature of Healthworkers' unique roles and scope of practice.

A fourth factor in Healthworkers' complex practice was the lack of clarity in their roles. The absence of explicit formal role definitions and/or job descriptions often resulted in misunderstandings and inadequate recognition for Healthworkers' scopes of practice and blurred community/professional boundaries. As a consequence, Healthworkers in this study reported having to define their roles or justify their skills, knowledge and capacity to perform within their scope of practice, particularly to their non-Aboriginal colleagues. This experience is also reported in the literature. Jackson et al (1999, p. 100) observe that 'many nurses have a lack of knowledge, in terms of understanding the roles and functions of Aboriginal Healthworkers'. Similarly, Mitchell and Hussey (2007, p. 529) report that doctors and nurses are often 'ignorant of the Aboriginal Health Workers' skills and abilities'. Genat (2006, p. 142) suggests that conflict between Healthworkers' broad client centred holistic approach and the narrow medical model underpinning medical and nursing practice results in nurses' and doctors' limited understanding of Healthworker practice.

These consequences of lack of clarity in Healthworkers roles point to the inadequacy of role definitions that fail to take into account the diversity and complexity of Healthworker practice. As long as this complexity is not recognised, Healthworkers will continue to struggle with the power imbalance in their relations with the health system and other practitioners, and their education pathways will remain inadequate to meet the challenges of their practice.

7.2.3 Education pathways for managing diversity and complexity

The third set of findings in this study relates to types of education that Healthworkers need for managing the diversity and complexity of their roles, discussed above, and the pathways they take to acquire this education.

The analyses in Chapter 5, and discussion in Chapter 6, showed a consistent set of relations between Healthworkers' types of education, their roles and scopes of practice,

and the ways in which they presented their education and practice. These relations were summed up in Table 8, reproduced here as Table 8'.

Table 8': Overlaps in groupings of roles and education

role type		qualifications	presenting education	presenting roles
clinical	PN	Cert III	listed, recounted	listed, recounted
	WH	Cert IV (RPLed)	listed, recounted	listed, recounted
	DB	Cert IV/degree	exemplified, argued	listed, recounted
community care	LT	Cert IV/Diploma	exemplified, argued	exemplified, argued
	RH	Cert IV/degree	reflected, related	exemplified, argued
	SW	Cert IV/degree	reflected, related	exemplified, argued
program management	CB	Cert IV/Cert IV	reflected, related	classified, explained
	JK	Post-grad degree	reflected, related	classified, explained
	CO	Cert III	listed, recounted	listed, recounted

These findings can be mapped on a continuum, from lower vocational to higher academic qualifications. At the start of the continuum Healthworkers who effectively had vocational Certificate III level qualifications listed and recounted their education and practice, which mainly comprised proceduralised routine clinical activities, with little evaluation. This group had relatively little workplace autonomy and variable levels of confidence. Two exceptions to this were a Healthworker with a Certificate III, who listed and recounted his education and program management activities, and another with an Aboriginal specific health degree, who listed and recounted her clinical practice yet also exemplified and argued for her education.

Further along the continuum were Healthworkers who had multiple qualifications including at a least a Certificate IV as well as either a diploma or degree. Healthworkers in this group were in community care roles in which they performed an unpredictable and diverse range of activities. They generalised, reflected on, and evaluated their roles and types of programs. They also discussed and exemplified issues affecting their clients, and presented arguments, and expressed confidence in their own capacities. One of the Healthworkers in the group with a diploma, also exemplified and argued for her

education, whereas two others had university degrees and reflected and related their education to their practice.

At the other end of the continuum were Healthworkers who were program managers performing complex roles, including a diverse range of administrative, clinical, educational and primary health care activities. These Healthworkers were more likely to classify and explain their practice and to reflect on and relate their education to their practice. They identified the communities' needs, prioritised issues, developed programs and argued for them on the communities' behalf. They also identified, exemplified and argued for the content of their education. Each had multiple qualifications at Certificate IV, diploma or degree level. Their presentations reflected a level of healthcare knowledge and critical learning skills commensurate with both the complexity of their roles and practice and their communities' health issues.

Clearly, this suggests that university degree level study is an ideal education goal to provide Healthworkers with the skills they need to manage the complexities of Aboriginal health and healthwork. Healthworkers with little more than Certificate III level education tend to be constrained to proceduralised roles, with limited autonomy, and without the discursive resources to generalise, reflect on, and argue for their practice. A higher level of skills, autonomy, and discursive resources are enabled by Certificate IV and Diploma level education, but only where multiple qualifications have been acquired. The highest level of analytical, organisational, critical and discursive skills, as well as power in the health workplace, are provided by an education pathway culminating in university qualifications.

With respect to the educational pathways required to gain these qualifications, the Healthworkers in this study had all forged their own pathways, often from starting points of low school achievement, academic literacy, and self-confidence. The first step for all them was with vocational education.

Vocational education has proved effective for providing access for Healthworkers to further education. The support provided was effective for building academic skills, knowledge and confidence, alongside the flexibility of courses. Dedicated Aboriginal

study centres were also a key element in effective support. Traineeships were particularly effective because they combined face-to-face classes with supervised workplace practice opportunities. The Aboriginal and Torres Strait Islander PHC training packages that include Aboriginal perspectives and that focus on primary health care were also effective. Primary health care was identified by Healthworkers in this study, as a key subject in health courses, that CB explained *'gave us a good idea of having a more holistic approach to health'*.

On the other hand, there are also a set of concerns about some dimensions of vocational education for Healthworkers, particularly with regard to consistency across qualifications. One such issue is that Aboriginal and Torres Strait Islander PHC training packages specify only competency outcomes, without specifying the curriculum content needed to attain these competencies. Thus Healthworkers may graduate with the same qualifications from different courses, having studied different content. Another issue is that primary health care is in the title of all Healthworker training packages, but the outcomes of Certificate III qualifications do not explicitly include comprehensive primary health care units of competence. This shortcoming reflects the finding above, that Certificate III level qualifications do not appear to provide Healthworkers with the skills and knowledge commensurate with the complexity of Aboriginal health and healthwork. Only the ATSIPHC (Practice) Certificate IV (HLT040213) and ATSIPHC (HLT40113) explicitly include comprehensive primary health care units of competence. In general, competency based training may not be ideal for development of the critical learning skills required for managing the complexity of primary health care in Aboriginal communities. This year, there has been an extensive increase in the content of the ATSIPHC Certificate IV qualification, from 13 to 21 units of competence (Community Services and Health Industry Skills Council 2013). This suggests there will be significant inconsistencies between Healthworkers with the old and new Certificate IV qualifications. But it also points to problems with constraining Healthworker qualifications to the vocational level.

The Healthworkers in this study all valued university qualifications as the ideal goal for their education pathways, yet it is not visible in the formal pathways set out in the ATSIPHC qualifications. Those who have progressed to university have done so

through a series of vocational qualifications that provided them with the support to accumulate the academic skills required for university study. Central to these skills is academic literacy, which is critical for coping with the demands of university. Furthermore, for Aboriginal Healthwork to develop as a distinct profession, a university based body of professional knowledge and theory of practice needs to be researched, defined and taught in university contexts. Although an educational pathway from vocational to university appears to be the most effective of all for providing Healthworkers with the skills and knowledge to manage the complexity of their roles, there remains no clear articulation for it.

7.3 Implications of findings

This chapter concludes with three sets of implications that flow from the findings presented above. The first implication of the findings is for professional recognition of Healthworkers' roles and scope of practice. The second is the implications for designing Healthworkers' educational pathways to manage the complexity of their practice. The third is the implications for further research in the field of Healthworker practice and education.

7.3.1 Recognition of Healthworkers' roles and scope of practice

Healthworkers' actual roles and scope of practice, outlined in this study need to be formally recognised in role definitions, job descriptions, and education and registration requirements. Formal recognition of Healthworkers' roles and scope of practice needs to systematically account for both the skills and knowledge they bring with their Aboriginal identities, and the diversity and complexity of their practice.

Role definitions that speak only in general terms such as 'culture and identity' do not do justice to the complex range of skills and knowledge that Healthworkers acquire from their family and community experience, and apply in their practice. Definitions should be based on what Healthworkers actually do in their practice, including the sets of skills, knowledge, values and practices identified in the findings above. These include 1) their knowledge and understanding of their communities' histories, membership, issues and concerns; 2) their skills in communication, cultural brokerage, interpreting

and advocacy; 3) their commitment to working for the well being of the community and for social justice; 4) their communities' recognition of Healthworkers as trustworthy, approachable and empathetic, 5) with the skills and knowledge to prevent ill-health, treat illness and promote wellbeing; and 6) the holistic concepts of health that derive from Aboriginal culture.

Secondly, Healthworkers' role definitions and job descriptions need to account for the diversity and complexity of their practice, outlined above. Currently, neither generalist titles such as Aboriginal Health Education Officer (AHEO), Aboriginal Hospital Liaison Officer (AHLO), nor specialist titles such as Aboriginal Mental Health Worker (AMHW), typically specify the actual scopes of practice that these roles deal with. Role definitions need to factor in 1) the complexity of health issues that Healthworkers contend with, the co-morbidity and prevalence of these health issues, and the contexts in which they occur; 2) the core disciplinary skills and knowledge that distinguish Healthworkers' diverse roles and practice 3) the scope of Healthworkers' comprehensive primary health care activities; 4) the diversity of settings and professional teams in which they work, including their roles in cultural mentoring of non-Aboriginal health practitioners.

Role definitions should also be aligned with Australian Qualification Framework standards, and job descriptions should be aligned with role definitions, scopes of practice, qualifications and titles. A useful starting point is the classification of Healthworkers roles as clinical, community care or program management, proposed in this study, and supported by the literature, such as Health Workforce Australia (2011, p. 11) quoted above. Registration should provide Healthworkers with a range of options in keeping with their different qualifications, to avoid excluding Healthworkers who do not meet minimum Certificate IV education requirements. These actions would clarify Healthworkers' roles and practice provide professional recognition and understanding.

7.3.2 Articulation of education pathways

Managing this complexity requires highly qualified professionals with an extensive range and level of skills and knowledge. The predominance of vocational courses as the preferred education pathway for Healthworkers shows that it satisfies their needs in

terms of access, flexibility, level, support, and skills and knowledge for performing routine roles and proceduralised activities. However vocational education alone appears to be inadequate for broader scopes of practice that require Healthworkers to deal with the complex health care issues discussed above. It is also inadequate for developing the knowledge base and theory of practice required for recognition of Aboriginal Healthwork as a distinct profession.

For these reasons, a formally articulated pathway needs to be developed from vocational to university education. This pathway would extend Healthworkers' opportunities to acquire healthcare knowledge and critical learning skills that will strengthen their roles and practice. It is particularly important that Healthworkers in roles that manage complex health issues are supported and provided with incentives to complete university health qualifications.

The ideal goal would be a specialised Aboriginal Healthwork degree qualification, that embodies the knowledge base outlined above. Such a degree would provide a professional qualification that equips Healthworkers with the skills and knowledge commensurate with the complexity of health issues they deal with in their communities, and that is equivalent to other healthcare practitioners such as nurses. It would distinguish Healthworkers' roles and practice and provide them with professional respect and recognition. It would provide avenues for research into the Aboriginal Healthwork field, building a distinct body of disciplinary knowledge.

In sum, Healthworkers fulfil roles that are unique in terms of their professional identities, their holistic view of health, the complexity of issues they manage, and the complexity of their practice. Healthworkers experience increasing pressure to 'close the gap' in Aboriginal health, yet their roles and practice are still not professionally recognised, understood or adequately supported. Most still do not have access to, or the support they need, to extend their skills and knowledge from the vocational to the university level. If the ongoing injustices in Aboriginal health are to be redressed, then Healthworkers must have access to the power to take control of the field. This handover of control from a medically dominated health care system will only come when it is

recognised, as the Healthworkers in this study have articulated, that *'knowledge is power'*.

7.3.3 Further research

The implications presented above, for recognition of Healthworkers' roles and scopes of practice, and design of educational pathways, demand focused research in both these fields. After three decades of Healthworker practice in community based and mainstream health settings, the extent of research into their practice and education remains limited. Nevertheless, the literature reviewed in Chapter 2 indicates that the issues associated with these topics are at least as multifaceted and complex as for any other health discipline, as this study has also shown. The complexity of these issues is amplified by the dynamic field in which they occur, which is itself in a constant state of flux, and their cross-disciplinary context, involving multiple professional disciplines in health, social sciences, and education.

Avenues for research into Healthworker practice include the knowledge and values they bring from their family and community experience, and the complexity of their health practice. Potential research into Healthworkers' Aboriginal knowledge base includes the scope and content of their knowledge of their communities' histories, membership, issues and concerns; their holistic concepts of health; the nature of their skills in communication, cultural brokerage, interpreting and advocacy; and the values underlying their commitment to their communities, and their communities' recognition and trust in them.

This study has gone some way to articulating these topics, by analysing interviews with just nine Healthworkers. But in addition to the commentary of Healthworkers, this research should also include systematic observation of how this knowledge, skills and values are applied in their health practice. The same research processes of empirical observation, alongside Healthworkers' voices, must be applied to teasing out the complexity of their practice, including the health issues they deal with, the contexts in which they occur, the scope of their primary health care activities, and the diversity of their settings and professional interactions.

The ideal researchers to carry out this work are Healthworkers themselves. But to do so, Healthworkers need the kinds of knowledge, academic skills, and discursive resources that only a university education provides. Experience with other professions, such as nursing, suggests that Aboriginal Healthwork will emerge as a distinct professional discipline, as a critical mass of Healthworkers gains the academic skills and qualifications to carry out the research outlined above, to build a distinct body of disciplinary knowledge. This is another reason why Healthworkers must be supported and provided with incentives to complete university qualifications. Vocational qualifications alone are insufficient for building this knowledge base, as they are for managing the complexity of Aboriginal health. Articulated pathways from vocational to university education are an essential component of this process.

7.4 This study's limitations

This study's investigation of Healthworkers' perspectives on the roles, practice, education and family and community connections has a number of limitations. Firstly, the small number of Healthworkers who were interviewed potentially limits the representativeness of the study and the transferability of the study's findings to other Healthworkers. Secondly, the study's focus on Healthworkers in New South Wales provides a snapshot of Healthworkers' preceptions of their roles, practice, education and family, community connections in the context of this state, but not necessarily in other states or territories. Thirdly, the application of the detailed discourse anlaysis method meant that it was only feasible to analyse selected extracts from Healthworkers' interviews. Moreover these were one off interviews that may not necessarily have provided a absolute representation of each Healthworkers percpetions. Arguably the analysis of whole interviews and/or the use of additional methods such as fieldwork and observation may have provided a richer and more nuanced interpretation and perhaps additional and/or alternative findings. Fourthly, Healthworkers' roles, practice and education are currently in a phase of unprecendent change, which means that the study's findings are limited to this particular point in time. Finally, it is important to acknowledge that although the study aimed to adopt a rigorous and valid research approach that was underpinned by principles of cultural safety, cultural security, and cultural competence it may neverthe less be inadvertently limited by my position as non-Aboriginal woman researcher exploring the perspectives of Aboriginal people.

7.5 This study's contributions to the field of knowledge

I would like to conclude this study by suggesting that it contributes useful new knowledge in two domains: in the analyses that have been applied to the data, and in the information provided by these analyses.

The data for the study was provided primarily by interviews with nine Healthworkers, alongside the review of literature in the field. While the interview methodology is not new, their recontextualisation as biographies, and their analysis using discourse analytic techniques is substantially innovative. Two basic innovations were to analyse the fields of Healthworkers' experience into three topic areas: their roles and scopes of practice, their education, and their family/community connections; and to group Healthworkers into three types of roles: clinical, community care, and program management. These groupings provided foundational structuring for the study.

The purpose of the discourse analyses in Chapter 5 was to provide detailed objective insights into the ways that Healthworkers presented their practice, education and family/community connections, their perspectives on these fields, and their evaluations of them. This was explicitly intended as an alternative to the subjective commentary that typically accompanies interview based studies. In particular, it was intended to bring out patterns of commonality, and subtle differences between Healthworkers, that would form a basis for informed discussion and interpretation.

The analyses drew on the methods of systemic functional linguistic theory, but adapted them to make the presentations intelligible and useful to readers with no experience of linguistics. Rather than a traditional linguistic technique, of taking isolated text fragments as examples of some linguistic principle, entire extracts from the interviews were presented, but organised line-by-line, and grouped into phases of information, so that the reader could both easily read them, and readily see the speaker's patterns of textual organisation. This presentation enabled an informed, comprehensible discussion of each Healthworker's mode of presentation of the three topic areas, which could be related to differences in their roles and education. Secondly, the entire interviews were analysed for the types of lexical items that each Healthworker used to represent their

practice, education, and family/community experience. These analyses revealed proportional differences in Healthworkers' use of everyday, technical and abstract terms that showed differing perspectives on these fields, which could also be related to differences in their workplace roles and education. Thirdly, whole extracts were presented, again line-by-line to make them readable, but analysed for their evaluations of the three topic areas. The innovative technique applied here was to divide the extracts into columns, showing the attitudes speakers expressed, the targets of these attitudes, and the engagement resources they used, such as identifying who expressed an attitude, or conjunctions that expected or countered expectations. Again this presentation made the analyses readable, but clearly displayed significant patterns of evaluation.

The recontextualisation of the interviews as Healthworkers' biographies in Chapter 4 provided a crucial context and counterbalance for the analyses of their discourse. Rather than a set of informants responding to researcher's questions, the biographies gave each Healthworker an explicit life story, which included their family/community experiences, the phases in their working careers, and the educational pathways they had taken. The process of recontextualising the interviews as biographies also provided insights into Healthworkers' experiences, perspectives and evaluations that contributed to the discussion, interpretations and findings.

The systematic analysis of each Healthworkers' discourse formed a coherent basis in Chapter 6, for identifying common patterns between them in the three topic areas, and interpreting these patterns. The method developed here was to examine the commentary on each analysis in Chapter 5, for patterns of similarity and difference, and select illustrative examples of these patterns from each Healthworkers' discourse. Discussion of each of the three topic areas was followed by a set of interpretations, that identified more global patterns, with implications for the study's findings, for example (6.1.4), that 'differences in the ways Healthworkers presented and evaluated their education appear to be associated with the different types of education programs, qualifications and the subjects they studied'. This method of analysis, discussion and interpretation is thus also a useful innovation for research.

With regard to the information provided by the analyses, this is the first in depth study I am aware of, into relations between Healthworkers' roles and scopes of practice, education, and family and community experience. It is a significant contribution to defining the parameters of what it is to be a Healthworker, and the experiences and education that shape it. Critically, it has made this contribution by drawing on the voices of Healthworkers themselves.

The first element of information presented in the study is the diversity and complexity of Healthworkers' practice, which is not recognised in current role definitions or vocational training for Healthworkers. Alongside this complexity is the knowledge, skills and values that the study shows Healthworkers bring to their practice from their families and community membership. This information, provided by the Healthworkers themselves, is more useful to defining Healthworker practice and education than vague references to culture and identity in most current role definitions.

A third element of useful information is the educational pathways that Healthworkers have forged for themselves, along with the components of those pathways that are most useful, and which Healthworkers value most. These components include not only supportive vocational programs that incorporate Aboriginal perspectives, and clinical experience, but crucially university education as their ultimate goal.

The fourth element of useful information, derived from the analyses, is the discursive power that a university education gives Healthworkers, to reflect on and explain their practice. This power, to articulate and organise their discussion, is part of the toolbox that university education has given these Healthworkers to manage the complexity of Aboriginal health, together with the recognition and confidence that accompanies this power. Alongside this information, provided by analysing their presentations, the analyses of their evaluations showed that Healthworkers with university education maintained the same values and connections with their families and communities, as Healthworkers with basic vocational training. In other words their Aboriginal identities were unaffected by their educational achievements.

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Appendix 1: Interview analyses

A1.1 JK

A1.1.1 Presenting practice: textual organisation

The analysed extracts in this section are formatted to make them easy to read, while making the textual patterns visible. Interview questions are numbered in bold, and Healthworker responses are set out line-by-line, with one clause to each line. Each phase of information is outlined, and the topic of each phase is marked in bold.

Role

Q19. Tell me about your roles and responsibilities as a coordinator?

Well it's, well it is **difficult to talk about** that because I've only just had a replacement in my old position so I've been doing like two jobs for the last 12 months so I've had a big clinical role as well as trying to balance clinical with a strategic role,
It is meant to be more of a **strategic role now** and I'm still trying to find my way through that. But basically it's ensuring that you know the whole, whole OM strategic plan is continued, continually you know implemented across the Area Health Service.

Q21. Do you have any clinical role at all?

I still, **so that I don't lose my clinical skills** I still do a lot of supervision of project officers and staff when there is no audiologist or nurse audiometrist around and just like go to clinics with them to make sure that they're doing everything right.

Q22. Are you testing children?

Yes, that's **part of my role** to oversee the other Healthworkers to carry out the audiometry screening on the children in schools

Q24. Can you tell me something about the strategic part of your role.

The main issues I've been dealing with lately is just trying to **monitor the budget**. To make sure that we're staying under budget and not going over budget and making sure the appropriate people are getting paid out of the budget and trying to look for more enhancement funding to maintain the current staffing level we've got at the moment, 'cause it's all a bit up in the air at the moment with the evaluation.
And, it's **an odd job**. It's basically whatever comes at my desk during the day, which is usually… you usually have lots of complaints from other Healthworkers about clinics not being run in certain towns and you know you have try and be nice to people and make sure that they're accommodated and try and include, it's just, it's **lots of organisation stuff, with the clinical side of things** and helping the project officers organise their clinical side of things .

And then we have we have **area network meetings and things**
just to make sure the program's running properly,
the **programs getting every thing it needs** as far as management and resources and things.
And we have, the program is also supported by two Human Services Advisory committees made up of audiologists and nurse audiometrists and Department of Education and Hearing support teachers.
So I'm working with a whole range of professionals
and those meetings usually bring up a lot of stuff.
you know, different children to follow up with,
different partnerships to try and create and maintain and develop with the Division of GPs and doctors and ENTS (Ear Nose and Throat specialists)
to make sure that the kids that we're concerned about and the urgent kids are getting followed up and having appointments and things.
And it's just about **developing those relationships with those professionals**
to run an effective program.

Education

Q7. Tell me about the experience of being the family support worker and what happened once you started studying?

The **study actually complemented the work** that I was doing
The different tasks and assignments directly related to what I was doing on the job
So it was helpful doing stuff like community profiles, business plans
I was able to understand the process of running a service a lot better as a result of having those educational skills

Q29. Did your university study help you?

Yes most definitely that **really taught me** how to be a critical thinker and analytical, how to communicate effectively through writing

Q30. What other skills?

Project development, project management and project evaluation, **those three subjects** really helped with nutting everything out and putting it all together…

Q33. What sort of knowledge do you need to do the job you do now?

A lot of **it is communication** …that's the most important thing.
You learn how to do stuff on the job…
which it's been a really interesting experience
You have to learn to be a support person for other people,
like advocate for other people, like within the program and more generally advocate for the community

Q43. How has education helped?

It's really helped with my **communication skills**, both written and verbal and non-verbal
…you have to be able to communicate effectively with various groups of people, professionals, and community members and governments and non-government people
…yeah education has a direct link with communication.
…I think my education has played a big part in that

A1.1.2 Perspectives on practice: lexical choices

Lexical items are classified as everyday, specialized, technical, institutional work, institutional education, and other abstract concepts. These analyses present the proportions of lexical choices in Healthworkers' entire interviews as pie charts and bar graphs, to enable generalized comparisons to be readily made.

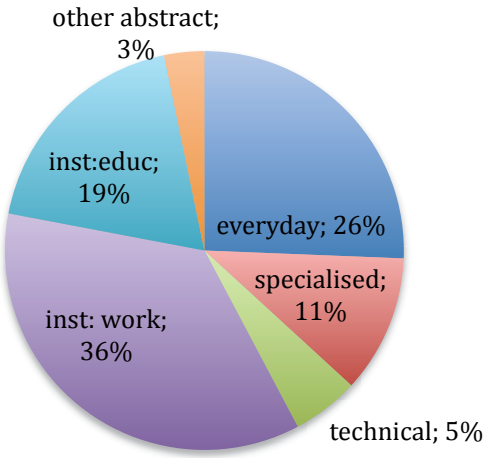

Figure A1.1: Proportions of lexical choices for each topic area

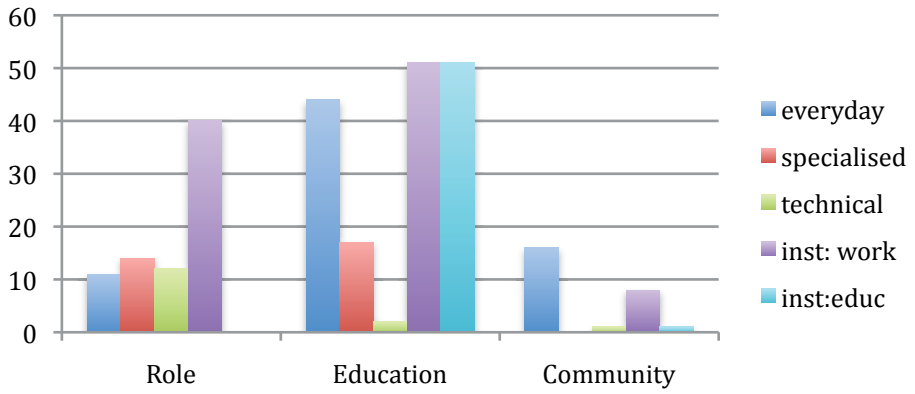

Figure A1.2: Proportions of lexical choices for each topic area

A1.1.3 Evaluating practice: appraisal

The analysed extracts in this section are formatted to make them easy to read. Appraisals include expressions of feelings, judgements of people, and appreciation of things and activities (attitudes), alongside the strength of evaluations (graduation), and the source of evaluation (engagement). Feelings include categories such as happiness, pleasure, affection, interest, confidence and desire. Judgements include people's capacity, tenacity, normality and propriety. Appreciations include valuations, reactions and complexity of things and activities. Each of these may be positive or negative, and they may be explicitly stated (inscribed), or implicit (invoked). Graduations include strong/weak force, or sharp/soft focus.

Each line of the presentation starts with engagement resources, that include expressions of expectancy, such as *well, before that, but now*, as well as explicit sources such as *you know*. The second column gives the target of the appraisal, and the third presents the attitude and its graduation. This order frequently corresponds to the sequence of each clause as it was spoken, greatly helping its readability.

Role

engagement	target	attitude/graduation	type
Q19. Tell me about your roles and responsibilities as a coordinator?			
Well	I've	only just been in this Area Coordinator position for the last 12 months	+capacity soft focus
before that	it	just more like a coordinator role	-valuation soft focus
but now	it's	lot more upper level strategic planning and stuff	+valuation strong force
Well	[I]	it is difficult to talk about that [roles and responsibilities as a coordinator]	-capacity
because	I've	only just had a replacement	soft focus
so	I've	been doing like two jobs	+capacity
so	I've	had a big clinical role	+capacity
as well as	[I]	trying to balance clinical with a strategic role	+capacity
meant to be	it	more of a strategic role	+capacity
	I'm	still trying to find my way through that	-capacity soft focus
basically you know	it's	ensuring that the whole OM strategic plan is continued	+valuation
you know	it's	continually implemented across the Area Health Service	+valuation
Q24. If that's the clinical component, can you tell me something about the strategic part of your role?			
	[role]	The main issues I've been dealing with lately is just trying to monitor the budget [iterates budget tasks]	+complexity
And so	it's	an odd job.	-normality
	It's	basically whatever comes at my desk during the day... [iterates staff management tasks]	+complexity soft focus
And then	[role]	we have area network meetings and things just to make sure the programs running properly [iterates professionals at meetings and goals]	+complexity
you know	[role]	to make sure the kids that we're concerned about and the urgent kids are followed up	+propriety
And	it's	just about developing those relationships with those professionals to run an effective program.	+complexity soft focus

Education

engagement	target	attitude/graduation	type
Q8. You were studying but working at the same time and I'm just trying to lead up to where you are now in terms of your work.			
	what I was doing and researching and learning	I was really enjoying	happiness
and just	I	really sort of put everything into it	+capacity
and realised that	I	really was enjoying myself and learning so much at the same time	happiness
and	I	was able to use those new skills in the job and in everyday life really	+capacity
Q41. How has the education and training that you've had contributed..			
Basically I think that if	I	didn't take those steps to educate myself	+tenacity
	I	wouldn't be in the position that I'm in today	+capacity soft focus
	I	wouldn't have this type of responsibility for an area health program without my Aboriginal health education	+capacity, soft focus
And you know		determination to continue to educate myself at that higher level	+tenacity
Q46. Anything else in terms of what impact your education has had?			
	It's	had an enormous impact on me, educationally, like mentally, physically, spiritually	+valuation
	I	can contribute to conversations and discussions about …world politics or anything	+capacity
	I've	developed a passion for things …	interest
	my mind	has just opened up so much	+capacity
	I	can have a general discussion with people about anything	+capacity
Q47. What about in relation to the people you work with, what role has education played ?			
Oh	its [education]	played a big part [with people you work with]	+valuation
because like you know	I'm	communicating on a daily basis with area managers of health services	+capacity
you automatically think you know,	they're	your superiors	+capacity
and so	they	should automatically know more than you	+capacity
and	[they]	more experience than you and stuff.	+capacity
but	I'm	really up there with the best of them	+capacity
and	I	can challenge people, and question people	+capacity
in order to	I	do what's right for my program and the community	+propriety
	I	don't feel intimidated anymore by that	confidence
	I'm	able to you know talk to them on the same level	+capacity
and	I	advocate on behalf of my program and my staff and my community	+capacity
and	I	Communicate effectively with them	+capacity
to	I	get what I want… basically	+capacity

Community

engagement	target	attitude/graduation	type
Q34. If you were looking for someone to replace yourself in your position what would that person need to know about?			
well	I'd	want the person to be just like me…[laughs]	desire
obviously			soft focus
you know,	[she'd]	have that, so many years of experience in Aboriginal health	+capacity
and	[she'd]	have that strong education and that background	+capacity
and		being Aboriginal and being part of the Aboriginal community helps as well	+capacity
obviously			
	[she'd]	be able to understand the community and what the community needs and what the community wants	+capacity
Q55. What does it mean to you to be an Healthworker?			
Well	it	means a lot	+valuation
I know that	I	doing something for the benefit of the Aboriginal community and Aboriginal children	+propriety
I don't know	contributing	in some small way	weak force
maybe			
maybe	I	contributing to better health outcomes for Aboriginal children,	+propriety invoked
you know	Aboriginal children	my passion	affection
	child health and stuff	I like	affection
I think	I'm	happy with my contribution at the moment	happiness
cause	I'm	coordinating an area otitis media program for Aboriginal children	+capacity invoked
so I think	that's	a pretty big achievement	+capacity soft focus

A1.2 CB

A1.2.1 Presenting practice: textual organisation

Role

Q1. What is your job description, title you work under and what does it entail?

Well at the moment I'm a **health promotion officer** and I work out of Population Health in D, and it's a population based position, and being in health promotion it's from the Ottawa Charter and it focuses on prevention, so a lot of **our programs target primary school and pre-schools and, and all prevention stuff**.
So you've got the… it **focuses on prevention**, and some of the stuff it focuses on prevention, is we've got the volunteer network where we provide the volunteer network and we provide them with training and insurance and support as well. We run the meetings for physical activity leaders in communities so its all, It's **capacity building as well**.
And we work in tobacco, **tobacco control** so we support, support the Smoke Check training and we organise other trainers as well. We've had the, the telehealth competency based training smoking cessation stuff and we've had AB she's coming out again in September. So we've organised her to come out and do a three day course for 25 health professionals so that's another capacity building exercise there. We're hoping that she can, she can through her training that health workers can, pass, **pass the training on to other Healthworkers and deliver programs**.

Q12. And in terms of the hospital work what did that entail?

…

I was still doing some **work on the ward** and a lot of the nurses thought it was good because they could use me to, **do showers and make the beds**…
Yeah, yeah but that was still useful because you form a relationship with the patients and you **build on your communication skills with the patients** doing all that sort of stuff
and then later on in the training you start paying more attention to how the nurses administer medication and, I was doing wound dressings and stuff in the ward in the **clinical environment** and, yeah there was also the stuff that we had to do as part of the training so we had to do the urinalyses and all that sort of stuff as well…blood pressures

Education

Q 10. In terms of the hospital work what did that entail learning about?

You start off on all the non-clinical stuff… then just learning about the basics of health, what health means to Aboriginal people and, and the history of health and Aboriginal people.

Q11. Did you do subjects like anatomy, biology?
Yeah, so we before we got right in to the anatomy and biology and all that, I was still doing some **work on the ward…** but that was still useful because you form a relationship with the patients and you **build on your communication skills with the patients** doing all that sort of stuff
And then later on in the training you start paying more attention to how the nurses **administer medication**. And I was doing wound dressings and stuff in the ward in the clinical environment and also the stuff that we had to do as part of the training. So we had to do the urinalyses and all that sort of stuff as well, blood pressures
Q28. When you did your traineeship did any of the modules look at the meaning of comprehensive primary health care and did you study what that means?
Yeah, **one of the assignments was to find a patient** and you had to like record all their history and their health problems and other things that were going on in their lives and how you would address all of it. Yes, so that was a pretty good exercise and it gave us a good idea of having **a more holistic approach to health**.
Q35. What would you say were the key skills and knowledge you got out of that course?
The most valuable skills and knowledge I got out of it, was looking at the **different ways of learning**. Like I finished Year 12 at Walgett and couldn't do a simple maths equation, even though I done Year 12 maths, and just had no idea about maths. And if you talk to people the right way you can get support off them. And yeah well at the first attempt of the maths exam for the drug administration I got 100% the first go. Plus, like **the support I was given and the way I was taught to study**, it's, I think I value. And some of the ways of learning, I learnt through the course, that there's **so many different ways you can research**.
It's **something that you can always use**, and straight away it helps as a Health Education Officer because you are jack of all trades.
And providing education to someone, it's so, so valuable. because you can always, even if you just know the basics about something you can, you can always study it a bit more and then you can elaborate as much as you want.

A1.2.2 Perspectives on practice: lexis

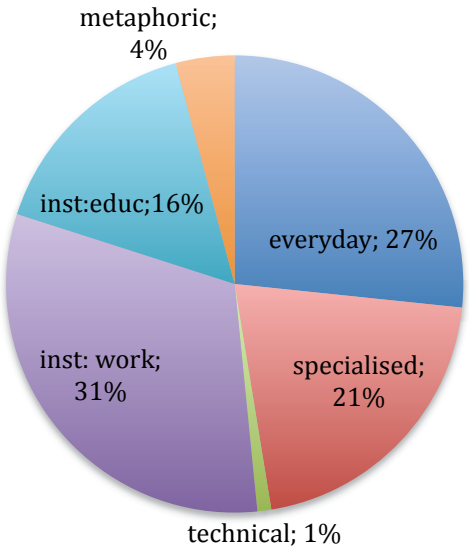

Figure A1.3: CB's proportions of lexical choices

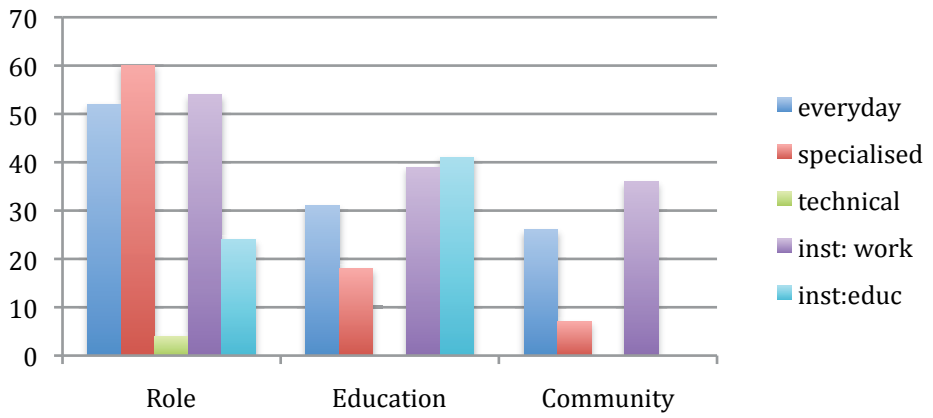

Figure A1.4: CB's lexical choices for each field

A1.2.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q20. Have you found as time has gone on that you've developed a particular interest in any one part of the field?			
	the education part	I like	+reaction
	it's [education part]	Good	+valuation
I suppose		one bad thing	-valuation
	it's	kind of hard to measure how successful	-valuation
You mean in terms of client outcomes?			
Yeah,	educating a group	especially like	sharp focus
most people say it's	for an Healthworker to go and speak to class at school	valuable	+valuation
	it's been	hard to know how successful	-valuation
you know	you've been	successful if the wound heals up	+capacity
yeah but	educations	a bit more wishy washy sort of	-valuation soft focus
Yes sometimes its not immediately apparent, sometimes it's the trigger.			
Yeah, exactly	when someone comes up to you 2 weeks after you've spoken to a group	the best feeling	+reaction
they say 'oh, yeah	that stuff you've been talkin' about	pretty good'	+valuation
or	that	something like	soft focus
Q18. What appealed to you most in that role?			
	It was	funny	-reaction
because to me	the things that nurses do	a lot of that, that appealed	+reaction
but at the same time I	becoming a nurse	wouldn't, wouldn't be at all interested in	-reaction
even a lot of people have said, you know	you	can be a community nurse	+capacity
I think	things you do as a Healthworker	the wide range of	+valuation
But,	you're	never bored	+reaction
you do	things	so many different,	+valuation
	[you]	sort of like jack of all trades	+capacity

Education

engagement	target	attitude/graduation	type
Q40. Have you got a view about what a university education might contribute or not to the role of a Healthworker?			
I mean	I'm	the only, on the, on the health promotion team that hasn't got a university degree of some sort	-capacity
Q41. How does that make you feel?			
I don't know	It's	only a piece of paper to me.	-valuation
But and…though I suppose	it	does make a difference in the world	+valuation
Q42. So does the degree, might it be something you might be interested in further down the track?			
I've been thinking about it	[the degree]	a lot	+valuation invoked
I've thought	university degrees	just the way society, looks on	+valuation invoked
like	[with a degree]	I can get, I can get paid more	+valuation
but I was thinking of it in terms of	[from a degree]	what new skills I'd learn	+valuation
and even if	[from a degree]	I only learn a few [skills]	-valuation
I think	[a degree]	it would be worthwhile	+valuation
Q43. When you say you're the only one in the team that doesn't have a degree and you look at the people you work alongside what do you think it gives to the position, to the roles that they carry?			
Yeah well I think from what I've seen	health promotion	people come from fairly wide range of backgrounds [iterates professions]	+valuation soft focus
so I think	as part of your team dynamic	good to have a good mix of people	+valuation
I think there's potential	for someone of my background	to fill an important part of that dynamic	+capacity invoked
because	[me]	my connection to the Aboriginal community	+capacity invoked
I think	someone [I]	not having a university degree	-capacity
	someone [I]	not of the same level of education	-capacity
	someone [I]	gives a different perspective	+capacity
well I suppose I might	I	come up with more of a common sense sort of answer	+capacity
might be you know thinkin'	someone who's more educated	'what have I learnt'	-capacity invoked
	I	struggling on a minimum income	+capacity invoked
	I	Aboriginal person	+capacity invoked
	I	can sort of enlighten them	explicit +capacity
Can you tell me more about that…what you mean?			
I mean	the teams	good	+propriety
they always say	C	'oh what do you think about this?'	+capacity
yeah hopefully, hopefully sometimes	it's	helpful	+capacity

Community

engagement	target	attitude/graduation	type
Q28. Do feel that as an Aboriginal man having done an Aboriginal health traineeship that it's a priority for you to represent the needs of Aboriginal people in this region? Or do you find that being employed as a population health officer is there any tension there for you?			
Yeah, I picked up	[tension between Aboriginal needs and his role]	straight away	-reaction
	a lot of programs	didn't really target the Aboriginal population	-valuation
But really, I mean	the delivery of services to Aboriginal people	still, still lacking	-valuation
I can see	the health determinants for Aboriginal people	there needs to be more focus on	-valuation
even though might be	a smoking cessation program aimed at Aboriginal people	designed more for Aboriginal people	+valuation
	being a part of the program	in a way that can make them more comfortable	+valuation
still	it	doesn't take into account the other factors	-valuation
more likely to be	an Aboriginal client	in contact with alcohol abuse	-normality
more likely to be	"	of a lower socio-economic status	-normality
could have	they	mental health problems	-normality
could, .. could be	they	coming into contact with domestic violence	-normality
you've gotta think	getting them people to quit smoking	is the biggest priority?	-valuation invoked
you know, is	that	going to have the, the biggest effect on their health?	-valuation invoked
I think	delivery of services to Aboriginal people	needs to be more of a holistic approach	+valuation
Yeah,	all the underlying factors	need to be addressed	+valuation
at the moment	it's	not happening	-valuation
I'd like to see	positions in health that are more social work based	more	+valuation
I think where there	that's	needs to be some big changes	-valuation

A1.3 CO

A1.3.1 Presenting practice: textual organisation

Role

Q1. What position are you in, and what is your title.

Now, I'm the Health Services Coordinator
and pretty much that consists of **monitoring or coordinating, or managing** pretty much, the general practitioners, the general practitioners' registrars, the senior clinical registered nurse, the registered nurse, early childhood registered nurse, two Healthworkers and hence, primary care Healthworker, social health worker and medical students and a phase three medical students as well.
So we have phase one and two medical students,
and we also have phase three medical students
they're a bit more qualified, and will have more competencies
and they actually come with us and stay for us for about a 12 month term.

When you say you're the manager of all of those staff, what does that entail?

So I look after their **HR, their training, OH&S, then staff development, staff planning, health services, which is our team planning**.

The **organisation is made up of four main team services**,
and Health Services is one of them,
the Dental Services is another one,
Administration and Operations are another one,
and Community Services is another one.
…

Q2. And before that, were you an Healthworker?

I was a, yeah…
In that role, I was **ground staff**
I was the face.
I had a supervisor and a manager,
because the registered nurses are supervisors for the Healthworkers and general health workers.

And I think one of my biggest passions, which has always been **chronic care management** or diabetes and asthma, being the most prevalent ones,
so I looked after that.

I ran a **number of clinics**.
I operated an eye clinic with an optometrist, a podiatry clinic with the podiatrist, an asthma clinic with the asthma educator nurse, a diabetes clinic with a diabetes educator nurse, and an endocrinology clinic with the endocrinologist.
So I did those clinics as well,

plus trying to keep focus on what my core business is, being the **male HW role**, which is men's health, looking after men's health, primarily looking at prostate, testicular, breast and impotencies.
And then, yeah, I started chronic and men's and mental and sexual
they're all my sort of four main flavours that I really like.

Q7. When you say it was clinical and you've just very quickly said, "I would do ECGs on women," in that clinical role, tell me some of the things that you…

Well, one of the main tools that we use when providing a clinical care or clinical focused care would be **our health checks**.
We actually are one of the top leading three across the nation with our adult health check
and we've also later on incorporated the children's health check and the elder person's health check as well…

So what we try to look at in the health check is **try to put these barriers up with the family history**
to prevent that from coming to them,
because they may get it or they may not get it;
it depends on, you know, how they live their lifestyle, I suppose,
because most type 2 diabetes is a lifestyle condition.
So yeah, we try to look at what mechanisms we can put into place
to prevent that from occurring to that person.
Then we look at their immunisation, we look at their sexual health, we look at their mental health, we look at their social health, we look at their social housing situation, like just basic stuff…

And so we can do an **internal referral** and sort of get in a little bit quicker.
and that's a bit of an incentive and a bonus for them for coming and doing the health check.
So that we can sort of do these little backdoor things through internal referrals, and even external referrals if need be,
because we do **both internal and external referrals to other network services**.

Education

Q20. And what were you enrolled in?

I want to do all core subjects in the Indigenous health program and I want to incorporate nursing subjects as well, and hopefully to incorporate some management.

So in the end when you finish, you come out with a …

Health Science.

Q21. Tell me more about what you've got out of it, so knowledge-wise, skills-wise.

How they look at us in Australia and how our governments are set up and how our health systems are set up, and the old public health and the new public health, and now mainstream is that thing the Aboriginal holistic health model finally and incorporating that in the mainstream settings.

Q22. Is that a mainstream degree that you're enrolled in?

Yes. Yes and no, because I'm doing a lot of core indigenous subjects.

Q23. But those subjects aren't specifically, can other students, non-Aboriginal students …

I'm hoping to do Aboriginal Identity and Contested Knowledges next semester.

A1.3.2 Perspectives on practice: lexis

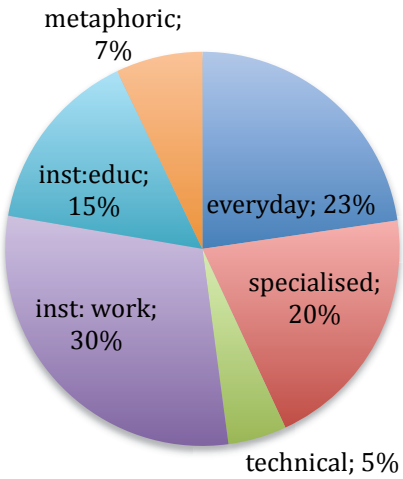

Figure A1.5: CO's proportions of lexical choices

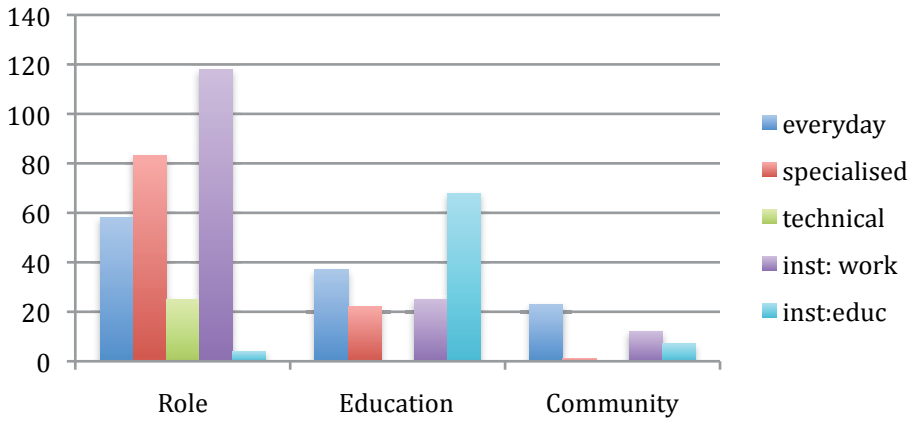

Figure A1.6: CO's lexical choices for each field

A1.3.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q8. So pretty comprehensive?			
	we	try to keep	mid capacity
	health checks	really friendly and really fun	+appreciation
	We're	always improving and enhancing	high capacity
	we've	worked so much	high capacity
	primary GPs, Dr RI and Senior Registered Nurse SP	the main ones that have been always looking at it	high capacity
and I suppose	myself		mid capacity
	we	actually the ones on the ground	high capacity
	the structure	primarily what we want	+valuation
	The Healthworker	can determine	high capacity
	we	primarily can	high capacity
	We've	sort of made it	mid capacity
	tool	a very user-friendly	+reaction
	we	can do it	high capacity
however	I	still take about an hour	graduation
because I think	(in health checks)	a lot can be shared	+appreciation
	we	have a lot of clients and community members	high capacity
	we	can get a really good snapshot	high capacity

Education

engagement	target	attitude/graduation	type
Q13 Tell me more about what you've got out of it (university), knowledge-wise, skills-wise.			
		Different perspectives.	+ capacity
I mean, I think	I	always critically analyse things	+ capacity
but	I	did not know the terminology or the reference that I did that in	- capacity
Now	I	understand exactly what it means and how to do that.	+ capacity
	I	always think outside the square	+ capacity
	I	brainstorm every possibility, every channel	+ capacity
	I	try to have solutions	+ tenacity
	I	quite assertive,	+tenacity
		probably a little bit over-assertive	-propriety
Yeah, I suppose	being at uni	main traits that I've found	
	"	opened my life to this whole new world	+appreciation
You know	"	there's just so much	strong force
I mean, really	university	played a massive role in my life	strong force
Tell me about the difference between doing the TAFE course and doing the uni course.			
		Big. Huge.	
it seems	with TAFE studies	to be more of a community level feel	+appreciation
	it's	a real grassroots feel	+appreciation
whereas	the academia	is definitely not (grassroots feel)	sharp focus
	it's	definitely what it is	sharp focus
	it's	the higher education of society	+appreciation
	that's	where you have to go	+appreciation
if	you	want to be an architect or a police officer or accountant or CEO or doctor	

Q29. In terms of the difference, between the two different kinds of courses and the value of each, what kind of a difference do they make, do you think, if any, to the way you do your job?

I think that	that I did the Certificate III	it's really important	+valuation
because	that's	what gave me the opportunity to work on the face and get community experience.	+valuation
And	academia	does not take into consideration is community experience, especially in the Aboriginal Torres Strait Islander world.	-propriety
You know, you can have	people	come across with degrees that don't have a clue how to interact with the community,	-capacity
	[people]	and therefore could be quite dangerous to the community.	-propriety
And then you've got	people	who have got great community skills	+capacity
	[people]	but just can't get that what we call "the white man's paper", the degree …	-capacity
	I	entered the academia world, dived in headfirst.	+tenacity
And	I	nearly failed,	-capacity
	I	should have built capacity,	-capacity
then	I	would have been prepared …with how to do academia, study, research and then convey that down in paper and reference it and all the rest of it.	-capacity
because	that's	my biggest downfall.	-capacity
	my presentations	are fine	+capacity
and	I	get distinctions quite often,	+capacity
but		it's my papers and my essays	-capacity

Community

engagement target attitude/graduation type

Q45. What's your view of health workers that don't have the qualifications but do have the community experience, versus other health workers who are going to TAFE and to university and the idea that the university qualification takes people away from community?

Because I know	a lot of researchers	have done that	-propriety
	they've	got what they wanted out of it	-propriety
		made themselves big and successful	-propriety
		not respecting the community that they've come from	-propriety
that's why	ethics approval processes	ensure that that doesn't occur	+appreciation
But yeah, I suppose because	I've come into management		
	I	see more paper than community faces	-propriety
which	for me	is a little bit sad sometimes	-affect
because	I am	a real community-focused person	+propriety
	The community	it took them a long time to realise that I was in management	-capacity
	for me	they kept asking	+capacity
	me	they kept wanting	+capacity
	me	they've congratulated and supported and all that	+capacity
	me	they want back out there in the community	+capacity

But	that (being in the community)	doesn't enhance me as an individual	-appreciation
	that "	doesn't really give me growth	-appreciation
So I think	it (university qualification) takes you away from the community	that yes, it does in a way,	-appreciation
but then	it "	doesn't	+appreciation

A1.4 SW

A1.4.1 Presenting practice: textual organisation

Role

Q1. Can you tell me what your role is and what it entails?

OK, I'm the **Aboriginal Hospital Liaison Officer** for X Hospital
and that role entails being a support person and somebody that acts as an advocate for Aboriginal patients in hospital, their families
and I support them whilst they're in hospital.
I follow up with them whilst they're there, when they go home
and I will liaise between the doctors and nursing staff and you know that kind of stuff.

A lot of doctors still use huge, great big medical terminology
when they're talking to the patients you know.
Like you have, I don't know 'hydrocephalus' or something like that
and the, you know patients, Aboriginal patients that are, are not educated and come from you know, smaller communities
they, they use big words like that
and they just think 'oh my God, I'm going to die'.
You know they just think it's the worst thing.
So just **being there when the doctors talk to the patients**,
so I can, explain to the patients,
or get the doctors to explain to the patients in lay terms what he's actually `talking about and that
it's, you know, not as devastating as it sounds.

Q3. And can you describe the teams. You work in the Social Work department, how does that work?

Well the Social Work department is kind of my managers,
so **I'm on the bottom of the rung** of, it goes, Allied and Community Health Manager, Allied Health Manager, Social Work Manager,
then there's Social Work One, Social Work Two, Admin and ALO, so even below Admin.
And so my reporting is through that channel,
and so I'm, supposed to you know, report to the social workers

apart from you know, supporting my clients I'm not really supposed to go over and beyond that.
Beyond that I'm not supposed to counsel them or, you know, support them with domestic violence, child protection, you know grief and loss issues and stuff,
I'm supposed to refer that on to the social workers
because, I'm not qualified.
But I have the qualifications,
however I've been advised that I must stick to my job description.

And a central part of the job description says that **you must always update your skills and education**,
and I've done that continually, even before I started.
Like I got my diploma from TAFE in Aboriginal health and education
and I also had a welfare diploma from TAFE,
so **I have the skills to counsel people and you know support and advocate for them**.

However **the role of ALO is merely a support role to work**,
I call it 'behind the social workers',
they like to refer to it as 'to work alongside the social workers'.
But I just think it's degrading for me as the ALO
and it's degrading for them as my clients,
that I have these skills, but I'm not allowed to practice it
because it's not what my job description says.
And I think it's unfair that the clients have to, you know, tell me the story
and I have to say OK, I'm not really qualified in this,
but let me get the social worker
and you can tell the story again.

Education

Q12. I'm looking to understand what you mean when you say it wont change your practice…

Even when I do have that piece of paper it's not going to change the way I work.
Yes I'll have the theoretical knowledge behind, you know the research and the readings and everything else that you learn at uni,
but it's not going to change the way I practice as an ALO or a Social Worker.

Q23. What are the key skills that you need to do your job, as different from knowledge what would you describe the skills you need?

Excellent communication skills, great advocacy, and empathic… probably they're the three main things that I would say any Healthworker or Liaison Officer needs to have.

Q30. What's the most important sort of knowledge that you need to be able to practice the way you do?

For Healthworkers to do their job they have to have knowledge of, the historical, the historical events in Aboriginal peoples' lives. You know like the Stolen Generation and you know that whole impact.
And you have to, not only have the knowledge of that, but you have to understand how that has impacted on Aboriginal people over, you know the last one hundred years.
And I think that's, that's probably the most important thing.
Apart from that just some you know basic welfare knowledge…

Q33. So what about the knowledge you've studied in your SW degree…the knowledge that's part of that?

We do subjects like sociology
so we've got to have a bit of sociology knowledge and a bit of law knowledge, obviously counselling, grief and loss stuff,
and we do social work theory and practice
so you know you do your one on one client
and then you do your group work stuff
and then you do your community development stuff.

Q34. Do you do any psychology?

We do psychology, psychology, child and adolescent psychology and the psychology of aging.

A1.4.2 Perspectives on practice: lexis

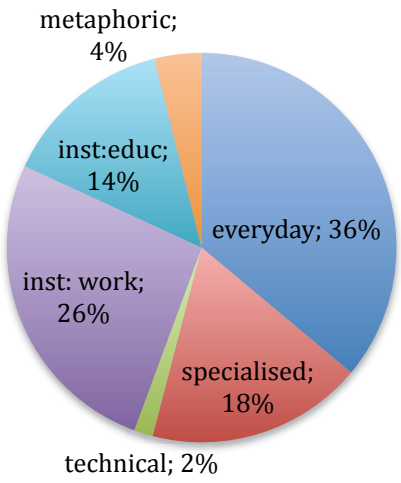

Figure A1.7: SW's proportions of lexical choices

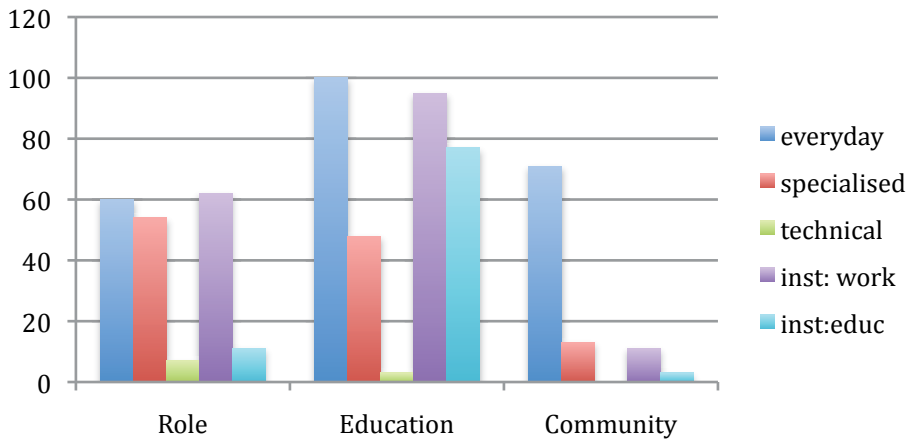

Figure A1.8: SW's lexical choices for each field

A1.4.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q1. Can you tell me what your role is and what it entails?			
OK	I'm	the Aboriginal Hospital Liaison Officer for X Hospital	
	that role	entails being somebody that acts as an advocate for Aboriginal patients in hospital, their families	+complexity
	I	follow up with them whilst they're, when they go home	+capacity
	I	support them whilst they're in hospital	
	I	will liaise between the doctors and nursing staff	
you know	[listed roles]	that kind of stuff	soft focus
	A lot of doctors	still use huge, great big medical terminology	-propriety invoked
when you know	they're	talking to the patients	
Like, I don't know	you have	'hydrocephalus' or something like that	+complexity invoked
you know	Aboriginal patients	that are not educated	-capacity
		come from smaller communities	-capacity invoked
	they [a lot of doctors]	use big words like that	-propriety invoked
just think	they [Aboriginal patients]	'oh my God, I'm going to die'	fear
just think	it's [illness]	the worst thing	-reaction
So just being there	I	can explain to the patients	+capacity
	I	get the doctors to explain to the patients in lay terms what he's actually talking about	+capacity
you know	it's [illness]	not as devastating as it sounds	+valuation
Q3. And can you describe the teams. You work in the Social Work department, how does that work?			
Well	the Social Work department	is kind of my managers,	
so	I'm	on the bottom of the rung of,	-propriety
	it	goes, Allied and Community Health Manager, Allied Health Manager, Social Work Manager,	
then	there's	Social Work One, Social Work Two, Admin and ALO, so even below Admin.	
And so	my reporting	is through that channel,	
and so supposed to you know,	I'm,	report to the social workers	-capacity
so	I	have the skills to counsel people and you know support and advocate for them.	+capacity
However	the role of ALO	is merely a support role to work	-capacity
I call	It	'behind the social workers',	+veracity
they like to refer to	it	as 'to work alongside the social workers'.	-veracity
But I just think	for me as the ALO	it's degrading	-propriety
and	for them as my clients,	it's degrading	-propriety
that	I	have these skills,	+capacity
but	I'm	not allowed to practice it	-propriety
because not what my job description says.	it's		

Education

engagement	Target	attitude/graduation	type
Q9. When you say not valued, do you mean by other professionals, by the system as a whole, by clients? Tell me what you mean by that.			
I think	no matter where they work in the system	all Healthworkers, if they're in an identified position, it is always a position that is on the lowest scale of everything else..	-propriety
	Social workers	don't value […]	-propriety
that	Healthworkers	whilst they might not have the formal qualifications	-capacity
	We	have a lot of informal qualifications	+capacity
and	We	can actually deal with our clients very well without the formal qualifications	+capacity
Q35. You've said it (university) doesn't change your practice. What's it done for you?			
	It's	given me power	+valuation
Tell me about that			
I guess, well they say	knowledge	is power	+valuation soft focus
	Power	is something	+valuation invoked
I guess	I	understand	+capacity soft focus
	I	do feel more educated	satisfaction
in the fact that	I	understand things better	+capacity
	I'm	not as black and white as I used to be	+propriety
I used to think you know	I	if you've done something wrong and you go to gaol then serve yourself right	-propriety
	I'm	not as black and white	+propriety
	I'm	more open minded	+propriety
	I	understand things a little bit better	+capacity
	I	understand	+capacity
	I	appreciate where people come from a lot better than I used to	+propriety
	it's	going to give me power	+valuation
	I	can apply for just about any job	+capacity
so	that's	very good	+valuation
But yeah I can't think of	it's	in any way how it's going to change the way I practice	-valuation
Q36. What about if you compare the studies you've undertaken in the degree with those you've undertaken at TAFE.			
I think	TAFE	really, really good	+valuation
	TAFE	more of a hands on thing	+valuation invoked
	jumping from TAFE to university	like jumping from kindergarten to year 6 with nothing in-between	-valuation
	when I first went to uni	so hard	-reaction
because you know	I	always, in the top at TAFE branch of the class	+capacity
	I'm	in the bottom at uni	-capacity
	I'm	like so dumb when it comes to uni	-capacity
What's that about?			
Because you have to	at uni	do all this research stuff and referencing	obligation
you can never	at uni	have your own words	-capacity
you've always got to	at uni	find something to back it up	obligation

Q37. Is it related to academic writing?

Yeah,	if I didn't have to do assignments	it wouldn't be a drama	-valuation
If	I	could role play everything no worries.	+capacity
But because it is you know	the academic writing	is so, so hard	-capacity

Community

engagement	target	attitude/graduation	type
Q16. If you're being constrained by the people you work with … can you explain how that works?			
	A lot of clients	get really angry	displeasure
and say		'you're the ALO'	+capacity
and	I	want you to do it with me	desire
	I'm	not talking with no-one else	displeasure invoked
	I'm	not talking to them white fellas	displeasure 'invoked
Especially, you know	older people		sharp focus
and actually as well	younger generation		sharp focus
are also starting to say	I	don't want to know them	displeasure
	You're [ALO]	who I feel comfortable with	trust
	I'm [clients]	not going to go through the whole thing again,	displeasure invoked
	I'm	not going tell me story a hundred times	displeasure invoked
	They [clients]	get quite cranky,	displeasure
so if	I	can avoid it I will	+capacity
most of the times	I	can avoid it	+capacity
but sometimes you know	Social Workers	have kind've caught me out	-propriety
so	I	I'll bring them along	+capacity
but most of the time you know	clients	just close up, they wont talk, about it with the Social Workers	insecurity invoked
Q40. Who has been your role model?			
I think that from a personal perspective	my mum , and two younger sisters	who have both been to university	+capacity
and	I'm	the oldest and I haven't	-capacity
if it wasn't for	mum 's	unconditional love and support and guidance	+propriety
	I	wouldn't be the person I am today	+capacity
And I think from a social work perspective	a social worker called J	my role model was,	+capacity
and	she (J)	was just brilliant	+capacity
	she	was really supportive out of all the social workers I've ever worked with	+propriety
and actually		encouraged me to do this social work degree	+propriety
and	I	wish she was still my boss.	affection

A1.5 LT

A1.5.1 Presenting practice: textual organisation

Role

Q1. Tell me the title of your position and then what that actually involves.

Well, I'm employed as an Aboriginal Health Education Officer and what technically that means is, part of my role is to run groups and basically it's non-clinical, but it's to **run groups and information** to those that are referred to me.
So basically it's by **referral**. Referral can be either from other work colleagues or an individual themselves, so they can self-refer.
And I guess it's mostly to provide information, support, advocacy and just a generalised information and education. So it's kind of **doing a community consult**, recognising what is it that they need education on, like what are the main issues surrounding that, and putting it together as to the target and getting a program together. So whether or not that means using somebody else's program from another area, which is usually a lot more helpful, and then implementing it to suit the community here.

Q2. Is the focus of the health education based on the individual rather than the population, or is it both?

Probably a **little bit of both**. I'm classified as the Aboriginal Education Officer, but sometimes, depending on the circumstances, I may have a non-Indigenous person referred to me because of some of the trainings that I have done, especially with smoking cessation. As much as population-wise, Aboriginal community is seen as being a higher prevalence than non-Aboriginal, but on the other side, when you have non-Aboriginal people who want to quit smoking, well, they're kind of referred to me as well. So it's probably a bit of both.

Q3. So maybe if I just ask you about the self-referral, can you give me an example of what a typical, if there is such a thing, case might …

Yeah, there's probably not so much of a typical, because I think what my employer sees as my role and what the community see as your role is a lot different. So this is where we get into the **other side of the real role**, which says basically somebody comes to you.
A lot of what I deal with is very much **social work side of things**, so we have a lot of housing issues so if they've come in, they've been turned out of somewhere or something like that or they need emergency housing, there's been a DV situation, so it's a lot of talking with a client and working out what is that they need.
And a lot of the time it's not just one thing, it's a **multitude of things**, and from a health perspective, all of those things impact on their health.

Education

Q11. And tell me how you came to be in this role and your previous role, just so that we get to talking about your skills and your education.

Area Health Service Healthworker traineeship Aboriginal Health Cert IV Practice Stream They had no idea what was involved in the competencies, what training we were doing. My training was very much that clinical focus more than anything with a little bit of community development and community programming and education, but primarily it was clinically-focused

Q43. What kinds of skills in the traineeship or Certificate IV directly contribute to you being able to manage?

I think just knowing a little bit about the medical side and the 'why your body works the way it does' and having that skill to be able to explain that. One, you can explain it on a professional level if you're standing there talking to a doctor, and talk their language, but then also being able to talk to your patient in their own terms as well and being able to have them understand you

A1.5.2 Perspectives on practice: lexis

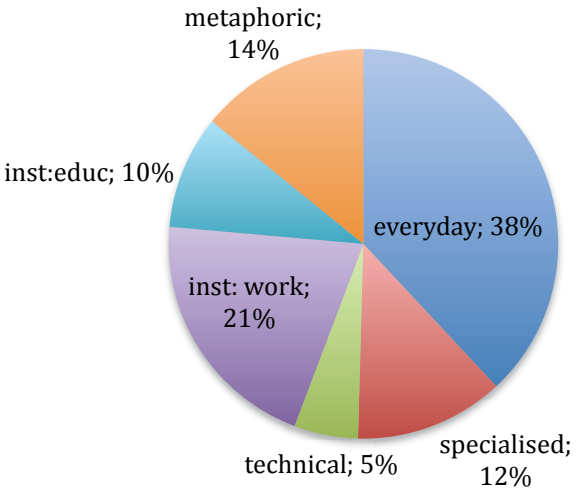

Figure A1.9: LT's proportions of lexical choices

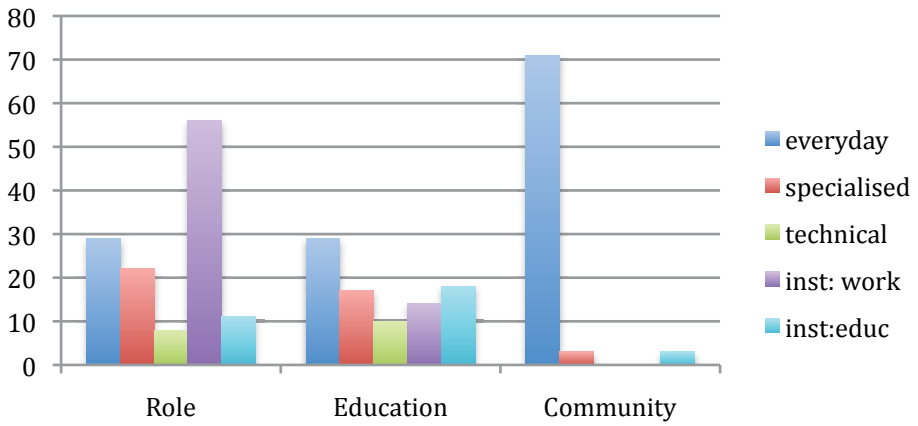

Figure A1.10: LT's lexical choices for each field

A1.5.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q1. Tell me the title of your position and then what that actually involves.			
Well	I'm	employed as an Aboriginal Health Education Officer	
and what technically that means is	part of my role	is to run groups	soft focus
and	it's	basically non-clinical	soft focus
but		to run groups and information to those that are referred to me	
So		basically by referral	soft focus
And I guess	it's	mostly to provide information, support, advocacy and just a generalised information and education	+complexity soft focus
So	it's	kind of doing a community consult	soft focus
recognising	they	need education	-capacity
like what are the	issues	main	sharp focus
and		putting it together as to the target and getting a program together	
So whether or not that means	using somebody else's program		soft focus
usually	"	a lot more helpful	+valuation
Q2. Is the focus of the health education based on the individual rather than the population, or is it both?			
Probably		a little bit of both	soft focus
	I'm	classified as the Aboriginal Education Officer,	
but sometimes depending on the circumstances,	I	may have a non-indigenous person referred to me	soft focus
because	I	have done some of the trainings especially with smoking cessation	+capacity
As much as population-wise, seen as	Aboriginal community	a higher prevalence	strong force
but on the other side when you have	non Aboriginal people	referred to me	
well,	they're	kind of referred to me as well	soft focus
So probably	it's	a bit of both	soft focus
Q3. The self-referral, can you give me an example of what a typical case might be?			
Yeah, there's probably because I think what my employer sees as	my role	not so much of a typical case	soft focus
and what the community see as	your role	is a lot different	+complexity invoked

So this is where we get	[role]	into the other side of the real role	sharp focus
which says	[role]	basically somebody comes to you	soft focus
	A lot of what I deal with	is very much the social work side of things	sharp focus
so we have		a lot of housing issues	sharp focus
So if	they've	come in	
	they've	been turned out of somewhere or something like that	-normality
or	they	need emergency housing, there's been a DV situation	-normality
so	it's	a lot of talking with a client	+complexity
and		working out what is that they need	+complexity
And a lot of the time	it's	not just one thing	soft focus
	it's	a multitude of things	+complexity
and	all of those things…	impact on their health	-valuation

Q4. When you said in the beginning there's the real and there's the community and there's the … tell me more about that.

Okay, so the community have the expectation that	their health worker	should know a bit about everything	+capacity
and	their health worker	can do a bit of everything	+capacity
so as much as	my role	is seen as being non-clinical	
sometimes	people	want just a bit of education	
and …	they	might want their blood pressure taken	
So sometimes it's a matter of	you	do the blood pressure,	+capacity
	you	give them the education	+capacity
because	you	know you're confident	+capacity
and	you're	capable of offering that service	+capacity

Education

engagement	target	attitude/graduation	type
Q12. And this was at the beginning of the traineeship?			
in my interview for my job I was told that	If you want to use those clinical skills you're	not actually covered	-capacity
	you	would need to go back and do at least a Cert III in AIN to have those clinical competencies recognised	-capacity
	I	was furious	displeasure
because	I'd	done a Cert IV,	+capacity
and	here they were	telling me that I needed to go back and do a Cert III level	-propriety
	which	is less than my qualification	-valuation

Q32. What are the sort of primary skills that you see as being necessary for being able to do what it is that you do, the way you see it needed to be done?

I guess	**[self]**	the primary skill is having the ability to be non-judgmental	+capacity
and	"	to have that rapport, to build that rapport with people	+capacity
and	"	have the skill to be able to recognise that	+capacity
and		not have the arrogance of "Well, this is the way I've taught, this is what I have to do and you just have to shut up and do what I expect"	+propriety
Like, sometimes	people	sort of get a bit funny about, "Well, why do you really want to do a urine analysis? Are you checking for drugs?"	insecurity soft focus
because	a lot of them	feel that	-affect
	They (white staff)	have that attitude, "Well, you're a blackfella and we need to do a urine analysis, so we're checking for drugs,"	-propriety
and instantly	they (Aboriginal clients)	feel that	insecurity
So I think	**[self]**	being able to build that rapport is probably the primary skill	+capacity
and	"	knowing how to go about asking people certain things	+capacity
and	"	to have them feel comfortable enough	+capacity
But within the role, I really strongly feel	that the clinical side	needs to be pushed	strong force
because	people	already have a sense of not wanting to access the Health Service	insecurity
	There's	that reluctance to access it	insecurity
but because it's	it's	the only one here,	+valuation
	they	feel like they're forced with no other choice	insecurity
	they	reluctantly access the service	insecurity
So whilst we've got the service,	you	want to be able to offer them the best service you can	desire
rather than (people) thinking "Well okay,	I	can access the service by at least speaking to the Healthworker	+capacity
but	she's	only going to fob me off to everyone else."	-propriety
	They	don't want that.	fear
	They	want being able to see their health worker	desire
and know that	the health worker's	competent to be able to pick up and do the basic assessments	+capacity
and	"	pick up on the abnormalities and then refer them to the specialised services	+capacity
not just	"	"Oh, you have to go and see the nurse because I can't read the urine stick"	-capacity

Q63. And then went on to uni?			
Yeah. Well	I	actually did Year 12	+capacity
and then	I	sort of was, I mean, I worked from the time I was 15 at Woolworths	+tenacity
and	I	didn't have any idea as to what I wanted to do or where I wanted to go or what field I wanted to go into.	-capacity
	I	was always good at school, science and maths.	+capacity
for me	English	was always probably a little bit of a downfall,	-capacity
but	I	could never really write in the way of essays.	-capacity
	I	could talk all day,	+capacity
but	I	couldn't really write them all down…	-capacity
whereas no		probably get finger cramps from writing	
So	**I**	just didn't know where I wanted to go	insecurity
and	one of my friends	was doing accounting when we were like 19 …	
I thought "Well,	I	might as well go and do it myself."	+capacity
for this			
So	I	sort of started it and I was very, very good	+capacity
but	I	hated it,	unhappiness
	it	was so boring	reaction
	it	was very good	+reaction
but, I don't know I	I	craved that personal contact	desire
think			soft focus
And	I've	always had that drive to want to make a difference within things	desire
So yeah	I	went to beauty therapy	+capacity
		[Laughs] make a difference	capacity invoked
like	I'll	make you very pretty	+capacity

Community

engagement	target	attitude/graduation	type
Q23. Are both your parents Aboriginal people?			
	it's	only my Dad	sharp focus
but in relation to my identity of	I	was 10 or 12	
where things came from, I think			
when we actually had it	we	were of Aboriginal descent	+veracity
confirmed that			
Because	my great grandmother	as dark and as gorgeous as she was	+reaction
sorry	I	was very close to her	security
and she always denied	it		-veracity
Like	there	was the shame factor	-propriety
because	she married a white fellow	her parents completely disapproved	-propriety
and	her	ostracised straight out	-propriety
	her	her parents didn't want to know about.	-propriety
So she never spoke about	that		-veracity
	it was something	she never, ever spoke even to my grandmother	-veracity
so	it	was never discussed	-veracity

And then as	my great grandmother	got into her older years	-capacity
and	“	dementia started to take place	-capacity
	“	all these things came out	+veracity
I mean, for a long time, she used to say		“Oh no, her parents were from India,”	-veracity
because	she	was dark	
So we just said		Okay	+valuation? reaction
but	it	never quite fit	-composition
and there was always that		“Alright, well we just won’t push the issue.”	+valuation
But when	she	became in her older years	-capacity
and	“	dementia started happening	-capacity
and	“	all these things came out	+veracity
I think	most of us	were just sitting beside her bed gobsmacked	insecurity
And it was sort of a bit of	“	“Wow, that makes sense”	+composition
But for me I guess when	we	went to school	
and being that	my Mum	is white	
	my Dad	is dark	
and		to find out later	
I've got	cousins on my Mum’s side	very cruel	-propriety
	that	I actually went to school with	
and	I	was blonde hair, fair skin, blue eyes	
and then suddenly	my cousins,	cruel	-propriety
	who	don't have Aboriginal descent,	-capacity
	“	had the dark hair and the olive skin	
	“	were being really cruel to sort of say	-propriety
	“	all the names came out	-propriety
And so then going through school, as much as	I	was always a high achiever at school	+capacity
	I	the A grade student	+capacity
and most people sort of don't recognise	me	as Aboriginal descent	-veracity
So when	it	came through school	
and	that	all came out in Year 7	
	it	really made it difficult all the way through	-reaction
because there was always that,		“Oh, you mustn’t be really Aboriginal as such	-veracity
Because the stereotypical side of things is	they're	the low grade student	-capacity
and	it	just so wrong	-propriety

So then	I	could understand	+capacity
why	my grandmother	protected us by not saying that	+propriety
but on some side of the fence	I	feel like I'm in no man's land	insecurity
because white society were calling	me	black	-veracity
at that point	we	weren't recognised from birth as such	-propriety
So after a while	we	got that acceptance anyway	+security
because my Aunt found	another relative	that my grandmother hadn't spoken about	
and so	it	all sort of came together	+composition
	we	kind of got accepted	+security
but	I	not accepted	insecurity
because	I'm	so fair	sharp focus
	it	always been a hindrance	-reaction
	I	kind of in the middle of no man's land.	insecurity

A1.6 RH

A1.6.1 Presenting practice: textual organisation

Role

Q7. Out of those positions can you describe to me what the work has been about?

Trying to get **Indigenous people in contact with health services**, which range from alcohol and other drug, mental health, family counseling, relationships counseling, all of the areas that you could see in health.
I did a lot of **outreach work** so I'd actually go and meet the people in the community, see them in their homes and ascertain what their needs were, and then go set about getting those needs met by whatever services were there. So keeping files, all the stuff that's involved with client work and case management.

Q8. So had they [clients] been referred into the Unit?

Most of my guys were brought in by police because they were in drug and alcohol induced psychoses or you know, they had a history of mental illness, schizophrenia, depression, attempted suicides and things like that. So it was an **acute unit that I was working in** and that involved hooking up with them.

…

A lot of them that I'd come across because they'd become so ill for so long it took a while for them to come back in contact with **any sort of services, police or the health system**. They'd often have, not have Centrelink payments for months on end. I really don't know how they were eating or living or anything. They had no where to live,
I'd first go in and **assess their health their mental state**, so if they were not really well psychologically I'd just sort of wait till they came back down. And usually when they got back out to the main population I'd start to really look at other needs that they had. But while they were in lock up it was more monitoring them, making sure that they had the care that they needed that was necessary and that it was done in an appropriate manner…

The **staff at the hospital** were pretty good.
You'd have particular ones that were really excellent.
And a lot of those, and a lot of the psych doctors that were from Iraq were absolutely terrific.

A lot of the **nursing staff had a really negative attitude**
and that was mainly around, well, 'that persons taken that many drugs and drunk that much alcohol and they're off their face and it's no wonder they're like they are'.
But they had no understanding of the issues that were under that,
which I thought was really bizarre,
'cause I thought you know if you were training to be a nurse in mental health,
wouldn't you have had all those reasons and possible underlying factors perhaps explained to you in that training?

Education

Q 20. How has the work you have done at university contributed to your practice, to these roles?

Oooh, now, ah, gee. Now if I was working in the government system
I would be able to understand to a better extent what actually is going on, how the policies are written how they're supposed to be implemented, are they being implemented?

Q 21. You've mentioned policies twice now…

Yes and just the way we do that, I mean I think there's a lot in the government system
and how health is delivered and how it's been delivered in the past to Aboriginal people.
I mean you can't get away from the medical model of health entirely.
You've really got to incorporate that wholistic approach as well.
So trying to blend this all in together I think will really, really help improve the health of Aboriginal people.
Did your understanding of this come from university study?
Oh yes…

Q 24. Is there any other particular area that you've studied and if you were giving advice to someone going into Aboriginal health that you would say were essential?

Well the essential things I think are things like, understanding human rights and social justice, professional practice, primary health care.
I mean primary health care, that never meant anything to me before until I started here.
So everywhere I go now, I look at it and think. You know what I mean?
I haven't done yet policy planning and evaluation but I'm interested in doing that.
Because as I said I want to look at how things are done, how the structure's set up even more.
Then I suppose those are the core things I would look at.
Then I'd say the other thing is whatever you love to do. What you know is your thing, whether it be mental health, drug and alcohol, community development.
Even community development's another core thing when you're first starting off know what I mean.
Because I don't imagine me going from here and having some top position somewhere.
I imagine I'm going to have to work hard and there's still a lot for me to learn.
So that community development stuff was really good to unpack how it all works and how you can actually improve things in communities. You know what I mean? How it works.

A1.6.2 Perspectives on practice: lexis

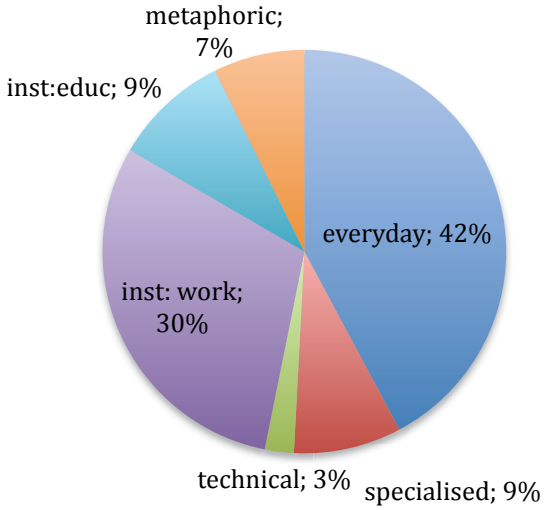

Figure A1.11: RH's proportions of lexical choices

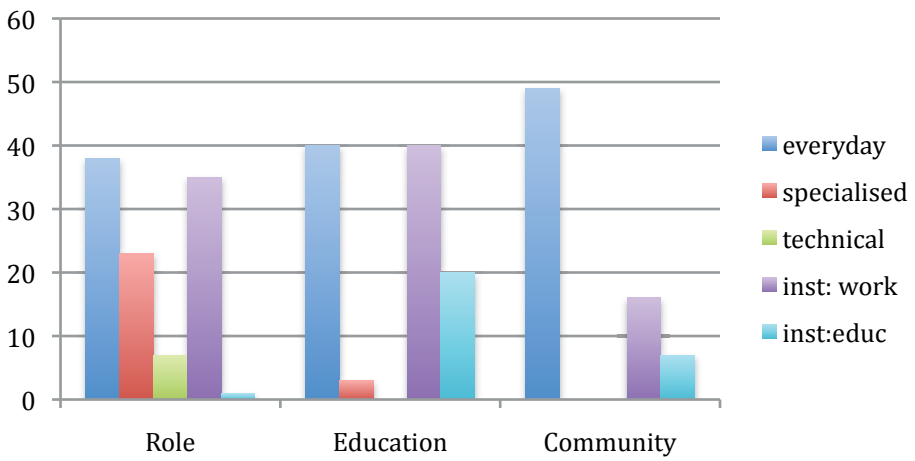

Figure A1.12: RH's lexical choices for each field

A1.6.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q7. Out of those positions can you describe to me what the work has been about?			
		Trying to get Indigenous people in contact with health services [iterated health services]	+tenacity
	I	did a lot of outreach work	+capacity
	I'd	actually go and meet the people in the community [iterated tasks]	+capacity
Q8. So had they been referred into the Unit?			
	most of my guys	were brought in by police	-normality
because	they	were in drug and alcohol induced psychoses [iterated mental illnesses]	-normality

So	it	was an acute unit that I was working in	+valuation
and	that	involved hooking up with them	+capacity
I used to call it the lock up, where	they	were watched, monitored 24 hours a day	-normality invoked
because	they	were a suicide risk	-normality
and then	they'd	be let out into the main population of the unit	
where	they	were still monitored very closely	-normality invoked
	A lot of them that I'd come across	they'd become so ill for so long	-normality
	them	it took a while to come back in contact with any sort of services	-normality
often	they'd	not have Centrelink payments for months on end	-propriety invoked
I really don't know	they	how were eating or living or anything	-propriety
	They	had nowhere to live	-propriety
so if	they	were not really well psychologically	-normality
	I'd	just sort of wait till they came back down	+capacity
And usually when	they	got back out to the main population	+normality
	I'd	start to really look at other needs	+capacity
But while they were in lock up,	it	was more monitoring them	
making sure		that they had the care that they needed that was necessary	+capacity
making sure		it was done in an appropriate manner	+capacity

Education

engagement	target	attitude/graduation	type
Q10. What would you say are the key sets of skills and knowledge you needed, to be able to do what you did?			
	is communication	Very first most important skill	+capacity
	[you]	to be able to communicate with clients, your work colleagues, whoever is out there	+capacity
	[you]	The ability to be able to communicate on multiple levels	+capacity
	you	have to be able to be really organized, really coordinated, really be able to allocate	+capacity
	[role]	just so many multiple skills that are involved	+capacity

when I first began in that family support	what	would have been so helpful	+valuation
Do you know what I mean?	I	would have been all the knowledge that I've learnt now, all that basic stuff of how that system works.	+capacity
I knew that	things	were wrong,	-propriety
but		to actually be able to pin point them	+capacity
and say "oh OK now	this	isn't working	-valuation
and	this	isn't just because people don't want to listen,	-valuation
you know	this	is the system problem	-valuation
and	it's	that the way the policy's been written that it's not working,	-valuation
and	this	is what needs to be looked at, the policy	-valuation
and then you know?	you	have to go ahead changing the policy and then implement that…	+capacity invoked
So	I	all those sorts of things I'm really starting to understand now and they've really opened my eyes up.	+capacity
so	that's	sort of a connection between the skills	soft focus
	you	like your personal attributes	+capacity
	you	what you're capable of doing,	+capacity
	you	and what your own code of conduct are and what you think about ethics what's your moral stance	+propriety
So	it's [role]	a whole conglomerate of personal being	+capacity
and then the other side	it [role]	all those systems, procedures, and how the world works	+capacity
	You	can have one, the skills is great	+capacity
but without the other	it's [role]	not going to be as effective and vice versa	-capacity
	you've	got to have the conglomerate of both	+capacity

Q12. You call it that 'other knowledge' tell me what you mean when you say that.

	[knowledge]	just your connection to your land, you know connection to your country, connection to your culture.	+capacity
just sort of	It's	inside of you	+capacity
and then if	you don't if you haven't got that connection	it's really difficult to explain	+capacity
	It	comes out in what you do	+capacity
so	it	really comes out in what you do	+capacity
and	Aboriginal people	know that	+capacity
I think in our communities too, I think	people	are scared as well	fear
I think that	people	are scared,	fear
that you know	a lot of us fellas	are starting to get training and getting the knowledge and going to universities and doing whatever course, doing TAFE courses or whatever	+capacity
and I think	people	are bit scared out there	fear
that	they're	actually trying to turn us white	-propriety
and	we're	going to go back to our communities and say 'you have to do it like this'	-propriety
so	[knowledge]	you've got to have the balance	

Q22. So if you compare what you learnt at TAFE versus what you've learnt at uni.			
Oh I think		there's really no comparison	-valuation invoked
I mean	at TAFE	you did learn stuff	+valuation
because	XX	was a dynamic teacher	+capacity
and	she	was university educated	+capacity
so	she	really knew her stuff .	+capacity
But	the stuff at university	it's at a different level.	+valuation
And	it's	really getting at the core, the core issues, the core inception of where sort of everything starts from	+valuation
And I'm just assuming	I'm	going to keep continuing to learn more and more and more	+capacity
and I think oh	I	know how that works	+capacity
and	I	how could possibly change those things	+capacity
Q23. What about its impact on you?			
	I've	metamorphosed to that many different things	+capacity
But	for me	it's really, really seemed to come together more this year	+capacity
and I've really started to think	I've	how much that I've changed in the way that I view things	+capacity
	I	not just in the way that I work but in the whole way I think, in my life personally	+capacity
and	I	the way I am approaching it is starting to become really different	+capacity

Community

engagement	target	attitude/graduation	type
Q15. And you had brothers and sisters?			
	[school]	we were singled out right from primary school	-propriety invoked
but now thinking back	[school]	I was stuck down the back of the class room doing something else while they were learning about history and Captain Cook and that	-propriety
	I	which I still don't know much about today	-capacity
	I	'cause I never bothered looking.	-capacity
You know, so	[school]	those sorts of things	-propriety soft focus
	I	could have been really channeled in a whole different way	-normality invoked
if	I	wasn't so strong in my convictions even from when I was young	+propriety
Q16. Where do you think that came from?			
I really think that that's got something to do with	me	me and my connection to my culture and my father	+propriety
	My father	was very… had very strong convictions	+propriety
and	[he]	had a lot of drive.	+capacity
I probably, looking at it now in hindsight, 'cause see	[me]	he died when he was forty one and I was only sixteen	-normality invoked
But looking at it now	[I]	and being older and understanding a bit more of how the world works	+capacity
	I've	probably got a lot more drive than what he had.	+capacity
But	we	had a really good connection, my father and I	affection

but, yeah so	I	went from high-school and did the factory bit which was horrible	antipathy
	[I]	got married and had kids cause that's what was expected of me.	antipathy invoked
	[I]	tried to work here and there just to feed everybody	+capacity
and	I	ran my own business for 10 years.	+capacity
and	I	worked 7 days a week for 10 years	+capacity
and I don't know	I	how I did it.	+capacity
	I	managed though,	+capacity
because see	I	could get somebody else in to fill in when my daughter was sick	-normality invoked
	we	just wouldn't say nothing and she'd do the work	+propriety invoked
and then	I'd	just come back in when my daughter was better	+propriety invoked
	I	could take the kids with me school holidays and stuff	+capacity
	I	took things with them to keep them occupied	+capacity

A1.7 DB

A1.7.1 Presenting practice: textual organisation

Role

Q1. Can you tell me the name of the job, your title, and then go on to describe it to me.

Look my title in this role is **Aboriginal Health Education Officer Chronic Care, with a diabetes focus** basically.
What we do in the role, I say we, because there's myself and a male partner in crime as I say,
and what we do is, our role is to target the Aboriginal clients and educate them on management of diabetes,
deliver education to the schools on chronic, chronic disease, diabetes,
to run programs such as exercise programs,
encourage the Aboriginal clients to use, utilise this service,
yeah support person, follow-up home visits.

We deliver **clinics as well in the community**.
We do four different clinics currently
and that's to cover all the different factions in the community.

Q2. Tell me what you mean when you say that.

Factions such as the different mobs, **different Aboriginal mobs** that like that one.
Bit like the Indians you know
like the Cherokee don't get on with the Sioux
and so that mob, they have their stuff happening in that that facility
and this mob and that one and this mob and that one
so we don't caught up in the politics of such.

And we just go to different locations
and offer a clinic, **deliver a clinic**.
What we do at these clinics is we do blood pressures, blood sugar checks,
we do one on one education.
We'll do group education
and just you know general support.
We do that on a fortnightly basis.

Q3. One clinic in each place every 2 weeks?

Every 2 weeks, yep
and we've done it, that was our choice, we've done it that way
because of the caseload that's increasing and basically the workload
and to allow us time to do those follow-up home visits
because we're getting more and more referrals from the GPs the doctors,
now that the word's got out there

Education

Q19. What would you say in terms of the skills that you are using? What do they consist of?

The skills, well I mean clinical skills, you need to have the clinical skills and that's
So that's the BSL and ...
Yeah that's doing your blood pressures and your blood sugars
and that's knowing how to read a pathology result you know which is a blood test result which comes with the patient or client now,
to read what their HBA1s they use or to read what their cholesterol is and to read what's happening with their kidneys.

Q20. Where did you learn to do that?

Well I actually learned to do that more when I was in community health when I went from the wards because basically when I was on the wards, enrolled nurses didn't have a lot of responsibility.
Then it was when I actually went into community health and was doing the primary health that,
I guess it's from self learning and your peers that you work with,' tell me what this is', 'how do I read this'.
So, and going off to different workshops, and so I learnt that through that
and of course the more you do it's just like riding a bike.

Q26. Have you done much anatomy and physiology?

Only, only in my nursing, I just can't remember whether we did some.
If we did some with – yeah we did do a little bit with the Bachelor of Health in Public and Community Health.
But there again like if you do the basics it's only when you're working with it, that, you know.
When I was nursing, like I never had a clue how the bloody heart worked you know.
But now I know that the heart is like the main pump and I explain it to my clients like it's like a pump that pushes the body, the blood around your heart and it's the way I sort of explain things too
Like I learn it simply so that I can explain it simply, and people really get the gist of it and they really understand it.
So, so you do need to have a basic knowledge of anat and phys.

Q27. Primary health?

Yeah definitely primary health, yeah definitely primary health, that's probably I guess – yeah primary health.
When you did that, what kind of things did they touch on?
Oh we – oh gosh I know we did health promotion you know and I remember health promotion.
Well basically we touched on what primary health was.
Because before that, before I actually did that course, I didn't really have much of an understanding of it.
I mean I had a basic understanding, but just sort of talked about more in depth about primary health and that it's preventative, that it's preventative and about health promotion.
How, different ways to get the word out there and what works for Aboriginal people and what doesn't, you know ?

A1.7.2 Perspectives on practice: lexis

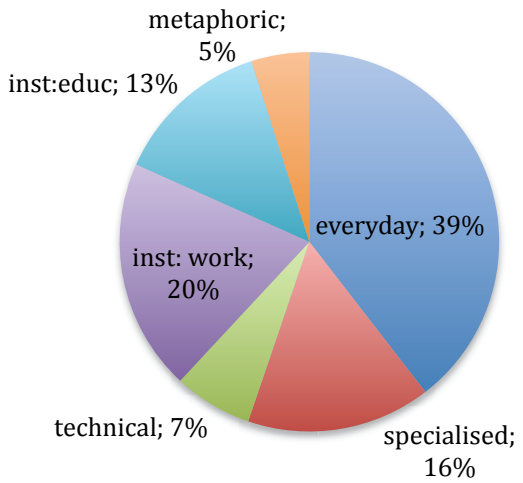

Figure A1.13: DB's proportions of lexical choices

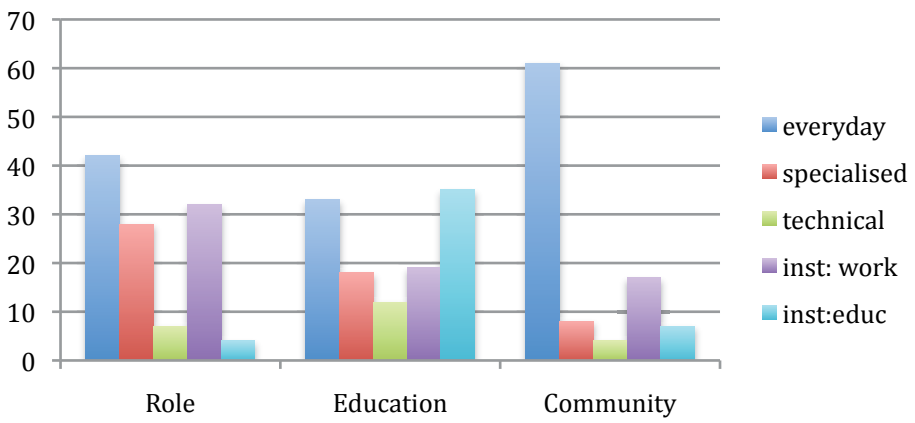

Figure A1.14: DB's lexical choices for each field

A1.7.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q1. Can you tell me the name of the job, your title, and then go on to describe it to me.			
Look	my title in this role	is Aboriginal Health Education Officer Chronic Care with a diabetes focus basically	soft focus
	in the role	What we do	
I say we, because	there's	myself and a male partner in crime as I say,	
and	what we do is, our role	is to target the Aboriginal clients [lists tasks]	+complexity
	We do	four different clinics currently	
and	that's	to cover all the different factions	+propriety
Q2. Tell me what you mean when you say that.			
	Factions	such as the different mobs, different Aboriginal mobs that like that one.	
Bit like the Indians you know like	the Cherokee	don't get on with the Sioux	-propriety
and so	that mob, they	have their stuff happening in that that facility and this mob and that one and this mob and that one	
So	we	don't caught up in the politics	+propriety
and	we	just go to different locations and offer a clinic	+propriety
Q3. One clinic in each place every 2 weeks?			
yep		Every 2 weeks	
and	that	was our choice	+propriety
	We've	done it that way	
because of	the caseload	that's increasing	
and	the workload	basically	soft focus
and	time	to allow us, us	
	referrals	more and more	sharp focus
	I	only been in this position since the middle of last year	-capacity
	it	kind of different	
	it	different sort of project	sharp focus
I guess you could say	it	really expanded	+valuation
	we do	home visits basically	soft focus
Here?			
	the cardiac rehab unit	We actually use	
	It's	slowly kicking off	+valuation
	we	never have high expectations in Aboriginal health	-reaction
but	the program	Rome wasn't built in a day	weak +valuation
so	we	don't get disappointed	+reaction
yeah as I said it's you know	the program	mainly for Aboriginal clients	soft focus
We're not saying	the program	Aboriginal only	soft focus
but we're encouraging	the program	Aboriginal only sort of	soft focus

Education

engagement	target	attitude/graduation	type
Q5. Tell me how you came to health			
Yeah, oh well	with me I	sort of always wanted to be a nurse…	desire soft focus
	I	left school in year 10	-capacity
and at that time	I	was very lucky	+ normality
and next thing	I'd	done…an enrolled nurses training	+capacity
Q6. Doing home visits?			
…Yeah so	**I**	did that for 15 years	+tenacity
but in between	I	did a Bachelor of Health in Public and Community Health	+capacity
Prior to that	I	actually part of a pilot program to do my registered nursing	+capacity
and	I	actually lasted 9 months	-capacity
and decided, no	it	wasn't what I wanted	-reaction
	it	I wasn't hungry for	-reaction
	I	was too stressed	insecurity
	The time	wasn't right	-valuation
Q12. What was in the course?			
I've always said that	Public and Community Health with an Aboriginal health focus	actually taught me a hell of a lot of more about my culture that I ever knew	+valuation
		stuff that I never really understood or knew or listened to	-capacity
yeah	I	really learnt through that	+capacity
	course	probably - helps you to find yourself as well	+valuation
	course	a pretty magic course really	+reaction
but	I	really grew from doing that	+capacity
you know	I	became a lot more confident	+capacity
I mean I say	I	all was a little pan carrier and you know back wiper sort of thing, and bum washer	-capacity
Yeah, yeah	I	really grew	+capacity
I always said	I'd	never go back to the wards	+capacity
you know	that community health	It really was what I was meant to do	+valuation
and	I	did lots of training over the years like in all areas	+capacity
because the expectation of the community, and even co-workers	as a generalist AHEO	is to have a better knowledge in all areas.	+capacity
So you know	I	did, I specialised in the otitis media	+capacity
	I	did the training in that	+capacity

Q33. Did the strength, you think come through the course or did it come through the fact that you were with a group of people that you were able to share together?

like I say now I can.		All of it, the education	
I really say to these young ones you know, or to people, like	education	is power	+valuation
	it (education)	really and truly is	+valuation
you know	you	the more you learn, the more you know, the more that, the bigger the confidence	+capacity
	my	understanding of my culture	+capacity
I guess	it (education)	made me even more proud of where I was at that stage in my life and of the path that I'd chosen to take	+valuation
I suppose	it (education)	did make me look at things differently	+valuation

Community

Q24. How do you manage that when you're a part of the community and at the same time you're employed?

engagement	target	attitude/graduation	type
I guess you know	[self]	that's by just being aware of people	+propriety
because I guess	I've	always worked in community health.	+capacity
And in community health	you	see lots of different families, lots of dysfunctional families, lots of people that float in and out of your town.	+capacity
I guess	you	just become sensitive to people from all walks of life	+capacity
I guess probably I think	to put it	the best way	+valuation
the fact that	you're	Aboriginal anyway,	+capacity
like I think	me	that's made even more sensitive	+capacity
because you know	you're	part of that Stolen Generation,	+capacity
	you're	part of racism,	+capacity
I guess	you're	part of, always having to, always, – just sensitive, just being really sensitive to all of that.	+capacity
I think	that's	a must in your role you know	+capacity
So I guess	the clinical side of it, that side of it		
and	the side	of being confident and assertive as well	+capacity
because	you	need to talk and liaise with doctors	+capacity
and	doctors	can be very intimidating people	-propriety
So you know	you	need to at least be able to get it across that you're confident anyway	+capacity
even if	you're	not as confident as what you'd like to be	-capacity
But at least		give that image	+capacity
I guess	you	need to be very motivated	+capacity
	You	need to yeah– it helps to love your job which I do	+reaction

A1.8 PN

A1.8.1 Presenting practice: textual organisation

Q1. Can you tell me what your position title is and what you do in that job?

I'm an Healthworker/Enhanced Primary Care Worker and what I do three days of it is I **look after our diabetic and chronic disease clients**.
Two days of those I'm out in the field seeing up to five or more people. We run through their health checks, GP management plans, diabetes plans, yeah and then come back chase up my referrals for all those. The appointments are made in the clinic, any specialist appointments they need, any bloods they need done, I do that. Any of our allied clinics we run here, I do that.
On Thursday and Fridays I am an Healthworker **in the clinic**, needed down in the clinic, any general observations, bloods, hearing tests, wounds, fixing up appointments, yeah basically…

Q2. On those three days when you're out in the field, describe a typical day.

So the week before I'll book in up to five people, times, an hour apart, give or take. I will get their Medicare billing ready, I have a doctor that comes out with me, one of the two registrars that'll come out with me, so like Monday I'll have a specific registrar that'll come out with me. We **go to the homes**, we run through their health checks, any referrals they need I'll jot all that down. I bring a laptop out with me so I can just get straight in their file which is much easier.

Q3. So when you say health check, what do you mean by that?

We **check them head to toe**. We run through questions, their family history, their medications, any illnesses they've got, any cancers in their family. We check their blood pressure, pulse, temperature, check their ears, eyes, teeth, any mental issues they have, I come back and I refer to our counselors. Yeah, any eye problems refer to the eye clinic, dental, hearing clinic, any feet problems for our diabetics, I run a podiatry clinic which I was doing today so I book them in for that.

Education

Q18. Did you do anatomy, like anatomy and physiology in the health worker course, can you remember sort of doing, you know…

We learnt a bit about stuff like that for blood pressures even though we weren't allowed to do blood pressures. We weren't allowed to do blood pressures in AIN.

Q19. So what was the focus of the AIN course?

That was mainly focused on aged care. So as if you were going to do aged caring work, so yeah that was mainly focused about that. **So lifting and…** Yeah, sprains, tears, skin tears, yeah. **Any of the psycho-social stuff like the aging process or…** Yeah, I think they did talk about stuff like that. Yeah.

Q20. So when you came to work here, did you find that the courses you'd done were a big help to the role you have here?

There would have been bits and pieces of the course that helped me work, started working here, with the health workers' course
because they talked about what everyone went through, getting taken away and the way our elders, you know, remember now
and like always respecting elders but just to try and find a way how to talk to them when they come into the service

Q25. …So you've got a certificate in pathology and that qualifies you to...

I can take bloods, do ECGs, swabs
And you learnt to do that, how did you...
Through Southern Pathology, here in Wollongong. Yeah.

Q26. So tell me what happened, so you didn't like...

... I reckon I probably would still have been doing it if I asked for help with the assignments.
That was … mind-blowing….
Go to class, go to the tutorials and listen to the people talk about different health things and your body and all that stuff

Q32. What's your view about qualifications and health worker roles, how do you see it?

I think they should have a Certificate that have done, like they've done an Healthworkers' Course,
I think they should have one to work on AMS.

Why?

To understands where Kooris have come from, because it teaches you, you know, history.
You've got to know what you're dealing with today with their health and their mental issues,
because yeah, they're still dealing with not so long ago stuff that's happened.
So you know you can't push them, so you know, get to this appointment, do this and do that, Koori time so whenever they can they will. Got to be patient, yeah.
Yeah, no I think, yeah, young people today if they're going to do the Healthworker Course they've got to do that.

A1.8.2 Perspectives on practice: lexis

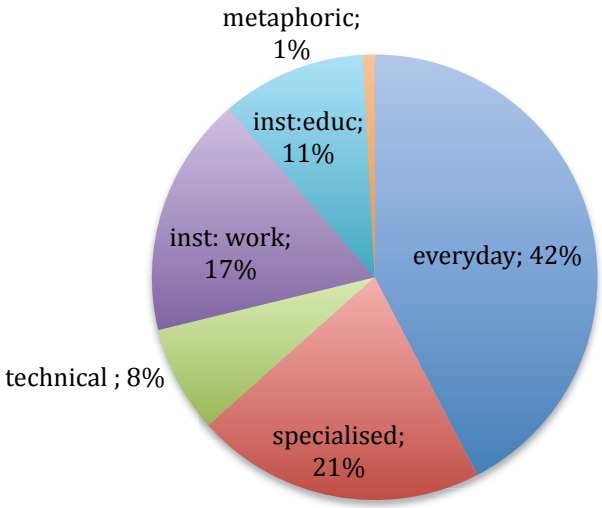

Figure A1.15: PN's proportions of lexical choices

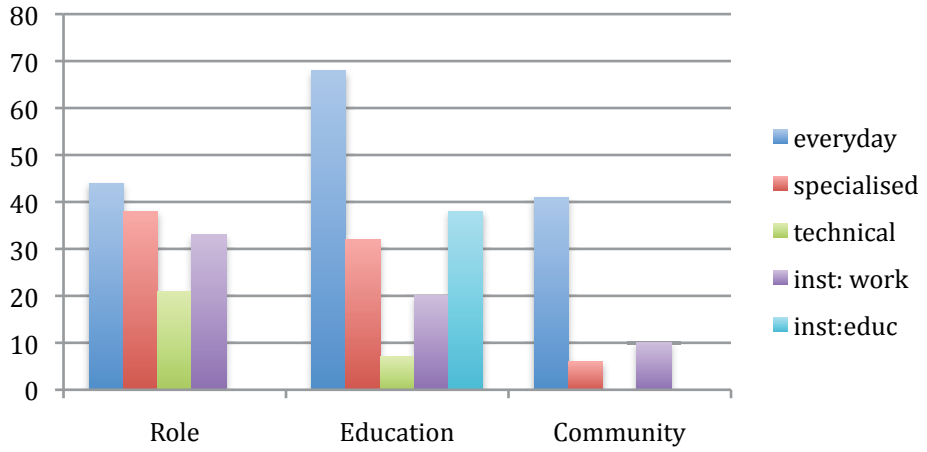

Figure A1.16: PN's lexical choices for each field

A1.8.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q2-5. Describe a typical day.			
So	I'm	trying to get through	+tenacity
	I've	just finished doing our, most of our diabetics,	+capacity
even if they're not diabetic	I	still go out and do health checks on them if they're due.	+capacity
and then	to get through all those	my goal is	+capacity
	and turn all those red ones blue,	which will be good.	+valuation
So then	I've	got to swing around and see all our diabetics and chronic disease clients again to do their care plans,	+capacity
So	I've	got to chase all that up	+capacity
Q6. And what is the care plan?			
	The care plan	is just making sure clients are seeing allied professionals	+valuation soft focus
		making sure medications fine	+valuation
		making sure they are handled okay	+valuation
		making sure sugars under control	+valuation
		making sure tablets correct for their heart conditions.	+valuation
So it gets sorted out at that moment?			
Yeah,		at that moment, at the house.	
And the clients	it	love	happiness
they	us coming out	love	happiness
	them	makes more comfortable	happiness
	I	can sort of suss out the house and how many people are in and out and hanging around	+capacity
	I	get an idea of how much affected their health	+capacity
yeah	I	can pick up on things	+capacity

Education

engagement	target	attitude/graduation	type
Q11. So if you started in 2003 how did you come to the role?			
	I've	always wanted to be a health, work in health,	desire
	my nan, my mum	was a health worker down at Eden, my mum was a nurse	+capacity invoked
so	I	decided to go and get it and did that	+capacity invoked
the teacher thought	I	was fine, I could handle it	+capacity
so	me	she put straight in to do the Assistant In Nursing course.	+capacity
so	I	did that	+capacity
Q14. What about when you were at school, did you…?			
	I	only went to Year 7.	-normality invoked
	I'm	the oldest of eight…	obligation invoked
so	I	helped,	+propriety
	I	left school Year 7 and decided to help pop, my grandfather, look after the boys.	+propriety
That wasn't in health?			
No. No,	that	was just something that came up	soft focus
so	I've	done that and… met my hubby and waited five years	
and	I	was just doing a bit of TAFE study and stuff around photography, other things and that, yeah.	+capacity soft focus
	myself	Just to sort of get myself back into like school type things	+capacity soft focus
How was that?			
	That	was really good	+valuation
	I	enjoyed it	happiness
because	it	was an Aboriginal class, all Kooris in there	+valuation
Q16. Having done the Certificate 3, what made you go on and do the AIN (Assistant in Nursing)?			
	I	didn't want to do the AIN	antipathy
my teacher kept saying look	you've	got the brains	+capacity
	you're	real cluey	+capacity
	you	can do it	+capacity
	you're	pretty good	+capacity
So	I	psyched myself up	+tenacity
and	she	managed to get me in there.	+capacity
And that was the main, so mainstream?			
Yeah	that	was mainstream	
	that	was hard	-reaction
Can you tell me about the difference?			
	people	are very ignorant about Koori culture	-propriety
	they	just don't get it	-propriety
Tell me, give me an example.			
	We're	in one class	
because	it	was only me and…	
	myself and E	were the only Kooris in the class out of 30 odd women there	sharp focus
we had	one situation	where we were talking	
and	the teacher	wanted to ask us about different cultures	desire
the women there	Aboriginals	just sit around drinking alcohol all the	-propriety

(said) "Oh but		time"	

Were you able to say anything?

we told them	the women	just being ignorant	-propriety
	the women	just didn't get it	-propriety
	I	ended up walking out of the classroom	antipathy

In front of the teacher?

	The teacher	jumped down their throats	+propriety
	she	was really good	+propriety
	she	told them off	+propriety

Q17. So when you came here how did you find that having had the Certificate 3?

	that	looks at the person's whole health and their family and everything around it, you know	+composition

And comes more from a primary health care? So how, did you find that those two went, you know?

	They (AIN course & Healthworker course)	didn't gel together	-composition
	The AIN	just very like cold type, yeah clinical	-reaction
	I	felt more comfortable doing the health workers' course	+security
	that	was terrific	+reaction
I think	it's	the best course I ever done	+valuation

Q25. Prompt: And I've heard you also went to uni and did nursing?

	I	tried uni for a year, oh my God!	

Tell me about that, if you can?

	the classroom,	I didn't like it at all.	dissatisfaction
	the way they teach you at the unit	"	dissatisfaction
I've said to the teachers there I said	this	is not the way it is out there	-valuation
and they said yeah, we know that but	this	is how we've got to teach it	obligation
Because	I've got my pathology certificate that	wasn't recognised at the uni	-propriety
	which	is I thought ridiculous	-propriety
	All the skill that I had, like I've got,	wasn't recognised there	-propriety

Community

engagement	target	attitude/graduation	type

Q41. Do you find that hard, being a part of the community and at the same time living this professional role?

sometimes	it	is hard especially when there's a death in the community with our elders	-reaction
If	it's	one of my clients that you know	
	I'm	not going to work, I'm going to a funeral.	+propriety invoked
If	they're	at the hospital and they're going to pass	
	I'll	be at the hospital	+propriety invoked
Yeah	that's	difficult	-reaction
I think of		the clients I've looked after	
		I expect that will happen down the track	
but	it's	still hard	-reaction
it's like yeah	mainstream people,	get the client in and out in 15 minutes	-propriety

	workers and that in clinics		invoked

And you know their families and you know their stories

	I	know	+capacity
some workers here [ask]	[I]	'I know this person can you track them down', detective as well, yeah	+capacity

So you're the source of a lot of that information?

	I	just have all these different things in my head that are sitting there	+capacity
one of the girls S [said]	you	oh you're the oracle, you're the oracle	+capacity
I thought	I	oh S don't	+reaction
	you	You know everything, you know that's going on around here	+capacity
	I	Oh no	+reaction

You're the ears and eyes.

Sometimes	I	just want to run away	disquiet
Yeah, but no,	[part of the community and professional role]	it's all good	+reaction
Yeah. I	working here	love	+reaction
	to be in health as well.	like	+reaction

A1.9 WH

A1.9.1 Presenting practice: textual organisation

Role

Q1. Can you tell me about your job, your job title and what you do?

I work for GWAHS, I'm an **Aboriginal Otitis Media Project Officer slash STEPS Project Officer**.
So I do, ah I go around and do the kiddies ears and whatever. I go around with an audiologist and then with the STEPS which is the State-wide Eyesight Preschool Screening, we go around and do the kiddies eyes.
It was meant to be just Aboriginal children, that's what the funding's for but now **it's everyone** which is good. Everyone's getting done, yeah so…

Q8. Just what do you do? What does it entail, as a job?

Well we go around and we, you know we **contact schools**, and that.
They've actually changed how they wanted us to do, by only referrals, which we thought, well no that's not going to work because we don't get referrals now from teachers, Child and Family Health nurses things like that
so we've, Sally and Mary just got together and put this big portfolio thing together and waiting to get that signed off by GWAHS.
But we've got a **new approach** now where we're just going to go out and do the kindergarten kids, Aboriginal kindergarten kids which is very similar to what it was it was the nought to six year olds before. But they had to move the target group, so now we're going out and we're doing that. And what we' do, we'll also, is we'll tell them if there is any other Aboriginal students they have concerns with, we'll also see them.

So me and Mary at the moment, Tuesdays are our days
we **ring the schools**
and we go around.
We went out to Town X last week,
we're going to Town Y this week, um then Town Z the following week,
and then doing the public schools around here.
So each Tuesday
and then we have a day back in the office to do our paper work and that.

And Mary is the audiologist that I work with.

Education

Q36. What are the primary or main skills you are using in both the roles you're doing at the moment or that you need?

How to use the equipment, how to write up paper work, data things like that.
What else? You got to have a good rapport with all government agencies, whether it be schools, you know doctors, whatever else
because they're your number one you know, that's who you've got to go to.
Always make sure your equipment's right.
You've got to be able to have excellent skills working with kiddies
because it's going to be very hard.

Q37. You make them sound not that big but they actually are big things aren't they

The audiogram well you've got to know how to, what numbers to push, or you know or what decibels to screen them at and things like that**…**

Q38. How to mark it…

How to mark it on your piece of paper you know
like you can get twenty five plus Db. you know hearing loss, dah, dah, dah.
which, that's usually when it's a Eustachian tube blockage or things like that, could be glue ear.
I'm only learning all this kind of stuff now
but I know there's bone conductive screening which I haven't done any of that yet.

Q41. You mentioned learning clinical skills when you were at TAFE, what kind of things did you learn there?

Blood pressures, taking blood pressures, pulses, what else .. do urinalysis,?
Blood sugars?
Yeah, blood sugar levels …
Sort of a baseline assessment…?
Similar to an EN. The role we done was very similar to an EN, only we didn't get signed off for all that part of it. Like we only got it done through TAFE, how do they say…simulatistically ….what do you call it…?

Q44. So we've talked about skills, using equipment and clinical skills, what about the knowledge you've talked about physiology, what else was a part of that course?

We just done, should've bought my resume. We just done, like reporting, case studies. What else? Drug and alcohol, our first aid,
Primary health care?
Yep, primary health care that's what the course was Cert 2 in primary health care. Yeah, we done primary health care and there was a lot that we only just done small bits on the subject but we passed it. Like only had the one session. Essay writing and..

A1.9.2 Perspectives on practice: lexis

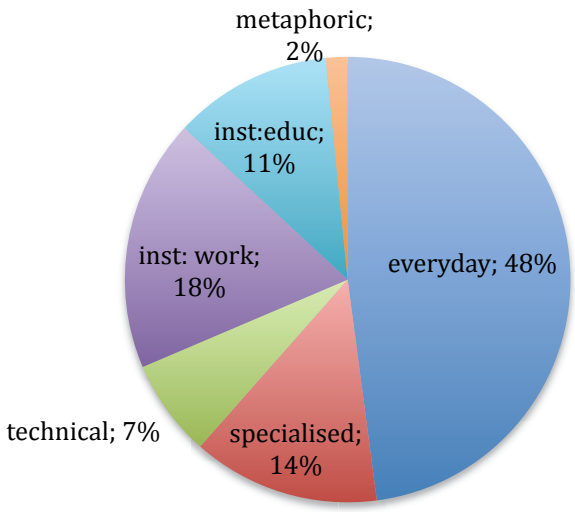

Figure A1.17: WH's proportions of lexical choices

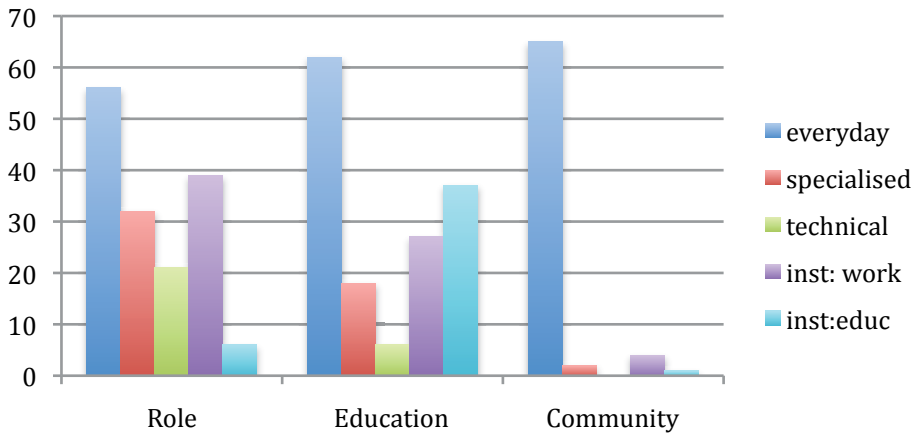

Figure A1.17: WH's lexical choices for each field

A1.9.3 Evaluating practice: appraisal

Role

engagement	target	attitude/graduation	type
Q19. OK, so tell me about the STEP side of the job and how that works.			
OK,	STEPS is the State-wide Eyesight Preschool Screening		
Now	what we do	is we just go out and do normal tests	-valuation soft focus
	I've	only more or less just started doing this	–capacity soft focus
But, yeah no,	we	just do the basic ones	-valuation soft focus
	We	haven't had that many kiddies	-valuation soft focus

If	it's	a priority	+valuation
like	some	might miss a couple of numbers on a line or whatever	soft focus
we'll say		OK	+reaction
but if	it's	one that's a high priority	+valuation
which means that you know	they've	missed a line or whatever	soft focus
	we	then pass it on to our clinical nurse consultant	-capacity invoked
I mean	I	don't know whether they check out to make sure everything's been followed up	-capacity invoked
but yeah	that's	how it goes	-capacity invoked
But usually	we'll	come back	
if	someone's	got a small issue	-valuation
		just ring the parents	soft focus
say 'look you know	it's	nothing to be concerned about'	-valuation
but	ours	is just a basic screen you know	-valuation
	[basic screen]	just to make sure they can see	+normality
and you know	"	that their eyes are you know the right way	+normality
and	"	not turned or anything	+normality
and you know 'if you think	there's	other concerns	-normality
maybe		take them off along to a you know optometrist'	

Q80. If you're going to be an Healthworker, what would you say are the most important skills that health workers need?

	compassion	that's the biggest one,	+valuation
	you	need compassion yep.	obligation
	It's	got to come from the heart	obligation
and	it's	'been there done that' experiences as well	+valuation
But	compassion	is one of the biggest things	+valuation
if	you're	not compassionate about your people	-propriety
or	you're	not compassionate about your job	-propriety
	you	don't do it	-capacity
because	for you	there's not a job there	-capacity
if	you	can't be like that	-propriety
You know	you've	got to, how would you put it, you've got to be there for them not judge them	+propriety

Education

engagement	target	attitude/graduation	type
Q55. You said that people who have been in positions for twenty years shouldn't have to do the Healthworker training. What difference has all the training made to you?			
Just that	where I've got to now like from what I've…		
	studying	I hated	antipathy strong force
and	it	I still hate now	antipathy strong force
	I'm	more a, I'm more a hands on than a book person,	-capacity
and	I	do have trouble you know writing things down on whatever,	-capacity
but	it's	something that I have to do	obligation
and	I'm	getting better at it	+capacity

Q56. When you say it's something you have to do what kind of things are you having to write? Things like stats…?

Oh, no, no, I don't mean	with that		
I mean with like	study wise		
Yes that's what I mean	study wise		
It's something like if	they	could sit there and they could ask me things,	
	I	could sit there and I could read it and whatever,	+capacity
but	as to putting it down on paper,	that's where it's you know, the hardest.	-capacity

Q57. What difference has your education made to you?

Well	my dad	couldn't read or write	-capacity
	I'm	really good at writing and reading, not essays things like that	+capacity -capacity
[I]	school	absolutely hated	antipathy strong force
they say	years are while you're at school.	the best	+valuation
but I	it [school]	absolutely hated	antipathy strong force
I want to show my kids that	what I done….	there's more to life than	-normality
	it's [education]	made a hell of a lot of a difference	+valuation strong force
I'm	what I'm doing	proud of	admiration
I	it	enjoy	happiness
I hope that	I'm	an inspiration to my kids and to their kids and whoever else.	+capacity
To just say to that you know like if	you	really put your mind to it	+tenacity sharp focus
	you	can do it.	+capacity
I mean	I	couldn't read…	-capacity
	I	could read and write	+capacity
	I'm	hopeless with maths and all that there	-capacity
	what	I'm proud of	admiration
I've you know,		actually achieved	+capacity sharp focus
I feel	to be…[that]	really obligated	obligation
people have	me	trust in	trust
you know let have, you know,	me	to give me the position in the first place	trust (invoked)
to prove to 'em	I	that I can do it.	+capacity

Community

Q35. But looking after your family and…

engagement	target	attitude/graduation	type
	about making changes for our people	I'm very passionate, very passionate	strong affection
and we do need	more health workers out there		obligation
You know like	to relate to other people	it's so hard to be able	-capacity
I thought	that job.	I want	desire
You know I	it…	really enjoyed	strong cheer

APPENDIX 2: Current Aboriginal and Torres Strait Islander Primary Health Care Qualifications

Certificate III Aboriginal & Torres Strait Islander Primary Health Care, HLT33207, Release 1 (CS&HISC 2012)

	14 Units of competency (13 core + 1 elective)
BSBNM201A	Process and maintain workplace information
HLTAHW301B	Work in Aboriginal and/or Torres Strait Islander Primary Health Care context
HLTAHW302B	Facilitate communication between clients and service providers
HLTAHW303B	Advocate for the rights and needs of clients and community members
HLTAHW304B	Undertake basic health assessment
HLTAHW305B	Plan and implement basic health care
HLTAHW306B	Provide information about social and emotional support
HLTAHW307B	Identify community health issue, needs and strategies
HLTAHW308B	Assists with basic health screening, promotion and education services
HLTFA301C	Apply first aid
HLTIN301C	Comply with infection control policies and procedures
HLTOH300B	Contribute to OHS procedures
HLTPOP307C	Provide information and support on environmental health issues
	1 elective from a list of 21

Aboriginal & Torres Strait Islander Primary Health Care Certificate III (HLT33207) is considered the 'minimum level' for Aboriginal Healthwork. It equips Healthworkers to work 'as part of a team with ongoing supervision and guidance' (Community Services and Health Industry Skills Council 2012, p. 3). The AQF (Australian Qualifications Framework 2013, p. 32-33) specifications for a Certificate III level states that graduates with this qualification will have: 'factual, technical, procedural and some theoretical knowledge of a ***specific area of work and learning***, …a range of cognitive, technical and communication skills to select and apply a specialised range of methods, tools, materials and information to complete ***routine activities*** and provide and transmit solutions ***to predictable and sometimes unpredictable problems***.' In addition they will 'apply knowledge and skills to demonstrate autonomy and judgement and take limited responsibility in known and ***stable contexts with established parameters'*** (2013, p. 32-33). The AQF also describes that the volume of learning is likely to be 1 to 2 years.

Certificate IV Aboriginal & Torres Strait Islander Primary Health Care Practice (ATSIPHC), HLT40213, Release 2 (CS&HISC 2013)

	21 units of competency (14 core + 7 electives)	Notes
CHCCS400C	Work within a relevant legal and ethical framework	
HLTAHW005	Work in an Aboriginal and/or Torres Strait Islander primary health care context	
HLTAHW006	Facilitate and advocate for the rights and needs of clients and community members	
HLTAHW016	Assess clients physical wellbeing	Not in HLT40113
HLTAHW017	Assess and support client's social and emotional well being	
HLTAHW018	Plan, implement and monitor health care in a primary health care context	
HLTAHW019	Deliver primary health care programs for Aboriginal and/or Torres Strait Islander communities	
HLTAHW020	Administer medications	Not in HLT40113
HLTAHW021	Provide nutrition guidance for specific health care	
HLTAHW022	Address social determinants of Aboriginal and Torres Strait Islander health	
HLTAHW037	Support the safe use of medications	
HLTAID003	Provide first aid	
HLTIN301C	Comply with infection control policies and procedures	
HLTWHS001	Participate in workplace health & safety	
7 elective units (at the same AQF level), including 4 from categories including: general, administration, age & disability care, alcohol & other drugs, burns treatment, cancer care, chronic disease care, community development, community services, ear and hearing health, family and community violence, health promotion, maternal and infant health*, mental health, mentoring, nutrition, oral health care, pathology*, policy development, smoking cessation, workplace training, youth work. *specific to HLT402313		
An additional 3 electives can be chosen from any other endorsed Training Package		

This Certificate IV ATSIPHC (HLT40213) qualification includes the units of competence that address the legislative requirements for practice as an Aboriginal Health Practitioner as per the national registration criteria set down by the Aboriginal and Torres Strait Islander Health practice Board of Australia. Aboriginal Health Practitioners with a Certificate IV in ATSIPHC (HLT40213) have a scope of practice that includes the provision of 'a range of primary health care services to Aboriginal communities including specific health care programs, advice and assistance with, and administration of medication' (HLT40213, Community Services and Health industry Skills Council 2013, p. 2). The AQF (Australian Qualifications Framework 2013, p. 35-36) specifications for a Certificate IV level states that graduates with this qualification will have 'theoretical and practical knowledge for ***specialised and or skilled work***… a range of cognitive, technical and communication skills to select and apply a specialised range of methods, tools, materials and information to complete ***routine and non routine*** activities and provide and transmit solutions to ***a variety of predictable and sometimes unpredictable problems'***.' In addition they will 'apply knowledge and skills to demonstrate and autonomy, judgement and limited responsibility in known or ***changing contexts*** and within established parameters'(Australian Qualifications Framework 2013, p. 35-36).

Certificate IV Aboriginal & Torres Strait Islander Primary Health Care (ATSIPHC), HLT40113, Release 2 (CS&HISC 2013).

	21 units of competency (14 core + 7 electives)	Notes
CHCCS400C	Work within a relevant legal and ethical framework*	
HLTAHW005	Work in an Aboriginal and/or Torres Strait Islander primary health care context*	
HLTAHW006	Facilitate and advocate for the rights and needs of clients and community members*	
HLTAHW007	Undertake basic health assessments	Not in HLT40213
HLTAHW017	Assess and support client's social and emotional well being	
HLTAHW018	Plan, implement and monitor health care in a primary health care context	
HLTAHW019	Deliver primary health care programs for Aboriginal and/or Torres Strait Islander communities	
HLTAHW021	Provide nutrition guidance for specific health care	
HLTAHW022	Address social determinants of Aboriginal and Torres Strait Islander health	
HLTAHW023	Plan develop and evaluate health promotion and community development programs	Not in HLT40213
HLTAHW037	Support the safe use of medications	
HLTAID003	Provide first aid	
HLTIN301C	Comply with infection control policies and procedures	
HLTWHS001	Participate in workplace health & safety	
7 elective units at the same AQF level including 4 from categories including general, administration, age & disability care, alcohol & other drugs, burns treatment, cancer care, chronic disease care, community development, community services, ear and hearing health, family and community violence, health promotion, mental health, mentoring, nutrition, oral health care, policy development, smoking cessation, workplace training, youth work.		
An additional 3 electives can be chosen from any other endorsed Training Package		

The ATSIPHC Certificate IV (HLT40113) is at a level that should enable Healthworkers to register with the Aboriginal and Torres Strait Islander Healthworker Practice Board of Australia, although at the time of writing 'no licensing, legislative or certification requirements applied to the qualification' (Community Services & Health Industry Skills Council 2012, p. 2). This qualification enables Healthworkers 'to provide a range of non-clinical primary health care services…in a variety of job roles and undertake a broad range of tasks either individually or as a member of a multidisciplinary team.' (Community Services & Health Industry Skills Council 2012, p. 2). It differs from the ATSIPHC Certificate IV (HLT40213) in that it does not include any competency units 'Assess clients physical wellbeing' (HLTAHW016) or Administer medications (HLTAHW020).